pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ABODE CARE OF MONROEVILLE LLC**
LEGAL ENTITY

To operate **ABODE CARE OF MONROEVILLE**
NAME OF FACILITY OR AGENCY

Located at **2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146**
(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 **66**
(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 **October 18, 2024** until **April 18, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **451191**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 18, 2024

[redacted]
Abode Care of Monroeville LLC
2560 Stroschein Road
Monroeville, Pennsylvania 15146

RE: Abode Care of Monroeville
License/COC #: 451191

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 1, 2024, May 6, 2024, July 9, 2024, and July 10, 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), mistreatment or abuse of residents being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a 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); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4) (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 18, 2024 to April 18, 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)
16(c)	II	37	$5	$185	5 calendar days from mailing date of this letter
42(b)	II	37	$5	$185	5 calendar days from mailing date of this letter

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

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

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

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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

Sincerely,

Juliet Marsala
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: *ABODE CARE OF MONROEVILLE* **License #:** *45119* **License Expiration:** *08/13/2024*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*

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

Administrator

Name: [redacted]

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA, 15146*

Phone: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *57* **Waking Staff:** *43*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *05/06/2024*

Inspection Dates and Department Representative

05/01/2024 - On-Site: [redacted]

05/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *35*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *34*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *22* **Have Physical Disability:** *2*

Inspections / Reviews

05/01/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/01/2024*

Inspections / Reviews *(continued)*

06/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/10/2024*

06/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/12/2024*

09/24/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2024*

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

On 5/1/24 at 10:55am, an agent of the Department overheard staff person A screaming at resident #1 while providing care to the resident in the bathroom; however, this incident was not reported to the Department as of 5/6/24.

REPEAT VIOLATION: 5/4/2023, et. al.

Plan of Correction ***Accept [redacted] - 06/10/2024)***

1. ACM's fax was down on 5/1/2024. Administrator contacted DHS via telephone on 5/1/2024, spoke to representative [redacted] gave me the email address to report incident. Administrator also contacted AAA on 5/1/2024 to report incident. Email was sent on 5/2/2024. Fax was sent to DHS and AAA as a back up on 5/6/2024.

2. System in place on 5/1/2024 to contact regional office to fax documentation over to DHS or other agencies (if applicable) within time frame should fax machine be inoperable. Administrator will also contact DHS via email as a back up as well to ensure documentation has been received. Documentation of incident report, fax, or email confirmation will be placed in administrator office for review, During daily morning meetings established in 2021 administrator, DON, ADON or shift supervisor will review daily communication notes to ensure all notes are in resident charts and any incident reports needed are submitted within a timely manner and placed in administrator office for review. Weekly Manager meetings are in place starting January 2023 to discuss all departments. Administrator will review all reportable incidents during quarterly quality management meetings. QM meeting held on 6/5/2024. Documentation placed in administrator office.

3. Monthly maintenance checks to device are still in place for copier/fax by Goldstar company starting February 2023. Monthly internet checks are still in place by Call Processing beginning January 2022. Administrator will ensure all devices are operable each month with both companies and documentation will be kept in office for review. QM meetings will continue to be done quarterly. Administrator and DON will review all documentation daily and monthly to ensure incidents have been documented, placed in file and sent to DHS if applicable.

Licensee's Proposed Overall Completion Date: *06/09/2024*

Not Implemented [redacted] - 09/24/2024)

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 5/1/24 at 10:55am, an agent of the Department overheard staff person A screaming at resident #1 while providing care to the resident in the bathroom. Staff person A was heard screaming at resident #1, "Go to the bathroom! Go! Go to the bathroom!" Resident #1 then let out a loud shriek, then told staff person A, "I'm not done yet". Resident #1

42b - Abuse (continued)

indicated the incident made [redacted] upset and felt verbally harassed. Resident #1 also indicated she felt that staff person A hates [redacted].

REPEAT VIOLATION: 2/22/2024

Plan of Correction ***Accept [redacted] - 06/10/2024)***

1. Employee was immediately terminated and escorted out of the home on 5/1/2024 at 11:00am. State documentation was submitted to authorities.

2. A new 0 tolerance policy has been implemented for ACM on 5/2/2024. Any staff member suspected of such allegation is immediately suspended pending . An all staff meeting was held on 5/8/2024 to review new policy, staff members have reviewed and signed off on. Documentation has been placed in all current employee files. Policy has been included in new hire packet on 5/2/2024. Administrator will review all documents with new team members on date of hire. Resident Council meeting held on 5/23/2024 to educate residents on new policy and to speak to Administrator or member of management if they feel their rights have been violated. System still in place for Administrator, DON, ADON and Shift supervisor to take 2 hour round checks to observe DCS daily during all 3 shifts (7-3,3-11, 11-7) system has been in place November 2023. System still in place from November 2023 for Administrator to perform weekly interviews with at least 3 residents and 3 staff members to ensure happiness and safety all documentation is on file in administrator office. Monthly staff and resident council meetings still in place to continue compliance. QM meeting held on 6/5/2024 to review POC, and all other topics associated with regulation 2600.26. All documentation is on file in administrator office.

3. Administrator, DON, ADON and shift supervisor will continue to complete 2 hour wellness checks on DCS and residents during all three shifts daily. Administrator will educate new staff members on resident rights and 0 tolerance policy on their first day of employment and sign off on policy. All employees and residents will be re-educated yearly on resident rights. Administrator will continue to perform weekly staff and resident interviews, QM meetings quarterly . All documentation will be kept in Administrator office

Proposed Overall Completion Date: 06/09/2024

Licensee's Proposed Overall Completion Date: *06/09/2024*

Not Implemented [redacted] - 09/24/2024)

104b - Dishes/Glassware/Utensils

3. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

On 5/1/24, 8 residents were observed by an agent of the Department using plastic cutlery during the lunch meal. According to numerous resident and staff person interviews, plastic cutlery is used by residents during meals on a regular basis.

104b - Dishes/Glassware/Utensils *(continued)*

Plan of Correction ***Directed [redacted] - 06/10/2024)***

1. Silverware was bought on 5/4/2024. There is enough silverware to accommodate residents at maximum capacity of 66.

2. Once weekly Administrator and dietary manager will complete a count of silverware to ensure there is enough silverware in the home to accommodate maximum capacity. System in place on 5/2/2024 for housekeeping and supervisor (Admin, DON, Shift supervisor) to complete a resident room check for missing silverware weekly. At least 2 staff members and one supervisor will be present during all meal times daily to observe and report to administrator daily if metal silverware isn't being used. (DIRECTED: The daily monitoring of all meals shall begin on 6/12/24 to ensure compliance with 2600.104b.[redacted] 6/10/24).

3. Administrator and dietary manager will count silverware once weekly to ensure maximum number. Once weekly Administrator, supervisor and housekeeping will complete a resident room sweep for missing silverware. documentation of silverware count will kept in administrator office. Once daily at least two DCS and supervisor will be present during all meal times to ensure compliance of regulation. Administrator will continue to have silverware on hand for maximum capacity

Proposed Overall Completion Date: 06/09/2024

Directed Completion Date: *06/12/2024*

Not Implemented [redacted] - 09/24/2024)

162c - Menus Posted

4. 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 5/1/24, the only menu posted in a conspicuous and public place ended on 5/4/24.

On 5/6/24, the only menu posted in a conspicuous and public place ended on 5/4/24.

Plan of Correction ***Accept [redacted] - 06/10/2024)***

1. menus were posted on site 5/6/2024

2. Administrator made a four week menu on 5/6/2024 and posted on bulletin board. Monthly physical site check still in place from 2023 to check menu posting to ensure menus are posted for at least two weeks. Physical site checklist completed on 5/6/2024. Kitchen has all four weeks posted. Administrator will continue to complete daily morning rounds (effective 2020) to ensure all four weeks are posted. Administrator re-educated dietary team on 5-1-2024 to check board daily to verify menus are posted and are being followed. QM meeting held on 6/5/2024 to review POC and other topics according to regulation 2600.26

3. Physical site checklist monthly is still in place. Administrator will complete paperwork monthly and file in office. Administrator will continue to check board daily during morning rounds to verify menus are posted and current.

162c - Menus Posted (continued)

Dietary team will check board daily in the morning and before shift ends to verify menus are posted effective 5-1-2024. QM meeting still in place for quarterly reviews effective January 2020. All documentation will be placed in administrator office

Proposed Overall Completion Date: 05/31/2024

Licensee's Proposed Overall Completion Date: *06/09/2024*

Not Implemented [redacted] - 09/24/2024)

187b - Date/Time of Medication Admin.

5. 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's April 2024 medication administration record (MAR) does not include the initials of the staff persons who administered the following medications to resident #1:

- *The 9:00pm doses on 4/1/24 and 4/6/24 of Levetiracetam 500mg tablet-Take 1 tablet by mouth twice daily*
- *The evening doses on 4/1/24 and 4/6/24 of Rosuvastatin Calcium 5mg tablet-Take 1 tablet by mouth at bedtime*

Resident #2's April 2024 MAR does not include the initials of the staff persons who administered numerous medications to resident #2, on numerous dates and times, to include the following:

- *The 9:00pm doses on 4/1/24 and 4/6/24 of Aspirin 81mg tablet-Take 1 tablet by mouth twice daily*
- *The 2:00pm doses on 4/12/24 and 4/13/24 of Baclofen 10mg tablet-Take 1 tablet by mouth 3 times daily*
- *The 8:00pm doses on 4/1/24 and 4/6/24 of Baclofen 10mg tablet-Take 1 tablet by mouth 3 times daily*
- *The evening doses on 4/1/24 and 4/6/24 of Bisacodyl EC 5mg tablet-Take 1 tablet by mouth at bedtime*
- *The evening doses on 4/1/24 and 4/6/24 of Trazodone 50mg tablet-Take 1 tablet my mouth at bedtime*

Resident #3's April 2024 MAR does not include the initials of the staff persons who administered numerous medications to resident #3, on numerous dates and times, to include the following:

- *The 2:00pm dose on 4/12/24 of APAP 500mg tablets-Take 2 tablets by mouth 3 times daily*
- *The 8:00pm doses on 4/1/24 and 4/6/24 of APAP 500mg tablets-Take 2 tablets by mouth 3 times daily*
- *The evening doses on 4/1/24 and 4/6/24 of Famotidine 40mg tablet-Take 1 tablet by mouth at bedtime*
- *The 8:00pm doses on 4/1/24 and 4/6/24 of Gabapentin 300mg capsule-Take 1 capsule by mouth 4 times daily*
- *The 2:00pm dose on 4/12/24 of Hydralazine 10mg tablet-Take 1 tablet by mouth 3 times daily*
- *The 8:00pm doses on 4/1/24 and 4/6/24 of Hydralazine 10mg tablet-Take 1 tablet by mouth 3 times daily*

Plan of Correction ***Accept [redacted] - 06/10/2024)***

1.EMAR computers were not syncing with the computers to the other hallway computers. medication audit was completed on 5/1/2024 all meds were given but signatures didn't record. Computer wifi was checked and IT team helped to sync the computers again for all three hallways

2. All medication techs were re-educated on 5/3/2024 about the back -up paper MAR should the computers not sync or are inoperable. Med tech's were also re-educated on the main computer in the nurses station to sign off on their med pass. A med audit was completed on 5/2/2024 by Admin and DON to ensure there were signatures for every

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

med pass. System still in place on 5/2/2024 for DON, ADON , and Administrator to check med carts MARS and paper MAR every two weeks. System still in place for Pharmacy to come once monthly during medication refill to complete medication audit. DON, ADON or Administrator will check MAR bi-weekly to ensure all signatures are written into MAR. Documentation will be placed on file in administrator office. QM meeting held on 6/5/2024 to discuss regulation 2600.26 topics. Documentation on file in administrator office

3. Administrator, DON, ADON or shift supervisor will complete med cart audits with MAR readings and paper MARS of all residents every two weeks starting 5/2/2024. Pharmacy and DON will continue to complete cart audit with MAR reading once monthly. All documentation will be placed on file in administrator office. QM meetings still in place quarterly., documentation will be placed on file.

Proposed Overall Completion Date: 06/09/2024

Licensee's Proposed Overall Completion Date: *06/09/2024*

Implemented [redacted] - 09/24/2024)

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

Facility Information

Name: *ABODE CARE OF MONROEVILLE* **License #:** *45119* **License Expiration:** *08/13/2024*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*

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

Administrator

Name: [redacted]

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA, 15146*

Phone: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *65* **Waking Staff:** *49*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date:** *07/24/2024*

Inspection Dates and Department Representative

07/09/2024 - On-Site: [redacted]

07/10/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *37*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *28* **Have Physical Disability:** *1*

Inspections / Reviews

07/09/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/21/2024*

Inspections / Reviews *(continued)*

08/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/23/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/29/2024*

09/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/23/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/23/2024*

09/24/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/23/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.

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

Description of Violation

On [redacted]5/24 at approximately 6:30pm, residents #1 and #2 joined approximately 4 staff persons in the outdoor designated staff smoking section in the rear of the home. Staff Person A, dietary aide, had liquor and marijuana, which [redacted] provided to residents #1 and #2. Residents #1 and #2 both consumed the unknown alcohol and staff person A and resident #2 smoked the marijuana together. Staff person A was scheduled to work on [redacted]/24 until 7:00pm. Staff person B was notified of this incident on the afternoon of 7/6/24 and reported the incident via text message to staff person C, Administrator, and staff person D, Director of Resident Care, on 7/6/24 at 2:31pm; however, this incident was not reported to the local Area Agency on Aging until 7/9/24.

On [redacted]/24 at approximately 1:00pm, numerous staff persons overheard staff person E call resident #4 a "whore" and yell obscenities at resident #4 in the home's common dining room. This incident was immediately reported to staff person C, Administrator; however, was not reported to the local Area Agency on Aging until 7/9/24.

Approximately 2 weeks ago, residents #4 and #5 were observed by numerous people kissing on the home's front porch. Resident #5 also had his pants unzippered, exposing his [redacted], and resident #4 was observed sucking on resident #5's fingers. According to resident #4's medical evaluation, dated [redacted]/23, resident #4 has a diagnosis of dementia. However, this incident was not reported to the local Area Agency on Aging until 7/10/24.

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. Administrator was out of town for the weekend. Internal investigation was completed upon arrival to home on 7/8/2024. Administrator was re-educated by DHS on 7/9/2024 regardless of testimonials from either side it must always be reported to authorities. Staff person A and E were sent home from the facility at 1:30pm on 7/9/2024. Both were terminated via phone call on [redacted]2024 at 5:00pm by Administrator
Resident 4 & 5 were removed from each other the minute staff members witnessed. There were no allegations given to administrator about exposing [redacted]self or sucking of lips. Both families were notified the day of incident by med tech who observed and documented in chart. As discussed and shown to DHS during investigation

2. Administrator held a meeting with DON on 7/9/2024 to discuss protocols. In the absence of the ED the DON is fully in charge of the community should situations arise. Should both ED and DON be absent from the home the next point of contact is ADON/Med tech on duty. Administrator educated management team on 7/9/2024 what to do in different situations they may come across. Manager meetings have been put in place since 2023 at least twice a week. A new implementation has been added to meetings on 7/9/2024. Once Monthly Administrator goes over potential scenarios that could come up and how to handle those situations should Administrator not be available. Weekly staff and resident interviews continue to be in place once weekly, administrator keeps documentation. All staff meeting was held on 7/23/2024 educating all members of chain of command and who to call during situations. Administrator educated all staff to notify All members of management of any situation they believe there is an

15a - Resident Abuse Report (continued)

issue. System in place on 7/10/2024 to notify staff members via communication board when ED will be absent and who to call prior to absence. Phone listings of all employees continue to be updated monthly and posted throughout the home and reviewed during monthly staff meetings and new hire orientation. All regional phone numbers continue to be posted throughout the home and programed into fax machine and reviewed monthly during physical site inspection. Administrator and DON will review all internal incidents and conditions to ensure timely reporting in accordance with 2600.15b Implementation date 7/10/2024. DIRECTED: Immediately: The administrator/DON/Designee shall review all internal incidents and conditions daily to ensure timely reporting to the local Area Agency on Aging for all allegations of suspected abuse in accordance with 2600.15a. [redacted] 9/3/24). Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b Next meeting scheduled for 9/23/2024.

3. Administrator will continue to hold monthly staff meetings tentatively third Wednesday of every month. Administrator will check employee phone listing once monthly to ensure all employees are listed and numbers are current. The administrator will continue to hold once weekly meetings with management ,(implemented 11/29/2024) to go over weekly agenda's. New policy implemented on 7/10/2024 to acknowledge if any member of management is to be out of touch who is in charge. No tolerance policy is still in place reviewed monthly and during new hire training. Administrator continues to do weekly resident and staff interviews. Once monthly administrator will hold an all resident meeting reviewing resident rights. All documentation will be placed in administrator office. Administrator will continue to hold QM mettings quarterly

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 09/24/2024)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 7/5/24 at approximately 6:30pm, residents #1 and #2 joined approximately 4 staff persons in the outdoor designated staff smoking section in the rear of the home. Staff Person A, dietary aide, had liquor and marijuana, which [redacted] provided to residents #1 and #2. Residents #1 and #2 both consumed the unknown alcohol and staff person A and resident #2 smoked the marijuana together. Staff person A was scheduled to work on [redacted]/24 until 7:00pm. Staff person B was notified of this incident on the afternoon of 7/6/24 and reported the incident via text message to staff person C, Administrator, and staff person D, Director of Resident Care, on 7/6/24 at 2:31pm; however, staff person A continued to work unsupervised in the home, including the morning of 7/9/24 when agents of the Department arrived at the home.

On [redacted]/24 at approximately 1:00pm, numerous staff persons overheard staff person E call resident #4 a "whore" and yell obscenities at resident #4 in the home's common dining room. This incident was immediately reported to staff person C, Administrator; however, staff person E continued to work unsupervised in the home, including the morning of 7/9/24 when agents of the Department arrived at the home.

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. Administrator was out of town for the weekend. Internal investigation was completed upon arrival to home on 7/8/2024. Administrator was re-educated by DHS on 7/9/2024 regardless of testimonials from either side it must always be reported to authorities. Staff person A and E were sent home from the facility at 1:30pm on 7/9/2024. Both were terminated via phone call on [redacted] 2024 at 5:00pm by Administrator
Resident 4 & 5 were removed from each other the minute staff members witnessed. There were no allegations given to administrator about exposing himself or sucking of lips. Both families were notified the day of incident by med tech who observed and documented in chart. As discussed and shown to DHS during investigation

2. Administrator held a meeting with DON on 7/9/2024 to discuss protocols. In the absence of the ED the DON is fully in charge of the community should situations arise. Should both ED and DON be absent from the home the next point of contact is ADON/Med tech on duty. Administrator educated management team on 7/9/2024 what to do in different situations they may come across. Manager meetings have been put in place since 2023 at least twice a week. A new implementation has been added to meetings on 7/9/2024. Once Monthly Administrator goes over potential scenarios that could come up and how to handle those situations should Administrator not be available. Weekly staff and resident interviews continue to be in place once weekly, administrator keeps documentation. All staff meeting was held on 7/23/2024 educating all members of chain of command and who to call during situations. Administrator educated all staff to notify All members of management of any situation they believe there is an issue. System in place on 7/10/2024 to notify staff members via communication board when ED will be absent and who to call prior to absence. Phone listings of all employees continue to be updated monthly and posted throughout the home and reviewed during monthly staff meetings and new hire orientation. All regional phone numbers continue to be posted throughout the home and programed into fax machine and reviewed monthly during physical site

15b - Supervisor Plan (continued)

inspection. Administrator and DON will review all internal incidents and conditions to ensure timely reporting in accordance with 2600.15a Implementation date 7/10/2024. (DIRECTED: Immediately: The administrator/DON/Designee shall review all internal incidents and conditions daily to ensure a plan of supervision or suspension is immediately implemented for any staff person involved in an allegation of abuse in accordance with 2600.15b. [redacted] 9/3/24). Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.65i. Next meeting scheduled for 9/23/2024 (DIRECTED: Documentation of all quality management reviews shall be kept. [redacted] 9/3/24).

3. Administrator will continue to hold monthly staff meetings tentatively third Wednesday of every month. Administrator will check employee phone listing once monthly to ensure all employees are listed and numbers are current. The administrator will continue to hold once weekly meetings with management ,(implemented 11/29/2024) to go over weekly agenda's. New policy implemented on 7/10/2024 to acknowledge if any member of management is to be out of touch who is in charge. No tolerance policy is still in place reviewed monthly and during new hire training. Administrator continues to do weekly resident and staff interviews. Once monthly administrator will hold an all resident meeting reviewing resident rights. All documentation will be placed in administrator office. Administrator will continue to hold QM mettings quarterly

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 09/24/2024)

16c - Written Incident Report

3. Requirements

2600.

16c - Written Incident Report *(continued)*

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

Description of Violation

On [redacted]/5/24 at approximately 6:30pm, residents #1 and #2 joined approximately 4 staff persons in the outdoor designated staff smoking section in the rear of the home. Staff Person A, dietary aide, had liquor and marijuana, which [redacted] provided to residents #1 and #2. Residents #1 and #2 both consumed the unknown alcohol and staff person A and resident #2 smoked the marijuana together. Staff person A was scheduled to work on [redacted]5/24 until 7:00pm. Staff person B was notified of this incident on the afternoon of 7/6/24 and reported the incident via text message to staff person C, [redacted], and staff person D, [redacted] Care, on 7/6/24 at 2:31pm; however, this incident was not reported to the Department until 7/9/24.

On [redacted]/7/24 at approximately 1:00pm, numerous staff persons overheard staff person E call resident #4 a "whore" and yell obscenities at resident #4 in the home's common dining room. This incident was immediately reported to staff person C, Administrator; however, was not reported to the Department until 7/9/24.

Approximately 2 weeks ago, residents #4 and #5 were observed by numerous people kissing on the home's front porch. Resident #5 also had his pants unzippered, exposing [redacted], and resident #4 was observed sucking on resident #5's fingers. According to resident #4's medical evaluation, dated 9/8/23, resident #4 has a diagnosis of dementia. However, this incident was not reported to the Department until 7/10/24.
REPEAT VIOLATION: 5/4/2023, et. al.

Plan of Correction ***Directed ([redacted] - 09/03/2024)***

1. Administrator was out of town for the weekend. Internal investigation was completed upon arrival to home on 7/8/2024. Administrator was re-educated by DHS on 7/9/2024 regardless of testimonials from either side it must always be reported to authorities. Staff person A and E were sent home from the facility at 1:30pm on [redacted]/2024. Both were terminated via phone call on [redacted]/2024 at 5:00pm by Administrator
Resident 4 & 5 were removed from each other the minute staff members witnessed. There were no allegations given to administrator about exposing himself or sucking of lips. Both families were notified the day of incident by med tech who observed and documented in chart. As discussed and shown to DHS during investigation

2. Administrator held a meeting with DON on 7/9/2024 to discuss protocols. In the absence of the ED the DON is fully in charge of the community should situations arise. Should both ED and DON be absent from the home the next point of contact is ADON/Med tech on duty. Administrator educated management team on 7/9/2024 what to do in different situations they may come across. Manager meetings have been put in place since 2023 at least twice a week. A new implementation has been added to meetings on 7/9/2024. Once Monthly Administrator goes over potential scenarios that could come up and how to handle those situations should Administrator not be available. Weekly staff and resident interviews continue to be in place once weekly, administrator keeps documentation. All staff meeting was held on 7/23/2024 educating all members of chain of command and who to call during situations.Documentation of trainig will be kept in accordance with 2600.65i. Administrator educated all staff to notify All members of management of any situation they believe there is an issue. System in place on 7/10/2024 to notify staff members via communication board when ED will be absent and who to call prior to absence. Phone listings of all employees continue to be updated monthly and posted throughout the home and reviewed during monthly staff meetings and new hire orientation. All regional phone numbers continue to be posted throughout

16c - Written Incident Report (continued)

the home and programed into fax machine and reviewed monthly during physical site inspection. Administrator and DON will review all internal incidents and conditions to ensure timely reporting in accordance with 2600.15a Implementation date 7/10/2024. (DIRECTED: Immediately: The administrator/DON/Designee shall review all internal incidents and conditions daily to ensure all incidents specified in 2600.16a are reported to the Department within 24 hours in accordance with 2600.16c. [redacted] 9/3/24). Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

3. Administrator will continue to hold monthly staff meetings tentatively third Wednesday of every month. Administrator will check employee phone listing once monthly to ensure all employees are listed and numbers are current. The administrator will continue to hold once weekly meetings with management ,(implemented 11/29/2024) to go over weekly agenda's. New policy implemented on 7/10/2024 to acknowledge if any member of management is to be out of touch who is in charge. No tolerance policy is still in place reviewed monthly and during new hire training. Administrator continues to do weekly resident and staff interviews. Once monthly administrator will hold an all resident meeting reviewing resident rights. All documentation will be placed in administrator office. Administrator will continue to hold QM mettings quarterly

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] 09/24/2024)

17 - Record Confidentiality

4. Requirements

2600.

17 - Record Confidentiality *(continued)*

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 7/9/24 at 10:20am, an empty medication card was present on the ground at the outdoor staff smoking area near the dumpster in the rear of the home. The medication card contained a pharmacy label for resident #3 indicating "Metromin-1,000mg-Take 1 tablet by mouth twice daily for diabetes".

REPEAT VIOLATION: 11/28/2023, et. al.

Plan of Correction ***Accept [redacted] - 09/03/2024)***

1. med card was thrown away onsite

2. Once daily during morning rounds Administrator, supervisor and maintenance director will check the perminiter of dumpster to ensure there is no trash on the ground and dispose of it properly. Daily rounds will be down on the insid of the home to ensure compliance, implemented on 7/12/2024. Daily dumpster checks have been implenmented on 7/10/2024. Staff members were educated on 7/23/24 to check the dumspters daily when outside smoking, when taking out trash and inside the home for trash during rounds. All documentation will be kept in accordance with 2600.65i. QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.
3. Administrstor, supervisor and maintenance director will complete daily dumpster and inside home checks. All employees will check when they dispose garbage to ensure all their garbage has been disposed of. Administrator or designee will check inside and outside of home daily to ensure compliance

Licensee's Proposed Overall Completion Date: *08/29/2024*

Not Implemented[redacted] - 09/24/2024)

42b - Abuse

5. 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 7/5/24 at approximately 6:30pm, residents #1 and #2 joined approximately 4 staff persons in the outdoor designated staff smoking section in the rear of the home. Staff Person A, dietary aide, had liquor and marijuana, which [redacted] provided to residents #1 and #2. Residents #1 and #2 both consumed the unknown alcohol and staff person A and resident #2 smoked the marijuana together. Staff person A was scheduled to work on [redacted]/24 until 7:00pm.

On 7/7/24 at approximately 1:00pm, numerous staff persons overheard staff person E call resident #4 a "whore" and yell obscenities at resident #4 in the home's common dining room.

Approximately 2 weeks ago, residents #4 and #5 were observed by numerous people kissing on the home's front porch. Resident #5 also had his pants unzippered, exposing [redacted], and resident #4 was observed sucking on resident #5's fingers. According to resident #4's medical evaluation, dated [redacted]23, resident #4 has a diagnosis of dementia.

42b - Abuse (continued)

REPEAT VIOLATION: 2/22/2024

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. Administrator was out of town for the weekend. Internal investigation was completed upon arrival to home on 7/8/2024. Administrator was re-educated by DHS on 7/9/2024 regardless of testimonials from either side it must always be reported to authorities. Staff person A and E were sent home from the facility at 1:30pm on 7/9/2024. Both were terminated via phone call on [redacted] each other the minute staff members witnessed. There were no allegations given to administrator about exposing himself or sucking of lips. Both families were notified the day of incident by med tech who observed and documented in chart. As discussed and shown to DHS during investigation

2. Administrator held a meeting with DON on 7/9/2024 to discuss protocols. In the absence of the ED the DON is fully in charge of the community should situations arise. Should both ED and DON be absent from the home the next point of contact is ADON/Med tech on duty. Administrator educated management team on 7/9/2024 what to do in different situations they may come across. Manager meetings have been put in place since 2023 at least twice a week. A new implementation has been added to meetings on 7/9/2024. Once Monthly Administrator goes over potential scenarios that could come up and how to handle those situations should Administrator not be available. Weekly staff and resident interviews continue to be in place once weekly, administrator keeps documentation. All staff meeting was held on 7/23/2024 educating all members of chain of command and who to call during situations. Administrator educated all staff to notify All members of management of any situation they believe there is an issue. System in place on 7/10/2024 to notify staff members via communication board when ED will be absent and who to call prior to absence. Phone listings of all employees continue to be updated monthly and posted throughout the home and reviewed during monthly staff meetings and new hire orientation. All regional phone numbers continue to be posted throughout the home and programed into fax machine and reviewed monthly during physical site inspection. Administrator and DON will review all internal incidents and conditions to ensure timely reporting in accordance with 2600.15b Implementation date 7/10/2024. (DIRECTED: Immediately: The administrator/DON/Designee shall review all internal incidents and conditions daily to ensure all allegations of abuse/neglect are reported timely in accordance with 2600.15a and 2600.16c and to ensure timely suspension of all employees involved in any abuse allegations in accordance with 2600.15b. [redacted] 9/3/24). Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b Next meeting scheduled for 9/23/2024. Admin holds weekly meeting with at at least 2 residents and 2 staff members. (DIRECTED: Beginning on 9/5/24: The administrator/DON shall interview at least 2 different residents and 2 different staff persons weekly to ensure resident rights are protected and that all residents are free from abuse and neglect. The interviews shall be conducted in private and documentation of all interviews shall be kept. [redacted] 9/3/24). documentation will be kept in accordance t0 2600.65i. Resident #4 has been seen by MD new orders have been implemented. Resident #4 continues to stay in the common livingroom during the day to be monitored by DCS

DIRECTED: By 9/9/24: The administrator shall review the records of residents #4 and #5, interview at least 3 direct care staff persons on the history of sexually inappropriate behaviors involving residents #4 and #5 and develop appropriate supervision plans for residents #4 and #5. The assessments and support plans of residents #4 and #5 shall be updated to include the new supervision plans and copies of the updated assessments and support plans

42b - Abuse (continued)

shall be placed in each resident's record and be accessible to all direct care staff persons at all times in accordance with 2600.227i. [redacted] 9/3/24

DIRECTED: By 9/20/24: The administrator shall re-educate all staff persons on resident rights, including abuse and neglect, as well as signs to observe for involving any sexually inappropriate behaviors between residents. The education shall also include the home's immediate reporting procedures for all abuse/neglect allegations, as well as the home's reporting procedures for residents with sexually inappropriate behaviors. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/3/24

3. Administrator will continue to hold monthly staff meetings tentatively third Wednesday of every month. Administrator will check employee phone listing once monthly to ensure all employees are listed and numbers are current. The administrator will continue to hold once weekly meetings with management ,(implemented 11/29/2024) to go over weekly agenda's. New policy implemented on 7/10/2024 to acknowledge if any member of management is to be out of touch who is in charge. No tolerance policy is still in place reviewed monthly and during new hire training. Administrator continues to do weekly resident and staff interviews. Once monthly administrator will hold an all resident meeting reviewing resident rights. All documentation will be placed in administrator office. Administrator will continue to hold QM mettings quarterly

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 09/24/2024)

42c - Treatment of Residents

6. Requirements

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

42c - Treatment of Residents *(continued)*

Description of Violation

Resident #7 is usually served [redacted] meals in [redacted] bedroom in styrofoam containers. On or around 7/4/24, staff person A began writing messages on the containers of resident #7's meals. On 7/9/24, an agent of the Department observed a styrofoam container in resident #7's bedroom with a handwritten message on the container indicating "good morning sunshine". Resident #7 indicated these messages make resident #7 feel uncomfortable.

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. Administrator was informed on 7/8/2024. on 7/8/2024 administrator spoke to staff person A and instructed them to stop it. Administrator spoke to resident #7 on7/8/2024 to let them know it was handled. Staff person A was set home at !;30 pm on [redacted]/2024 , they were then notfied by Admin at 5:000m on 7/9/2024 they were terminated

2. Staff meeting was held on 7/23/2024 to educate staff members on resident rights. Abuse training for all staff was held on 7/23/2024. (DIRECTED: Documentation of all staff education shall be kept in accordance with 2600.65i. [redacted] 9/3/24). Resident meeting held on 7/29/2024 reviewing resident rights. Monthly staff and resident meetings will continue to be put in place. Weekly resident and staff interviews with administrator will continue to be implemented.At least 2 staff and residents are interviewed weekly documentation will be kepted on file 2600.65i. (DIRECTED: Beginning on 9/5/24: The administrator/DON shall interview at least 2 different residents and 2 different staff persons weekly to ensure resident rights are protected and that residents are treated with dignity and respect. The interviews shall be conducted in private and documentation of all interviews shall be kept. [redacted] 9/3/24). Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

3. Administrator will continue to hold monthly staff meetings tentative every third wednesday. Administrator will complete weekly staff and resident interviews. Administrator will hold monthly resident meetings to review resident rights and QM meetings .

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 09/24/2024)

[redacted]

85e - Trash Outside Home

8. 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 7/9/24, at approximately 10:30am, the left lid to the home's dumpster was open. At the time, the dumpster contained numerous bags of trash.

On 7/9/24, at approximately 4:30pm, the right lid to the home's dumpster was open. At the time, the dumpster contained numerous bags of trash.

Plan of Correction ***Accept [redacted] - 09/03/2024)***

1. Dumpster lids were closed on site. Lid side was closed at 2:00pm after all trash was collected and discarded,

2. All staff meeting was held on 7/23/2024 to re-educate staff members to keep dumpster lids and door closed at all times after use. Sytem in place on 7/10/2024 for managment and supervisors on shift to check dumpster lids are closed. Signs have been posted on back door on 7/12/2024 to remind staff members to close lids when done. documentation of all education will be kept in accordance to 2600.65i. Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

85e - Trash Outside Home (continued)

3. Administrator, manangement and supervisor will check daily during their shift rounds to ensure dumpster lids are closed and all garbage is put in dumpster. Sytem in place 7/12/2024.

Proposed Overall Completion Date: 08/29/2024

Licensee's Proposed Overall Completion Date: *08/29/2024*

Not Implemented [redacted] - 09/24/2024)

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 the morning of 7/9/24, the following items were unlabeled and undated in the silver refrigerator, located in the home's kitchen:

- *A plastic container of leftover pasta with marinara sauce*
- *A styrofoam cup of what appeared to be a red gelatin dessert*

On the morning of 7/9/24, there was an unlabeled and undated cake in large pan on the table to the right of the small sink in the home's kitchen.

Plan of Correction ***Accept ([redacted] - 09/03/2024)***

1. all food was removed from refrigerator on7/9/2024. Cake was discarded on 7/9/2024 at 2:00pm

2. meeting held with dietary staff on 7/12/2024 re-educating them on the importance of dating foods and placing them in proper containers. Reminders have been posted on the refrigerator and freezer to date food on 7/10/24. System in place check refirigerator and freezers daily upon start of shift to ensure all food is dated. If not dated they are to throw all food away. Once weekly during inventory count Administrator will check refigerator, freezer and pantry to ensure all food is labeled. if no label is provided food is to be thrown away. training will be placed on file in accordance to 2600.65i, Daily refridgerator and freezer checks will be done by dietary manager or lead cook of the day. Administrator will check once weekly on friday or as need to ensure complaince, Sign off sheets have been posted on 7/10/2024 to sign off before closing kitchen that all food is dated in both kitchen and freezer. Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.Daily refridgerator and freezer checks will be done by dietary manager or lead cook of the day. Administrator will check once weekly on friday or as need to ensure complaince, Sign off sheets have been posted on 7/10/2024 to sign off before closing kitchen that all food is dated in both kitchen and freezer. Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

103e - Left Overs (continued)

3. Dietary personel to check refirgerator, freezers and pantry daily for udated items. Administrator to check everything eery friday during inventory to ensure all food is dated and able to be used. System put in place on 7/13/2024.

Proposed Overall Completion Date: 08/29/2024

Licensee's Proposed Overall Completion Date: *08/29/2024*

Not Implemented [redacted] - 09/24/2024)

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On the morning of 7/9/24, numerous food items were opened and unsealed in the home's dry food storage room, to include the following:

- *A 16 oz. bag of beef flavored gravy mix, which was approximately 1/2 full*
- *A 25 lb. bag of all-purpose flour, which was approximately 1/2 full*
- *A 25 lb. bag of salt, which was approximately 1/4 full*
- *A 25 lb. bag of cornmeal, which was approximately 1/2 full*
- *A 25 lb. bag of rice, which was approximately 1/4 full*
- *A 49.8 oz. bag of stuffing mix, which was approximately 1/2 full*

On the morning of 7/9/24, there was a large open and unsealed bag of bacon inside a box in the right freezer of the home's kitchen.

Plan of Correction ***Directed [redacted] 09/03/2024)***

1. all food was removed on7/9/2024.

2. meeting held with dietary staff on 7/12/2024 re-educating them on the importance of dating foods and placing them in proper containers. Reminders have been posted on the refrigerator and freezer to date food. System in place check refirigerator, freezers and pantry daily upon start of shift to ensure all food is dated. If not dated they are to throw all food away. Once weekly during inventory count Administrator will check refigerator, freezer and pantry

103g - Storing Food (continued)

to ensure all food is labeled. if no label is provided food is to be thrown away. Daily refridgerator and freezer checks will be done by dietary manager or lead cook of the day. Administrator will check once weekly on friday or as need to ensure complaince, Sign off sheets have been posted on 7/10/2024 to sign off before closing kitchen that all food is dated in both kitchen and freezer. Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

DIRECTED: By 9/20/24: The administrator shall re-educate all staff persons, including all dietary staff, that all food items must be kept in closed or sealed containers. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/3/24

3. Dietary personel to check refirgerator, freezers and pantry daily for udated items. Administrator to check everything every friday during inventory to ensure all food is dated and able to be used. System put in place on 7/13/2024. (DIRECTED: The daily/weekly checks conducted by dietary staff and the administrator shall also include a check of all food storage areas to ensure all food items are stored in closed or sealed containers. [redacted] 9/3/24).

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented ([redacted] - 09/24/2024)

103i - Outdated Food

11. Requirements

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

Description of Violation

On the morning of 7/9/24, there were 2 dented 6.9 lb. cans of tomato paste present in the home's dry food storage room.

On the morning of 7/9/24, numerous food items were not labeled and dated in home's chest freezer, located in dry food storage room, to include the following:

- *A large bag of what appeared to be breadsticks. The bag was tied in a knot; however, was unlabeled and undated*
- *A bag of frozen hamburgers which contained approximately 6 burgers. The bag was tied in a knot; however, was unlabeled and undated*
- *A large bag of frozen hamburgers, which contained approximately 20 burgers. The bad was tied in a knot; however, was unlabeled and undated*

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. all food was removed on7/9/2024.

103i - Outdated Food (continued)

2. meeting held with dietary staff on 7/12/2024 re-educating them on the importance of dating foods and placing them in proper containers. Reminders have been posted on the refrigerator and freezer to date food. System in place check refirigerator, freezers and pantry daily upon start of shift to ensure all food is dated. If not dated they are to throw all food away. Once weekly during inventory count Administrator will check refigerator, freezer and pantry to ensure all food is labeled. if no label is provided food is to be thrown away. Daily refridgerator and freezer checks will be done by dietary manager or lead cook of the day. Administrator will check once weekly on friday or as need to ensure complaince, Sign off sheets have been posted on 7/10/2024 to sign off before closing kitchen that all food is dated in both kitchen and freezer. Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

DIRECTED: By 9/20/24: The administrator shall re-educate all staff persons, including all dietary staff, that dented cans may not be used. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/3/24

3. Dietary personel to check refirgerator, freezers and pantry daily for udated items. Administrator to check everything every friday during inventory to ensure all food is dated and able to be used. System put in place on 7/13/2024 (DIRECTED: The daily/weekly checks conducted by dietary staff and the administrator shall also include a check of all food storage areas to ensure dented cans are not used. [redacted] 9/3/24).

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 09/24/2024)

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 7/9/24, the only menu posted in a conspicuous and public place in the home was dated 7/8/24 through 7/14/24.

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. menu was posted on site by administrator at 9:45am and given to inspectors while on site in confrence room

2. System in place on 7/12/2024 to post monthly menus on board and in kitchen. board posted in dinning room should menu have to change. Once weekly Administrator will check board to ensure monthly menus are posted.

162c - Menus Posted (continued)

implemented on 7/12/2024. (DIRECTED: The weekly administrator checks ensure the home's current menu, as well as a menu for at least 1 week in advance, is posted in a conspicuous and public place in the home. [redacted] 9/3/24). Daily refridgerator and freezer checks will be done by dietary manager or lead cook of the day. Administrator will check once weekly on friday or as need to ensure complaince, Sign off sheets have been posted on 7/10/2024 to sign off before closing kitchen that all food is dated in both kitchen and freezer. Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

3. Administrator will check menus once weekly to ensure they dates are correct. Once monthly administrator will check to verify menus are are still current (implemented 2023 site checklist). Once daily Administrator will check menu and food prep to enusure they are following the menu. Should something arise, administrator will check board for menu change

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 09/24/2024)

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 the morning of 7/9/24, there was a small, round orange tablet with script on the tablet indicating "38" on the floor to the left of the recliner in resident #6's bedroom. There was also an unlocked medication cup containing 2 small, round white tablets and 1 large gel capsule on the table to the right of resident #6's recliner.

Plan of Correction ***Directed [redacted] - 09/03/2024)***

1. Medications were removed from room on site.

2. Meeting held with resident #6 that med techs need to be present in the room during medication pass. Re-education with medication techs were held on 7/23/2023. (DIRECTED: Documentation of staff education shall be kept in accordance with 2600.65i. [redacted] 9/3/24). Med techs are to watch all residents take medications before signing off on medications. meeting held and system in place for DON on 7/10/2024 to hold meetings with medication techs after med pass every morning and ADON/Med techs daily to review second and third shift medication records the noght prior. System in place 8/23/2024 for Admin and DON to inspect at least 3 bedrooms weekly for 1 month starting 8-24-2024. going forward Admin and DON will inspect rooms once monthly to ensure complaince. all documentation will be kept in admin office

3. Administrator will hold ameeting with DON once daily to discuss medication pass for the last 24 hours starting on 7/12/2024 to ensure all medications were given to residents and ant medications that were refused are documented in chart accordingly

DIRECTED: By 9/23/24: The home shall conduct a quality management review which includes a review of all

183b - Meds and Syringes Locked (continued)

items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 9/3/24

Proposed Overall Completion Date: 08/29/2024

Directed Completion Date: *09/23/2024*

Implemented [redacted] - 09/24/2024)

227d - Support Plan Medical/Dental

14. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #4 has a history of sexually inappropriate behaviors, including approximately 2 weeks ago when resident #4 was observed by numerous people kissing another resident on the home's front porch and was observed sucking on the other resident's fingers. Resident #4's assessment, dated [redacted] 23, indicates resident #4 requires moderate supervision in the home; however, resident #4's sexually inappropriate behaviors are not indicated in resident #4's support plan, dated [redacted]

REPEAT VIOLATION: 11/28/2023, et. al.

Plan of Correction ***Accept [redacted] - 09/03/2024)***

1. Resident #4 RASP has been updated on 7/10/2024 by DON.

2. All resident RASP have been reviewed by DON and Administrator on 7/16/2024 to ensure they are current with any addiditonal updates. System still in place for DON and adimistrator to review care plans quarterly to add any addidtional information (implemented in 2023). Administrator held QM meeting on 8/24/2024 to review POC and any issues anyone has had within the last 30 Days following inspection. All documentation will be kept in accordance with 2600.26b. Next meeting scheduled for 9/23/2024.

3. Administrator and DON will review updates once monthly beginning 7/16/2024 and all resident RASP every three months to ensure all important information is documented. Review documentation will be placed in administrator office .

Licensee's Proposed Overall Completion Date: *08/29/2024*

Not Implemented [redacted] 09/24/2024)