pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HUGH ROBINSON**
LEGAL ENTITY

To operate **ROBINSON PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **4104 WEST GIRARD AVENUE, PHILADELPHIA, PA 19104**
(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 **20**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

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 **December 17, 2024** until **June 17, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **198811**

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: DECEMBER 17, 2024

[redacted] Robinson
Administrator
[redacted]
4104 West Girard Avenue
Philadelphia, Pennsylvania 19104

RE: Robinson Personal Care Home
License #: 198811

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection May 9, 2024, June 14, 2024, and July 9, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 198810 dated August 25, 2024 to August 25, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated August 25, 2024 to August 25, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 17, 2024 to June 17, 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.

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]

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
[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

[redacted]

Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted], Office of General Counsel
[redacted], Director, Bureau of Human Services Licensing
[redacted], Director of Operations
[redacted], Regional Director, Bureau of Human Services Licensing

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

Facility Information

Name: *ROBINSON PERSONAL CARE HOME* **License #**: *19881* **License Expiration**: *08/25/2024*

Address: *4104 WEST GIRARD AVENUE, PHILADELPHIA, PA 19104*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *HUGH ROBINSON*

Address: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/14/2012* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *05/09/2024*

Inspection Dates and Department Representative

05/09/2024 *On Site*: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *20* **Residents Served**: *16*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *16* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

05/09/2024 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *06/08/2024*

06/14/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/04/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/19/2024*

06/24/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/04/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/05/2024*

07/31/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/04/2024*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident 1 is prescribed [redacted], one tablet by mouth daily as needed for [redacted]. However, Resident 1 was administered [redacted] resulting in a medication error. The home did not report this incident to the department.

Resident 1 is prescribed [redacted], take one tablet by mouth daily as needed for [redacted]. However, Resident 1 was administered [redacted] resulting in a medication error. The home did not report this incident to the department.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

*** A written incident report was sent to the Department of Human Services on 5/9/24 immediately after the Inspection, the prescriber was also notified on 5/9/24. The home has obtained a Narcotic count book on 5/15/24 to track all narcotic medication. Starting on 5/15/24 the administrator briefs all direct care staff members on the importance of updating the narcotic records and to report any errors to the administrator. The Administrator/Designee will ensure that all medication error reported to the Department of human services and all other relevant authority. Starting on 7/1/24 the Administrator/designee will check 1/3 of resident's narcotic log monthly to ensure appropriate recordings. Staff training was completed by a certified train the trainer personal on 6/9/2024 regarding reportable incidents.*

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/31/2024)

42b - Abuse

2. 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] at approximately [redacted], Resident 1 had [redacted]. Resident 1 had a pro re nata (PRN) prescription of [redacted] for this purpose, however, there were no staff in the home that evening or overnight who were authorized to administer medication. Resident 1 soiled their clothes a total of three times overnight from [redacted] into [redacted]. On the morning of [redacted], when the medication was available to the resident, the [redacted] had subsided.

On [redacted] staff person B, [redacted], provided a 2 week staffing schedule dated 6/19/23 through 7/2/23. Staff person B reported that the schedule is ongoing and accurately reflects current staffing of the home. On a regular basis, there is no staff available in the home certified in first aid, obstructed airway techniques and CPR during the following times:

- *every other Sunday, from 7 am to 7 pm, beginning 6/25/23.*
- *every other Tuesday, from 8 pm to 7 am, beginning since 6/27/23.*

42b - Abuse (continued)

- every other Wednesday, from 8 pm to 7 am, beginning since 6/28/23.

Plan of Correction ***Accept (- 06/24/2024)***

** The home immediately revised the staff schedule and made changes as per violation on 5/9/24. As of 5/9/24 the schedule has a certified CPR/First Aid staff on schedule at all times. Medication training is schedule to be completed by 7/31/24 by a certified train the trainer personal. After which the schedule will have a staff who is certified and authorized to administer medication on schedule at all times. Attached please see copy of staff schedule with CPR certified staff also a copy of all CPR training.

** With the resident right to not be neglected, the home will ensure medication is administered on schedule according to MAR started immediately on 5/9/2024. The Administrator/designee will conduct spot check every 3 months starting July 1, 2024, for Medication and CPR certifications to ensure all staff members are up to date with medication and CPR requirements.

Licensee's Proposed Overall Completion Date: 07/01/2024

Not Implemented (- 07/31/2024)

51 - Criminal Background Check

3. Requirements

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

Description of Violation

Staff member A was hired on [redacted] The staff member's Pennsylvania criminal background check was completed on [redacted]

Plan of Correction ***Accept (- 06/24/2024)***

** Staff member (A) who was hired on [redacted] as a Direct care Assistant, at the time of employment staff member (A) had a Criminal Background check recently completed in Baltimore, Maryland. The Pennsylvania background check was not completed at the time of employment because staff member (A) was not living in the state of Pennsylvania for more than 2 years prior to being employed at the home. The home now understands that employees that have not reside in Pennsylvania for a duration of at least 2 years will need to have an FBI background check completed prior to being employed in the home. The Pennsylvania criminal Background Check was immediately obtained on 5/9/24 during the inspection. The administrator/hiring staff will prioritize Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102), and 6 Pa. Code Chapter 15 as a part of the hiring process. The Administrator/Designee will review employee files annually to ensure all employees record including Pennsylvania background checks are on file starting July 1, 2024.

Licensee's Proposed Overall Completion Date: 07/01/2024

Not Implemented (- 07/31/2024)

63a First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

Based on the schedule provided by the home no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR at the following times:

- *every other Sunday, from 7 am to 7 pm, since 6/25/23*
- *every other Tuesday, from 8 pm to 7 am, since 6/27/23*
- *every other Wednesday, from 8 pm to 7 am, since 6/28/23*

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

*** The home's schedule is now equipped with staff that is trained in CPR/First Aid. In the future the Administrator/Designee will ensure that all staff hired will be trained in CPR/First Aid prior to being on the schedule. The administrator/designee will check every 3 months to ensure that all staff are trained in CPR/First Aid starting July 1, 2024. Please see attachment for copy of missing CPR training.*

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/31/2024)

85b Infestation

5. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 5/9/24, at 11:30 am, there were mouse droppings in the bureau drawers of Room 3.

Plan of Correction ***Directed [redacted] - 06/24/2024)***

*** All mouse droppings were removed immediately after inspection and exterminator called to service the home on 5/9/24 and the extermination was done on 6/5/24. Exterminating materials was bought and dispense throughout the home. All staff members will spot check periodically throughout their shifts for mouse droppings, cleaning the entire area and report it to the administrator immediately. The administrator will immediately schedule on exterminator to do a full building sheep for mouse extermination.*

*** The administrator will also ensure that monthly extermination is done by a professional Exterminator starting 6/5/2024.*

Proposed Overall Completion Date: 06/18/2024

In addition to the above mentioned plan: Within 3 days of receipt of the accepted plan of correction, the administrator or designee, shall monitor the home weekly for potential causes of infestation and signs of infestation. The audits shall be conducted for 3 months. Documentation will be kept.

85b - Infestation (continued)

Directed Completion Date: *07/01/2024*

Not Implemented [redacted] - 07/31/2024)

85e - Trash Outside Home

7. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/9/24, there were three uncovered trash cans, and one trash can with a hole in the lid, behind the home. There was also one uncovered trash can out front of the home.

Plan of Correction ***Directed (CE - 06/24/2024)***

*** The trash can that was found uncovered in the backyard is now covered and the trash receptacle that was found with hole in the lid was repaired on 5/10/24. The uncovered trash can in front was also discarded on 5/9/24. Started on 5/10/24 All staff members will check for uncovered and damaged trash cans throughout their shifts and cover them. In addition, all staff members will report damaged trash cans to the administrator/designee for immediate repair or replacement when necessary. In the future all staff members are responsible for closing a trash can immediately after usage. Trash can usage oral training was completed on 5/10/2024*

85e - Trash Outside Home (continued)

Proposed Overall Completion Date: 06/18/2024

In addition to the above mentioned plan: Within 3 days of receipt of the accepted plan of correction, the administrator or designee shall check the home weekly to ensure sanitary conditions are maintained, including that trash outside the home is kept in covered receptacles. The audits shall be conducted for 3 months. Documentation shall be kept

Directed Completion Date: *07/01/2024*

Implemented [redacted] - 07/31/2024)

88a - Surfaces

8[redacted]

[redacted]

88a - Surfaces *(continued)*

Implemented ([redacted] - 07/31/2024)

94b - Non-Skid Surface

9. Requirements

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

Description of Violation

The stairs leading to the upper floors of the home do not have a non-skid surface.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

*** Non-skid strips were purchased on 6/3/24 and installed on 6/7/2024. Started on 6/7/2024 all staff members are responsible for checking and reporting of any non-skid strips in the home. Administrator verbally spoke with each staff member at the beginning of their shift about the reporting of any damage non-skid stripes started on 6/7/2024. The administrator is responsible for repairing or replacing any damaged non-skid stripes.*

Licensee's Proposed Overall Completion Date: *06/18/2024*

Implemented ([redacted] - 07/31/2024)

101j3 - Bed/Linens/Pillows/Blankets

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 5/9/24, there was a brown, dried substance on the bed sheets in room 2.

Repeat Violation: 5/31/23.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

*** Bed linen was removed, and mattress was checked for substance and sterilized. Bed was made with clean linen on 5/9/2024. The administrator conducted a face to face at the beginning of staff members shift to explain the importance of clean linen and substance usage start on 5/10/2024 and ended on 5/26/2024*

*** All Staff members will do linen inspection throughout their scheduled shift going forward started on 5/10/2024.*

Licensee's Proposed Overall Completion Date: *06/18/2024*

Implemented ([redacted] - 07/31/2024)

131f - Fire Extinguisher Inspection

11. 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.

131f - Fire Extinguisher Inspection *(continued)*

Description of Violation

The fire extinguishers in the first floor hallway and on the second floor had no inspection tags.

Plan of Correction ***Accept (- 06/24/2024)***

*** Fire extinguisher tag was removed by one of our residents. Fire extinguisher with updated tags was replaced immediately on 5/9/24. Started On 5/10/2024 administrator briefings about the importance of the fire extinguisher tag and why all extinguishers need to have a tag at all times. On 5/26/2024 the administrator had covered the entire staff roster with the fire extinguisher tag knowledge.*

*** All Staff members will check extinguisher tags throughout their scheduled shift started on 5/10/2024.*

Proposed Overall Completion Date: 06/18/2024

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 07/31/2024)

132b - Safety Inspection/Fire Drill

12. Requirements

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

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 2/9/2023.

Plan of Correction ***Accept - 06/24/2024)***

*** A fire safety inspection completed on 6/7/2024 by the fire safety expert (Philadelphia Fire Department). The administrator/designee will spot check bi-annual the fire drill records and schedule the fire department with adequate amount of time to do annual inspection started on 6/7/2024. The administrator will ensure that a fire safety inspection is done year to date.*

**Attached please see copy of fire safety inspection that was done.*

Licensee's Proposed Overall Completion Date: *06/18/2024*

Implemented - 07/31/2024)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

141a 1 10 Medical Evaluation Information *(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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 1's medical evaluation dated [redacted] did not include medication regimen, contraindicated medications, medication side effects and the ability to self administer medications.

Repeat Violation: 5/31/23.

Plan of Correction ***Directed ([redacted]- 06/24/2024)***

*** Medical Evaluation for resident 1 dated [redacted] now include resident ability to self administer, and a medication regimen was included on the medical evaluation at the time of inspection. The Administrator/Designee is responsible and will ensure all that the Medical Evaluation is completely filled out and all required fields are reviewed started on 6/6/2024. The administrator will spot check medical evaluations every 6 months and make necessary changes.*

** Staff training was completed on 6/6/24 for medical evaluations by the administrator.*

Proposed Overall Completion Date: 06/18/2024

In addition to the above mentioned plan: Within 10 days of receipt of the accepted plan of correction, the administrator or designee shall review all current medical evaluations to ensure medical evaluations are completed timely, accurately and in their entirety to include a medication regimen. Any incomplete medical evaluations will be returned to the physician for completion or new in person medical evaluations will be scheduled and completed. Documentation of audit shall be kept.

Directed Completion Date: *07/05/2024*

Implemented [redacted] 07/31/2024)

141b1 - Annual Medical Evaluation

14. 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 8/22/2023

141b1 - Annual Medical Evaluation (continued)

. The resident's previous medical evaluation was completed on 7/19/22.

Repeat violation: 6/28/23

Plan of Correction ***Accept (- 06/24/2024)***

***The administrator/designee started the check for dates of renewal of all resident's medical evaluation record to quality check for dates of renewal. Administrator/designee are responsible and will ensure that all medical evaluation records are up-to-date and updated annually. The administrator/designee will also conduct a monthly audit of medical evaluations starting 7/1//2024*

Licensee's Proposed Overall Completion Date: *06/18/2024*

Implemented (- 07/31/2024)

183d - Prescription Current

15. 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 prescribed for Resident 1, was in the home's medication cart; however, the individual does not have a current order for this medication.

Plan of Correction ***Accept - 06/24/2024)***

** Resident (1) do have a current prescription/order for , but the Pharmacy did not provide an updated MAR. An updated MAR was received from the pharmacy on 6/1/24. Starting 7/1/24 The administrator/designee are responsible for checking the MAR monthly to ensure all medication(s) are listed and accounted for. In the future all Direct care staff will check to ensure MAR received from pharmacy has all necessary information started on 5/10/2024.*

** Attached please see current order for said spray.*

**Attached please see copy of current MAR with listed.*

Proposed Overall Completion Date: 06/18/2024

Licensee's Proposed Overall Completion Date: *06/18/2024*

Not Implemented - 07/31/2024)

185a - Implement Storage Procedures

16. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

The home does not maintain narcotic count sheets, nor a record of narcotic administrations or disposals, aside from the medication administration record. On 5/9/2024 there were 2 Diazepam 2 mg tablets and 3 Tramadol HCL 50 mg tablets, all prescribed to Resident 1, unaccounted for.

Plan of Correction ***Directed (- 06/24/2024)***

** The home purchased a narcotic book to administrate all narcotic records on 5/10/24. The administrator/designee are responsible for the updating and maintenance of the Narcotic records. The administrator/designee will conduct spot check quarterly updates and disposal starting 7/1/2024. All staff members will be trained on how to properly maintain the Narcotic records. Narcotic records are now up to date as of 5/15/24.*

Proposed Overall Completion Date: 06/18/2024

In addition to the above mentioned plan: Within 3 days of receipt of the accepted plan of correction, a narcotic count shall be conducted by the administrator or designee weekly. The audits shall be conducted for 3 months. Documentation will be kept.

Within 5 days of receipt of the accepted plan of correction, all staff persons qualified to administer medication shall be educated on how to maintain narcotic records. Documentation will be kept.

Directed Completion Date: *06/18/2024*

Not Implemented - 07/31/2024)

187b - Date/Time of Medication Admin.

17. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 1 is prescribed tablet. Resident 1's May 2024 medication administration record does not include the initials of the staff person who administered .

Resident 1 is prescribed . Resident 1's May 2024 medication administration record does not include the initials of the staff person who administered

Plan of Correction ***Directed (- 06/24/2024)***

***As of 5/9/24 the MAR is up to date with signatures. The administrator/designee will have a training/refresher course a medication administered recordings. The administrator/designee are responsible for maintaining and making sure all medications that is administered is signed in the MAR immediately after it is given to residents. Started on 7/1/24 there will be spot checks done by the administrator/designee quarterly to ensure the upkeep of all medications administered and reported in the MAR.*

187b - Date/Time of Medication Admin. (continued)

Proposed Overall Completion Date: 07/01/2024

Immediately: A designated staff person qualified to administer medications shall review all resident MARs at least weekly to ensure the proper documentation of medication administration at the time of administration. The audits shall be conducted for 3 months. Documentation of reviews shall be kept.

Within 10 days of receipt of the accepted plan of correction: All staff persons qualified to administer medications shall be re-educated on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education shall be kept.

Directed Completion Date: *07/05/2024*

Not Implemented (- 07/31/2024)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident 1 is prescribed , one tablet by mouth daily as needed for pain. However, Resident 1 was administered .

Resident 1 is prescribed , take one tablet by mouth daily as needed for anxiety. However, Resident 1 was administered .

Plan of Correction ***Directed - 06/24/2024)***

*** A written incident report was sent to the Department of Human Services on 5/9/24 immediately after the Inspection, the prescriber was also notified on 5/9/24. The home has obtained a Narcotic count book to track all narcotic medication. The Administrator/Designee will ensure that all medication error will be reported to the Department of human services and other relevant authorities immediately are notified. Started on 5/9/2024 the Administrator/designee will brief all medication certified staff members on the importance of reporting medication errors to the administrator immediately after occurring. The administrator/designee will conduct quarterly spot checks to maintain medication error reports starting on 7/1/24.*

Proposed Overall Completion Date: 07/01/2024

Immediately: The administrator or designee qualified to administer medications shall complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b).

In addition to the above mentioned plan: Within 3 days of receipt of the accepted plan of correction, the

187d - Follow Prescriber's Orders (continued)

administrator or designated staff person qualified to administer medications shall monitor medication administration at least twice a week and monitor all resident MAR's at least weekly to ensure all resident medications are administered as prescribed. The audits shall be conducted for 3 months.

Documentation of all training and audits shall be kept.

Directed Completion Date: *07/01/2024*

Not Implemented [redacted] - 07/31/2024)

188b - Medication Error Reporting

19. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 1 is prescribed [redacted], one tablet by mouth daily as needed for [redacted]. However, Resident 1 was administered [redacted]. These medication errors were not reported to the prescriber until [redacted]

Resident 1 is prescribed [redacted], take one tablet by mouth daily as needed for [redacted]. However, Resident 1 was administered [redacted] am and Noon. These medication errors were not reported to the prescriber until [redacted]

Plan of Correction ***Directed ([redacted] - 06/24/2024)***

*** A report of the incident was sent to the Department of Human Services on 5/9/24 immediately after the Inspection, and the prescriber was also notified on 5/9/24. Started on 5/9/2024 the Administrator/designee will brief all direct care staff members on the importance of reporting medication errors to the administrator immediately after occurring. The Administrator/Designee will ensure that all medication error gets reported to the Department of human services and other relevant authorities immediately are notified. The administrator/designee will conduct quarterly spot checks to maintain medication error reports starting on 7/1/24.*

Proposed Overall Completion Date: 06/19/2024

In addition to the above mentioned plan: Within 3 days of receipt of the accepted plan of correction, the administrator or designee shall monitor medication administration at least twice a week and monitor all resident MARs at least weekly to ensure any medication errors are properly reported. The audits shall be conducted for 3 months.

Documentation of all training and audits shall be kept.

Directed Completion Date: *07/01/2024*

Not Implemented ([redacted] - 07/31/2024)

224a - Preadmission Screen Form

20. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 3's preadmission screening form, dated [redacted], does not include a determination that the resident can safely handle poisonous materials.

Plan of Correction ***Directed [redacted] - 06/24/2024)***

*** On [redacted] esident (3) pre-screening records were updated stating that resident can safely handle poisonous material. On [redacted] the Administrator/Designee scheduled pre-screening refresher training to all staff members. The training was completed on 6/6/24. Starting on 7/1/24 The Administrator/designee will conduct checks of residents pre-screening every 3 months to ensure all records are updated.*

Proposed Overall Completion Date: 06/24/2024

In addition to the above mention plan:

Immediately: The administrator or designee shall review all resident records to ensure all residents have a preadmission screening completed, including documentation that the home can meet the needs of the resident, and the Department's preadmission screening form is present in each resident record. Documentation of the audit shall be kept.

Directed Completion Date: *06/26/2024*

Implemented ([redacted] - 07/31/2024)

225a - Assessment 15 Days

21. 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 1's assessment, signed [redacted], does not include a date on the front page.

Resident 3's assessment, is signed, but not dated on the front page or signature page.

Plan of Correction ***Directed ([redacted] - 06/24/2024)***

*** Administrators update RASP with all required dates on [redacted] Started on [redacted] the Administrator/Designee ensure the RASP is completed within 15 days of admission. The Administrator/designee will conduct checks of all RASP every 3 months to ensure all records are updated. The Administrator schedule training to refresh staff members on RASP, training was done on 6/6/24.*

** Attached please see copy of signed assessment.*

Proposed Overall Completion Date: 06/19/2024

225a - Assessment 15 Days (continued)

In addition to the above mentioned plan:

Within 5 days of receipt of the accepted plan of correction, the administrator or designee shall review all resident assessments for accuracy and completion. Any incomplete or inaccurate assessments will be corrected immediately.

Directed Completion Date: *06/30/2024*

Implemented (- 07/31/2024)

227d - Support Plan Medical/Dental

[redacted]

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

Facility Information

Name: *ROBINSON PERSONAL CARE HOME* **License #**: *19881* **License Expiration**: *08/25/2024*

Address: *4104 WEST GIRARD AVENUE, PHILADELPHIA, PA 19104*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *HUGH ROBINSON*

Address: *4104 WEST GIRARD AVENUE, PHILADELPHIA, PA, 19104*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/14/2012* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *06/14/2024*

Inspection Dates and Department Representative

06/14/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *20* **Residents Served**: *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *17* **Are 60 Years of Age or Older**: *16*

Diagnosed with Mental Illness: *17* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

06/14/2024 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *07/01/2024*

07/09/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/19/2024*

07/31/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2024*

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

20b1 - Financial Records

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages the finances for resident 1. However, The home does not maintain a record of financial transactions.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The home update financial records and will maintain all financial transactions. The administrator/designee will be responsible for recording financial transactions with residents, including the dates, amounts of deposits/withdrawals along with the balance. In addition, the administrator or designee will conduct quarterly audit to ensure residents financial records are being maintained and managed correctly started on 07/01/2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented [redacted] - 07/31/2024)

20b3 - Written Receipts

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

The home has been giving resident #1 cash disbursements of roughly [redacted] at a time since April 2024. However, the home did not obtain the resident signature for the receipts of the disbursements.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

The home updated financial records and will maintain all financial transactions. The administrator/designee will be responsible for making sure there is a written receipt for all cash disbursement at the time of disbursement. In addition, the administrator or designee will conduct quarterly audits to ensure residents financial records are being maintained and managed correctly started on 07/01/2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented [redacted] - 07/31/2024)

85b - Infestation

3. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 6/14/2024 at 9:45 am, a roach crawled out of a vent above the baseboard in the dining room and was scaling the dining room wall.

85b - Infestation *(continued)*

Plan of Correction ***Accept [redacted] - 07/09/2024)***

*** Exterminating materials was bought and dispense throughout the home. All staff members will check periodically throughout their shifts for any visible sign of insects or rodents and report it to the administrator immediately. The administrator will immediately schedule exterminator to do a full building sweep for any form of insects or rodents. ** The administrator/designee will monitor the home weekly for potential causes of pest and signs of pest. The audit was start on 07/01/2024 and will be conducted for 3 months.*

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented [redacted] - 07/31/2024)

221a - Program Activities

4. Requirements

2600.
221.a. The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

Description of Violation

The home has not implemented a program of activities designed to promote the active involvement of residents with families and the community.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

The administrator/designee is responsible for creating the calendar of activities and posted in a conspicuous area. In addition, the administrator/designee will coach all staff members to execute the posted activities, and also encourage all residents to take part in daily activities. Effective date 07/01/2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented [redacted] - 07/31/2024)

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

Facility Information

Name: *ROBINSON PERSONAL CARE HOME* **License #**: *19881* **License Expiration**: *08/25/2024*

Address: *4104 WEST GIRARD AVENUE, PHILADELPHIA, PA 19104*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: [redacted]

Address: *4104 WEST GIRARD AVENUE, PHILADELPHIA, PA, 19104*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/14/2012* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *16* **Waking Staff**: *12*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/09/2024*

Inspection Dates and Department Representative

07/09/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *20* **Residents Served**: *16*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

07/09/2024 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *08/03/2024*

08/22/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/07/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/26/2024*

09/09/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/07/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/07/2024*

10/29/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/07/2024*

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

20b8 - Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Resident #1 has not received a quarterly account of financial transactions. The home is not completing the quarterly accounts for the resident.

Resident #2 has not received a quarterly account of financial transactions since [redacted]

Plan of Correction ***Accept [redacted]S - 08/27/2024)***

Quarterly accounts were prepared and reviewed for Resident #1 and resident #2 on 07/15/2024. In the future the Administrator/Designee will ensure that all residents quarterly accounts are updated and kept on file. The Administrator is responsible for reviewing and maintaining quarterly accounts to department specifications. Administrator/designee will conduct quarterly review of residents quarterly account at the end of each quarter. Started on 7/15/2024 administrator executed quarter 2 (Apr-Jun 2024). Audits will be conducted 30 after the ending of each quarter. For example: Quarter 3 (Jul-Sept 2024) audit will be prepared and reviewed within 30 after September 30th.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented ([redacted] 10/28/2024)

28f - Resident's Funds and 30-day Refund

2. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #1 was discharged on [redacted] *4. The home received a payment from the Social Security Administration for this resident for the month of May but the home could not provide verification that the money was refunded to the resident.*

Plan of Correction ***Directed [redacted] - 08/27/2024)***

Resident #1 was still in the home during inspection even though [redacted] *received a notice. Resident received* [redacted] *allowance, and remainder goes to room and board.*

Directed Plan of Correction:
Within 24 hours of the receipt of this plan of correction, the administrator shall update the current resident staff list to include all current residents, and also update a list of discharged residents with the reason for discharge. The discharge list shall contain the date resident was discharged, and the date that any refund due was returned to the resident. Documentation of the discharge record and refund shall be kept and made available for Department review.
Within 5 calendar days of the receipt of this plan of correction, the administrator or designee shall update residents

28f - Resident's Funds and 30-day Refund (continued)

file to indicate that resident was given a 30-day notice, but was not discharged.
The administrator or designee shall update the current

Directed Completion Date: *09/09/2024*

Not Implemented (- 10/28/2024)

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

The assessment for resident #3, dated was completed by staff member A. In the summary of resident's overall wellness, it is written that resident#3 "wets the bed periodically because she is too lazy to go to the bathroom".

Plan of Correction ***Accept (- 09/09/2024)***

The administrator educated all Staff of the importance of dignity and respect for all residents at the beginning of their work shifts between 7/10/2024-7/17/2024. The administrator/designee is responsible for ensuring that all staff show dignity and respect to all residents. In the future no derogatory words will be used to describe the residents behaviour.
Started on 7/10/24 administrator/designee conducted observation on staff to residents interaction and reviewed support plans for dignity issues. This observation will be done periodically throughout staff shifts and audited monthly for 6 months.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented (10/28/2024)

60a - Staff/Support Plan

4. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Between the hours of , 16 residents in the home did not receive their medications as required by their assessments and support plans. Staffing schedule was reviewed and staff and resident interviews were conducted were it was identified that these services were not rendered due to a lack of staff certified in medication administration during these times.

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

The home hours to administer medication is between 7AM and 8PM for all residents. In the future all medication certified staff will ensure that residents receive medication according to their assessment and support plan. All medication certified staff members are responsible for reporting all medication issues to the administrator/designee immediately. The administrator is responsible for training and taking all necessary action to ensure medication policies are maintained to department specifications. Medication training will be completed by 09/01/2024 for all staff.

Licensee's Proposed Overall Completion Date: *08/15/2024*

60a - Staff/Support Plan *(continued)*

Not Implemented ([redacted] - 10/28/2024)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted].

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

Direct care staff B did complete and pass the competency test, but the actual transcript was not on file only the certificate. On 7/10/24 the transcript for the competency test was obtained and placed on direct care staff B's file. Direct care staff member B took the department approved direct care training on 7/10/24 and the certification is now on file.

Going forward all new direct care staff member will provide all training materials and placed on their file before the scheduled shift. Started on 7/15/2024 All employee files were reviewed and checked for compliance. The administrator/designee will conduct quarterly spot check for 6 months on all employee's files. The next review will be done by the 15th of October, and 15th Jan, etc.

Please see attachment!

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented ([redacted] - 10/28/2024)

65g - Annual Training Content

6. 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.

Description of Violation

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year January 2023 to December 2023.

65g Annual Training Content *(continued)*

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

A fire safety training is scheduled to be completed September 10, 2024 for staff person C. In the future the Administrator will ensure that all staff has the required annual training and documents kept on file. The Administrator will conduct spot checks of staff members training to make sure all required training is completed to department specifications.

Started on 7/15/2024 All employee files were reviewed and checked for training compliance.

The administrator/designee will conduct quarterly spot check for 6 months on all employee's files. The next review will be done by the 15th of October, and 15th Jan, etc.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented [redacted] - 10/28/2024)

85b - Infestation

7. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 7/9/24 at 1:36pm, a mouse was observed in the dry food storage area near the main kitchen.

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

Administrator immediately schedule exterminator to do a full building sweep for any form of insects or rodents. Full building sweep was done on 7/31/2024 by the exterminator.
The administrator was responsible for training that was done on 8/7/2024 See attachment

*** The administrator/designee will monitor the home weekly for potential causes of pest and signs of pest. The audit was start on 07/15/2024 and will be conducted for 3 months.*

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented [redacted] 10/28/2024)

92 - Windows

8. Requirements

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

Description of Violation

On 7/9/24, the window screens in the second and third floor bathrooms are ripped creating gaps in the screen and need to be repaired.

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

The window mesh for the 2nd and the 3rd floor was damaged and was noticed on the day of the audit. The home immediately removed and repaired the mesh for both floors on 7/15/2024. All staff members were coached to

92 - Windows (continued)

inspect all bathroom window screens periodically throughout their shifts and report anything out of place to the administrators/designee for immediate repairs. Attached please see pictures of window screens. Going forward administrator/designee will conduct quarterly audit for 12 months to track window surface damages

Licensee's Proposed Overall Completion Date: *08/25/2024*

Implemented ([redacted] 10/28/2024)

103e - Left Overs

9. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 7/9/24, there were three unlabeled, undated leftover pitchers of juice in the kitchen fridge. Additionally, there were unlabeled and undated bags of left-over meatballs, potato sticks, and hashbrown patties in the lower-level freezer.

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

The home immediately discards the unlabelled items in the freezer and provided training to all staff members at the start of their shifts instructing them to label all open leftovers with the date, name of item, etc before placing opened leftovers in the freezer.
In the future administrators and designee will check to ensure all leftovers are labelled with all required information weekly for a 3-month started on 8/10/24.
The administrator conducted training on leftovers labelling on 8/10/2024

Licensee's Proposed Overall Completion Date: *08/25/2024*

Implemented ([redacted] 10/28/2024)

123c - Evacuation Diagrams

10. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 16 residents. However, on [redacted] there are no emergency evacuation diagrams posted in the home.

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

On 7/10/2024 The administrator revisited the floor plans, copy, laminate and post on the required floors. All staff members were coached to check for floor diagrams on each floor periodically throughout their shift and report any missing diagram to the administrators/designee immediately for replenishment.

The administrator/designee will conduct spot checks weekly for evacuation diagrams on each floor started on 8/10/2024 for 3 months.

Please see attachment...

123c - Evacuation Diagrams *(continued)*

Licensee's Proposed Overall Completion Date: *08/25/2024*

Implemented (- 10/28/2024)

144d - Smoking Outside

11. Requirements

2600.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 07/09/24 at 2pm, resident #4 was smoking on the front porch of the home which is not the home's designated smoking area. The home's designated smoking area is on the front steps.

Plan of Correction ***Accept (- 09/09/2024)***

Resident #4 and all other smoking residents were reminded to use the designated smoking area and not the porch for smoking. All staff members were reminded to do spot checks on the residents smoking routine and to remind the residents of the designated smoking area and also report it to the administrators/designee to further remind the residents.
All staff members are responsible for reminding all residents about smoking designated area and not to smoke on the porch. On 7/10/2024 staff training was completed, and weekly audit will be conducted for 3 months.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Implemented - 10/28/2024)

162c - Menus Posted

12. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On , the menus from 6/30/24 to 7/13/24 were posted. However, the menus for the upcoming week was not posted.

Plan of Correction ***Accept (- 09/09/2024)***

The home normally posts menus every 2 weeks. After revisiting PA code, the home now ensure that menus are always posted with a week in advance. Additionally, all staff members were briefed/responsible for making sure menu policies are maintained in the home and reported to the administrators/designee for immediate correction if menus not displayed with the correct information.
The administrator/designee are responsible for the posting of the menus a week in advance. Staff training was done on 7/10/2024 for menus posting and weekly audit will be completed for 3 months beginning 7/10/2024

Licensee's Proposed Overall Completion Date: *08/25/2024*

Implemented - 10/28/2024)

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

On [redacted], the medication cabinet was unlocked, unattended, and accessible in the medication room which was not locked.

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

The medication room/office was initially locked, staff member C was back and forth assisting the DHS Inspector and did not lock the room during this timeframe. All medication certified staff was coached to make sure the medication room is always locked and report to the administrators if it is found unlocked.

The administrator/designee are responsible for making sure the meds room/office is always locked. Staff training was done on 7/10/2024 for the importance of keeping the meds room/office locked and weekly audit will be completed for 6 months beginning 7/10/2024

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented ([redacted] - 10/28/2024)

183d - Prescription Current

14. 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 [redacted], two bottles of [redacted] were in the home's medication cart for resident#3. However, the resident does not have a current order for this medication.

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

The 2 bottles of [redacted] spray that was in the home medication area for resident #3 was to be returned to the pharmacy. The 2 bottles were returned to the pharmacy on 7/10/2024. All medication certified staff was coached to make sure all pharmacy returned are stored separately in the designate return to pharmacy area until the pharmacy makes their pickup and report to the administrators if it is found out of place.
The administrator/designee are responsible for making sure all pharmacy returns are in the return to pharmacy area. Staff training was done on 7/10/2024 for the importance of separating pharmacy returns from the regular meds storage area. Weekly audit will be completed for 6 months beginning 7/10/2024.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented [redacted] - 10/28/2024)

190a - Completion Medication Course

15. Requirements

2600.

190a Completion Medication Course *(continued)*

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, who has not successfully completed the Department approved medications administration course, administered medications to residents to include the following:

On [redacted] to resident #3.

On July 4, 2024, at 8 am [redacted] to resident #4.

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

The home did not notice that staff person A medication certification was not correctly completed by the last trainer until 7/9/24 the day of the audit. Training date to have this corrected is set and should be completed by 9/1/2024 by a certified trainer. Going forward all medication staff personnel will quality check the trainer's certification upon completing training courses to ensure that the training is department approved.

Started on 8/25/2024 All employee files were reviewed and checked for compliance. The administrator/designee are responsible and will conduct quarterly spot check for 6 months on all employee's files.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented ([redacted] - 10/28/2024)

191 - Resident Right to Refuse

16. 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 #5, admitted [redacted], 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 [redacted] - 09/09/2024)***

Residents #5 initial application was done on the old form that did not have rights to refuse as the new application does. As of [redacted] resident #5 file was updated with the rights to refuse, and the resident was educated on these rights.

Administrators/ designee are responsible for making sure all residents are knowledgeable about their rights to refuse, and all files are up to date with these rights.

Staff training was done on 7/10/2024 for the importance of all residents being knowledgeable about their rights to refuse, and all files are up to date with these rights and quarterly audit will be completed for 12 months beginning 7/10/2024

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented [redacted] - 10/28/2024)

252 - Record Content

17. 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

Resident #5's record does not include a photograph of the resident that is no more than 2 years old.

Repeat Violation Date: 6/28/23 et al.

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

Resident #5 now have a current photo added to [redacted] file and administrators/designee will conduct annual review of resident's files to ensure all files have photograph that was taken no more than 2 years old.

The administrator/designee are responsible for the making sure resident records are up to date with photo that was taken within 2 years. Started on 7/15/2024 All residents file is up to date with current photo. The administrator/designee will conduct spot checks quarterly to ensure all residents files are current for 12 months.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Not Implemented [redacted] - 10/28/2024)