pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LUTHER RIDGE FACILITY OPERATIONS LLC**
LEGAL ENTITY

To operate **LUTHER RIDGE AT SEIDERS HILL**
NAME OF FACILITY OR AGENCY

Located at **160 RED HORSE ROAD POTTSVILLE, PA 17901**
(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 **Assisted Living**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **135**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

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 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **January 3,** **2025** until **July 3,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **224663**

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

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 3, 2025

[redacted]
Executive Director
Luther Ridge Facility Operations, LLC
160 Red Horse Road
Pottsville, Pennsylvania 17901

RE: Luther Ridge at Seiders Hill
License: 224663

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 7, 2024, May 13, 2024, May 14, 2024, May 20, 2024, July 10, 2024, July 16, 2024, July 18, 2024, August 27, 2024, September 24, 2024, and September 25, 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. 2800 (relating to Assisted Living Residence), the Department hereby Refuses to Renew your certificate of compliance (license number 224662) dated April 19, 2024, to October 19, 2024, and issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated April19, 2024, to October 19, 2024, is NOT reinstated upon expiration of this THIRD 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 SECOND PROVISIONAL license is enclosed and is valid from January 3, 2025 to July 3, 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. 2800 (relating to Assisted Living Residence), 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 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 30 days of the date of this letter by:

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

This decision is final 31 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: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *10/19/2024*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *PA Dept. of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *92* **Waking Staff:** *69*

Inspection Information

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

Reason: *Complaint, In* **ate:** *05/20/2024*

Inspection Dates and

05/07/2024 - On-Site: [redacted]
05/13/2024 - Off-Site: [redacted]
05/14/2024 - Off-Site: [redacted]
05/20/2024 - Off-Site: [redacted]

Resident Demograph

General Informatio

License Capacity: *135* **Residents Served:** *73*

Special 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:** *71*

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

Have Mobility Need: *19* **Have Physical Disability:** *0*

Inspections / Reviews

05/07/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/07/2024*

06/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/13/2024*

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

12/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/13/2024*

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

15a Resident abuse report

1. Requirements

2800.
15.a. The residence 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 3/11/24, Staff Person A filmed residents in a common area of the home on [redacted] cellphone and posted the footage to social media. This was not reported in accordance with the Older Adults Protective Services Act.

Plan of Correction ***Accept ([redacted] - 06/07/2024)***

Step 1: An internal investigation was conducted surrounding this incident. Employee was terminated as of [redacted]
Step 2: Conducted resident statements of that day and if they were affected or felt violated. No negative outcomes regarding, no new findings.
Step 3: Staff education on abuse, social media, electronic policy. Completed 5/20/2024.
Step 4: Director of Nursing/designee will ensure regulatory reporting within allotted time frame to state agencies.
Step 5: Reviewed in Quality Management plan May 2024.

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

Implemented [redacted] - 08/08/2024)

23a ADL assistance

2. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #4 required physical assistance with incontinence care. Per staff interviews, Resident #4's incontinence briefs were soaked through to [redacted] clothes on several occasions. Staff stated that they performed 2-hour checks for the resident and that they did not perform any additional checks.

Plan of Correction ***Accept ([redacted] - 06/07/2024)***

Step 1: Resident no longer residing at facility.
Step 2: DON/designee audited all care plans and incontinence program for residents utilizing. No concerns noted during this process.
Step 3: Staff educated on immediately notifying and addressing changes with all residents and LPN/DON. Completed on 5/20/2024. Staff educated same day on properly conducting interviews with any outside provider, families, state agencies, etc. 5/20/2024.
Step 4: DON/designee to review B and B documentation daily x5 x2 wk then 1x weekly x 2 wk.
Step 5: Discussed in detail at May 2024 quality management meeting.

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

Not Implemented [redacted] - 11/18/2024)

42s Privacy - self/possessions

3. Requirements

42s Privacy - self/possessions *(continued)*

2800.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 3/11/24, Staff Person A filmed residents in a common area of the home on [redacted] cellphone and posted the footage to social media, violating residents' privacy.

Plan of Correction ***Accept [redacted] - 06/07/2024)***

Step 1: An internal investigation was conducted surrounding this incident. Employee was terminated as of [redacted]

Step 2: Conducted resident statements of that day and if they were affected or felt violated. No negative outcomes regarding, no new findings.
Step 3: Staff education on privacy, resident rights. Completed 5/20/2024.
Step 4: Director of Nursing/designee will ensure regulatory reporting within allotted time frame to state agencies as needed. Review of resident rights with residents with residents during resident council meetings.
Step 5: Reviewed in Quality Management plan May 2024.

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

Implemented [redacted] - 08/08/2024)

95 Furniture & Equipment

4. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Based on a conversation and emails provided by Staff Person C, it was determined that the smaller of the 2 elevators in the home has been inoperable for several weeks. Despite repairs being made on the elevator, it cannot be used until an inspection is completed and a permit is obtained by the home.

Plan of Correction ***Accept [redacted] - 06/07/2024)***

Step 1: Small elevator went down April 5, 2024 in the evening. It was repaired with TKE Elevator doing a weight adjustment next business day April 8, 2024. Small elevator went down again on April 9, 2024 in the evening. TKE came in April 10, 2024 and determined it needed a software upgrade and a valve replacement. TKE stated they had to order in the valve, apply for a state permit for repair, and have a complete state inspection.
Step 2: Valve was replaced on 5/21/2024. State inspected and approved Tuesday May 28, 2024. Small elevator has been up and running since 11AM 5/28/2024.
Step 3: Reviewed at May 2024 monthly quality management meeting.

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

Implemented [redacted] 08/22/2024)

132c Fire drill records

5. Requirements

2800.

132c Fire drill records *(continued)*

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

Description of Violation

The home's fire drill logs were reviewed. The time for the drill held on 1/3/24 is not clearly indicated; with 3:35pm and 5:30am documented and both times crossed out. The time for the drill held on 2/12/24 is documented as 3:45pm with an evacuation time as 5:30am. Repeated violation 2/21/24 et al.

Plan of Correction ***Accept ([redacted] - 06/07/2024)***

Step 1: Reviewed policy and state regulations with maintenance director 5/21/24.
Step 2: Monthly fire drills utilizing the 2800 regulation form.
Step 3: Monthly fire drills conducted and reviewed for accuracy per 2800 regulations by maintenance department/designee.
Step 4: Reviewed at May 2024 monthly quality management meeting.

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

Not Implemented ([redacted] - 11/18/2024)

132d Evacuation

6. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

The home's fire drill logs were reviewed. The start time for the drill held on 2/12/24 is documented as 3:45pm with an evacuation time as 5:30am. Based on this information, it cannot be determined if the residents were evacuated within the time 7-minute time frame as determined by the Fire Safety expert on 11/15/23.

Repeated violation 2/21/24 et al.

Plan of Correction ***Accept ([redacted] - 06/07/2024)***

Step 1: Reviewed policy and state regulations with maintenance director 5/21/24.
Step 2: Monthly fire drills utilizing the 2800 regulation form.
Step 3: Monthly fire drills conducted and reviewed for accuracy per 2800 regulations by maintenance department/designee.
Step 4: Reviewed at May 2024 monthly quality management meeting.

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

Not Implemented ([redacted] - 11/18/2024)

187d Follow prescriber's orders

8. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

187d Follow prescriber's orders *(continued)*

Description of Violation

Resident # 1 has a physician order to hold resident's medication Metoprolol Tartrate Tablet 100mg BID if systolic blood pressure is less than 110 or if heart rate less than 55. On 5/2/24 at 5:00pm resident's systolic blood pressure was recorded on the medication administration record as 98. However, the medication was marked as administered. Also, on 5/5/24 at 9:am resident's systolic blood pressure was recorded on the medication administration record as 81. However, the medication was marked as administered.
Resident # 2 has a physician order to hold resident's medication Metoprolol Tartrate 12.5 mg BID if systolic blood pressure is less than 100 or if heart rate less than 60. On 5/1/24 at 9:00am resident's heart rate was recorded on the medication administration record as 54. However, the medication was marked as administered.
Resident #3 has an order to have their blood sugar level tested once daily. Review of the resident's glucometer indicates Resident #3's blood sugar level was not tested on 5/2/24.

Repeated violation 2/21/24 et al..

Plan of Correction ***Accept [redacted] 06/07/2024)***

Step 1: No adverse effects suffered by resident.
Step 2: Physician orders reviewed for accuracy for all residents. Negative findings addressed.
Step 3: Medication technicians and LPNs educated on parameters and proper reading of physician orders on 5/20/24.
Step 4: Reviewed at May 2024 Quality Management meeting.

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

Not Implemented [redacted] 12/02/2024)

227d Support plan – med/dental

9. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Per staff interviews, Resident #5 required a 1-person assist with transfers and showering. Resident #5 also ambulated with the use of a wheelchair due to being nervous and fearful of walking. Resident #5's ASP dated [redacted] does not include documentation regarding these care needs and use of assistive device.

Repeated violation 2/21/24 et al.

Plan of Correction ***Accept [redacted] 06/07/2024)***

Step 1: Resident 4 and 5 no longer a resident of facility.
Step 2: Reviewed resident care plans needing an increase in care in facility. No negative findings.

227d Support plan – med/dental (continued)

Step 3: Staff educated 5/20/24 of care plan, review, documentation.

Step 4: Monthly care plan reviews of residents needing status change by DON/Designee. 1x weekly x4 weeks. 1x monthly.

Step 5: Reviewed at QM meeting May 2024.

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

Not Implemented [redacted] 11/14/2024)

251b Record entries - legible

11. Requirements

2800.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on the staff statement dated 4/12/24 provided by Staff Person B. Staff person (B) wrote the statement in response to an incident concerning Resident #6.

Plan of Correction ***Accept [redacted] 06/07/2024)***

Step 1: White out removed from building 5/8/2024.

Step 2: Staff educated on not using corrective fluid 5/20/24.

Step 3: Reviewed at May 2024 quality management meeting.

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

Implemented [redacted] 08/08/2024)

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

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *10/19/2024*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *85* **Waking Staff:** *64*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *07/18/2024*

Inspection Dates and Department Representative

07/10/2024 - On-Site: [redacted]
07/16/2024 - On-Site: [redacted]
07/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served:** *73*

Special 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:** *73*

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

Have Mobility Need: *12* **Have Physical Disability:** *0*

Inspections / Reviews

07/10/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/17/2024*

08/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/24/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/04/2024*

09/09/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/24/2024*

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

12/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/24/2024*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

The home's blue book containing the 2800 regulations was located inside a locked cabinet in the entry area of the home and was inaccessible to the residents. during the inspection on 7/10/2024. Repeated violation 2/21/24 et al.

Plan of Correction ***Accept [redacted] - 09/05/2024)***

1.2800. 3.d.
The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.
Description of Violation
The home's blue book containing the 2800 regulations was located inside a locked cabinet in the entry area of the home and was inaccessible to the residents. during the inspection on 7/10/2024
POC: The blue book will be located in the binder in the lobby with the violations and accessible to residents and visitors at all times.
Completion Date: 7/10/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Administrator will check daily during morning rounds.

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

Implemented [redacted] 10/16/2024)

57b 1 hour/day/resident

3. Requirements

2800.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 7/6/24 & 7/7/2024, the home had 73 residents which requires a daily staffing of 73 direct care hours. On 7/6/24, direct care staff were scheduled for 60 hours and on 7/7/24, direct care staff were scheduled for 62 hours. The home did not have enough staff to provide 1 hour of direct care to each mobile resident.

Plan of Correction ***Directed [redacted] 09/05/2024)***

3. 2800. 57.b.

Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.
Description of Violation
On 7/6/24 & 7/7/2024, the home had 73 residents which requires a daily staffing of 73 direct care hours. On 7/6/24, direct care staff were scheduled for 60 hours and on 7/7/24, direct care staff were scheduled for 62 hours. The home did not have enough staff to provide 1 hour of direct care to each mobile resident.
POC: The scheduler at Luther Ridge will make sure the home has the required staffing to meet the hours to care for

57b 1 hour/day/resident (continued)

the residents. Call off staff will be replaced as needed.
Completion Date: 7/10/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: The scheduler will meet with the Administrator, DON and ADOW daily to review staffing hours.
**Documents attached*

Proposed Overall Completion Date: 9/04/2024

Directed: Beginning 9/12/2024 and through 12/12/2024, the daily review of staffing hours by the scheduler and administrator/designee will be documented on a separate audit sheet that will be dated and signed by all participants upon completion of the daily schedule review. Any call off, no show, or staff member that arrives late or leaves early from their shift will also be documented on the audit sheet. The home will replace any staff member needed to meet the home's required staffing hours for mobile residents.

Directed Completion Date: *09/23/2024*

Implemented [redacted] - 10/16/2024)

57c 2 hrs/day/immob. resident

4. Requirements

2800.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 7/6/2024 & 7/7/2024, the homes had 73 residents and 12 immobile residents. On 7/6/24, direct care staff were scheduled for 60 hours and on 7/7/24, direct care staff were scheduled for 62 hours. The home did not have enough staff to provide 2 hours of direct care to each immobile resident. The home was required to provide 85 hours on each of these days.

Plan of Correction ***Directed ([redacted] - 09/05/2024)***

4.2800. 57.c.

Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.
Description of Violation
On 7/6/2024 & 7/7/2024, the homes had 73 residents and 12 immobile residents. On 7/6/24, direct care staff were scheduled for 60 hours and on 7/7/24, direct care staff were scheduled for 62 hours. The home did not have enough staff to provide 2 hours of direct care to each immobile resident. The home was required to provide 85 hours on each of these days.
POC: The scheduler at Luther Ridge will make sure the home has the required staffing to meet the hours to care for the residents. Call off staff will be replaced as needed.
Completion Date: 7/10/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: The scheduler will meet with the Administrator, DON and ADOW daily to review

57c 2 hrs/day/immob. resident (continued)

staffing hours.
**Documents attached*

Proposed Overall Completion Date: 09/04/2024

Directed: Beginning 9/12/2024 and through 12/12/2024, the daily review of staffing hours by the scheduler and administrator/designee will be documented on a separate audit sheet that will be dated and signed by all participants upon completion of the daily schedule review. Any call off, no show, or staff member that arrives late or leaves early from their shift will also be documented on the audit sheet. The home will replace any staff member needed to meet the required 2 hours for each resident with mobility needs.

Directed Completion Date: *09/23/2024*

Implemented [redacted] 10/16/2024)

57d Waking staff hours

5. Requirements

2800.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 7/6/24, 7/7/2024, and 7/8/2024, the home had 73 residents and 12 immobile residents. On 7/6/24, the total direct care hours required during waking hours was 63.75 but only 45 were provided. On 7/7/24, the direct care hours required during waking hours was 63.75 but only 46.5 were provided, and on 7/8/24, the direct care hours required during waking hours was 63.75 but only 57.375 were provided.

Plan of Correction ***Directed ([redacted] 09/05/2024)***

See attached5. 2800. 57.d.

At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 7/6/24, 7/7/2024, and 7/8/2024, the home had 73 residents and 12 immobile residents. On 7/6/24, the total direct care hours required during waking hours was 63.75 but only 45 were provided. On 7/7/24, the direct care hours required during waking hours was 63.75 but only 46.5 were provided, and on 7/8/24, the direct care hours required during waking hours was 63.75 but only 57.375 were provided.

POC: The scheduler at Luther Ridge will make sure the home has the required staffing to meet the hours to care for the residents. Call off staff will be replaced as needed based on census.

Completion Date: 7/10/2024

Who's responsible: Administrator will ensure the POC will be followed.

57d Waking staff hours (continued)

How will it be maintained: The scheduler will meet with the Administrator, DON and ADOW daily to review staffing hours for each shift.

**Documents attached .*

Proposed Overall Completion Date: 09/04/2024

Directed: Beginning 9/12/2024 and through 12/12/2024, the daily review of staffing hours by the scheduler and administrator/designee will be documented on a separate audit sheet that will be dated and signed by all participants upon completion of the daily schedule review. Any call off, no show, or staff member that arrives late or leaves early from their shift will also be documented on the audit sheet. The home will replace any staff person needed to meet 75% of the required staffing during waking hours

Directed Completion Date: *09/23/2024*

Implemented [redacted] - 10/16/2024)

60a Staffing/support plan needs

6. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

On 7/6/24 2 staff persons were working the overnight hours (11pm to 7am) and on 7/7/24 and 7/8/24 only 1 staff person was working the overnight hours from 11pm to 7am. The home had 73 residents, 12 of them are immobile and 3 of them require an assist of 2 staff members to transfer from bed. There was not enough staff working to safely evacuate residents in an emergency.

Plan of Correction ***Directed [redacted] - 09/05/2024)***

6. 2800. 60.a.

Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.
Description of Violation
On 7/6/24 2 staff persons were working the overnight hours (11pm to 7am) and on 7/7/24 and 7/8/24 only 1 staff person was working the overnight hours from 11pm to 7am. The home had 73 residents, 12 of them are immobile and 3 of them require an assist of 2 staff members to transfer from bed. There was not enough staff working to safely evacuate residents in an emergency
POC: The scheduler at Luther Ridge will make sure the home has the required staffing to meet the hours to ensure safe evacuation takes place in the event of a fire. Call off staff will be replaced as needed based on census.
Completion Date: 7/10/2024

60a Staffing/support plan needs (continued)

Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: The scheduler will meet with the Administrator, DON and ADOW daily to review staffing hours to ensure safe evacuations and safety of all residents in the building.
**Documents attached*

Proposed Overall Completion Date: 09/04/2024

Directed: Beginning 9/12/2024 and through 12/12/2024, the daily review of staffing hours by the scheduler and administrator/designee will be documented on a separate audit sheet that will be dated and signed by all participants upon completion of the daily schedule review. Any call off, no show, or staff member that arrives late or leaves early from their shift will also be documented on the audit sheet. This documentation will include if the staff member was replaced or the reason that the staff member was not replaced. The determination of required staff needed will be based upon the home's census and the current needs of residents residing in the home.

Directed Completion Date: *09/23/2024*

Not Implemented [redacted] - 10/16/2024)

63a First Aid/CPR 1:35

7. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On 7/6/24, 2 staff persons trained in CPR/first aid were working from 11pm to 7am and on 7/7/24 and 7/8/24, 1 staff person was working from 11pm to 7am that was trained in CPR/First aid. The home has 73 residents and requires 1 CPR/first aid qualified staff per 35 residents present at all times.

Plan of Correction ***Directed [redacted] 09/05/2024)***

See attache7. 2800. 63.a.

For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On 7/6/24, 2 staff persons trained in CPR/first aid were working from 11pm to 7am and on 7/7/24 and 7/8/24, 1 staff person was working from 11pm to 7am that was trained in CPR/First aid. The home has 73 residents and requires 1 CPR/first aid qualified staff per 35 residents present at all times.

POC: The home will make sure there's 1 CPR/first aid qualified staff per 35 residents present at all times. If any changes, schedule will be reviewed to meet CPR requirements.

63a First Aid/CPR 1:35 (continued)

Completion Date: 7/10/2024

Who's responsible: Administrator will ensure the POC will be followed.

How will it be maintained: The scheduler will meet with the Administrator, DON and ADOW daily to review staffing hours, CPR requirements and expirations to ensure safety of all residents in the building.

**Documents attached d.*

Proposed Overall Completion Date: 09/04/2024

Directed: Beginning 9/12/2024 and through 12/12/2024, the daily review of staffing hours by the scheduler and administrator/designee will be documented on a separate audit sheet that will be dated and signed upon completion of the daily schedule review. Any call off, no show, or staff member that arrives late or leaves early from their shift will also be documented on the audit sheet as well as if the staff member was replaced. Staff members will be immediately replaced if needed to maintain the required 1:35 ratio

Directed Completion Date: *09/23/2024*

Implemented [redacted] 10/16/2024)

64a Initial admin training

8. Requirements

2800.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

Description of Violation

Staff Member [redacted] has been working at the facility since [redacted] as the facility's administrator. Although this staff member has completed the Personal Care Home Administrator 100-hour course, they are not qualified as an Assisted Living Administrator since they have not completed the required 15-hour supplemental ALR administrator course, associated competency test, and the ALRA orientation.

Plan of Correction ***Accept [redacted] - 08/23/2024)***

8. 2800. 64.a.
Prior to initial employment as an administrator, a candidate shall successfully complete the following:
Description of Violation
Staff Member [redacted] has been working at the facility since [redacted] as the facility's administrator. Although this staff member has completed the Personal Care Home Administrator 100-hour course, they are not qualified as an Assisted Living Administrator since they have not completed the required 15-hour supplemental ALR administrator course, associated competency test, and the ALRA orientation.
POC: Administrator will complete the 15-hour supplemental ALR administrator course, associated competency test, and the ALRA orientation.
Course completion Date: 7/22/2024 and ALRA orientation 9/5/2024.

64a Initial admin training (continued)

Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Administrator will complete the 15-hour supplemental ALR administrator course.
**Documents attached*

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented [redacted] 10/16/2024)

85a Sanitary conditions

11. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/18/2024, the windowsill in the 2nd floor laundry room was covered with dead insects. Also, in various parts of the home, there was a very strong odor of urine and bowel movement.

Plan of Correction ***Accept [redacted] - 08/23/2024)***

11. 2800. 85.a.
Sanitary conditions shall be maintained.
Description of Violation
On 7/18/2024, the windowsill in the 2nd floor laundry room was covered with dead insects. Also, in various parts of the home, there was a very strong odor of urine and bowel movement.
POC: Housekeeping will clean windows weekly or as needed with deep cleaning to ensure no spider webs frow on windows.
Completion Date: 7/18/2024 and as needed with deep cleanings.
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Housekeeping supervisor will ensure weekly rounds are completed to look over window cleaning for common areas and residents' rooms.
**Documents attached*

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented [redacted] 10/16/2024)

85e Trash outside

12. Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

There was a garbage bag left on the sidewalk outside the back door by the laundry room on 7/10/2024.

Repeated violation 2/21/24 et al.

Plan of Correction ***Accept [redacted] - 09/05/2024)***

12. 2800. 85.e.
Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

85e Trash outside (continued)

Description of Violation
There was a garbage bag left on the sidewalk outside the back door by the laundry room on 7/10/2024. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.
POC: Maintenance and housekeeping will make sure all outside areas are free of trash and all trash is kept in a covered receptacle. Maintennace disposed of all items in a dumpster.
Completion Date: 7/10/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Maintenace and housekeeping will complete daily rounds.

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

Implemented [redacted] - 10/16/2024)

92 Windows/screens

13. Requirements

2800.
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

The screen from the 2nd floor laundry room was lying on the ground behind the building and the laundry room window was open on 7/10/2024

Plan of Correction ***Accept [redacted] - 08/23/2024)***

13. 2800. 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
The screen from the 2nd floor laundry room was lying on the ground behind the building and the laundry room window was open on 7/10/2024.
POC: Housekeeping and Maintenace will make ensure all screens and window are closed during daily rounds.
Completion Date: 7/10/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Administrator will follow up with Maintenance and housekeeping Director daily during morning meeting.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented [redacted] - 10/16/2024)

101n Walls, floors & ceilings

14. Requirements

2800.
101.n. The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

Several holes measuring 1-3 inches in diameter were observed in the wall of resident room 115 in the area located behind the resident's recliner on 7/16/2024.

101n Walls, floors & ceilings *(continued)*

Plan of Correction ***Directed ([redacted] - 09/05/2024)***

14. 2800. 101.n.

The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.
Description of Violation
Several holes measuring 1-3 inches in diameter were observed in the wall of resident room 115 in the area located behind the resident's recliner on 7/16/2024.
POC: Maintenance fixed holes by spackling and will look over rooms as requested by residents and fix anything damaged immediately.
Completion Date: 7/19/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Maintenace will continue to look over residents' rooms for damage to walls, floors, ceiling s and complete any work orders that come through the system.

Proposed Overall Completion Date: 09/04/2024

Directed: Beginning 9/12/2024 and through 12/12/2024, the administrator or designee will perform weekly checks of all resident rooms and ensure the walls and ceiling are clean and in good repair. Any issues will be reported and immediately cleaned, repaired, or replaced. The weekly checks will be documented with the date and name of the staff member that performed the checks.

Directed Completion Date: *09/23/2024*

Implemented [redacted] - 10/16/2024)

103f Fridge/Freezer Temps

15. Requirements

2800.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/16/2024, the drink cooler in the front of the kitchen was holding a temperature of 52 degrees and the walk-in freezer was holding a temperature of 11 degrees.

Plan of Correction ***Accept[redacted] - 08/23/2024)***

15. 2800. 103.f.
Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.
Description of Violation
On 7/16/2024, the drink cooler in the front of the kitchen was holding a temperature of 52 degrees and the walk-in freezer was holding a temperature of 11 degrees.
POC: A new cooler was ordered and replaced. The walk-in freezer was fixed and now functioning at 40 degrees or lower.
Completion Date: 8/6/2024

103f Fridge/Freezer Temps (continued)

Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: The Dining Director will review temp logs to make sure the freezer and refrigerator are functioning properly.
**Documents attached*

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented ([redacted] - 10/16/2024)

105d Changing bed linens/towels

16. Requirements

2800.
105.d. Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.

Description of Violation

Through resident interviews it was confirmed that bed linens for Resident #1 were not being changed weekly. Resident #1 indicates that their bed linens are changed every 2 weeks.

Plan of Correction ***Accept [redacted] - 08/28/2024)***

16. 2800. 105.d.
Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.
Description of Violation
Through resident interviews it was confirmed that bed linens for Resident #1 were not being changed weekly. Resident #1 indicates that their bed linens are changed every 2 weeks.
POC: RA's and CNA's will change linen weekly on shower day.
Completion Date: 7/11/2024 (New shower and linen schedule created)
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: LPN, ADOW and DON will ensure all residents' linen are changed.
**Documents attached*

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented ([redacted] 10/16/2024)

105g Dryer lint removal

17. Requirements

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

It appears that the dryer vent had not been cleaned in a while as there was dryer lint that was caked on the outside of the vent. There was also a thick layer of dryer lint that was on the sidewalk and on the bushes outside the first-floor laundry room on 7/10/2024.

105g Dryer lint removal *(continued)*

Plan of Correction ***Accept [redacted] 08/23/2024)***

17. 2800. 105.g.
To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.
Description of Violation
It appears that the dryer vent had not been cleaned in a while as there was dryer lint that was caked on the outside of the vent. There was also a thick layer of dryer lint that was on the sidewalk and on the bushes outside the first-floor laundry room on 7/10/2024.
POC: Maintenance and housekeeping cleaned all dryers. Dryers are now free of lint on 7/10/2024.
Completion Date: 7/10/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Housekeeping will check dryers for lint daily.
**Documents attached*

Licensee's Proposed Overall Completion Date: *08/22/2024*

Implemented [redacted] 10/16/2024)

132h Designated meeting place

18. Requirements

2800.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 7/10/24, at 0630 resident # 1, #2, #6, and #8 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept [redacted] 09/05/2024)***

17. 2800. 132. H
Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill
Description of Violation
During the fire drill on 7/10/24, at 0630 resident # 1, #2, #6, and #8 did not evacuate to a designated meeting place away from the building or within the fire-safe area
POC: Fire drill completed on 8/7/2024 and all residents were evacuated. Staff was educated and aware all residents must be evacuated.
Completion Date: 8/7/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Maintenace and staff are aware that all residents will be evacuated at all times unless hospice with a doctor's order stating resident can stay behind closed fire safe doors.

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

Implemented [redacted] 10/16/2024)

227d Support plan – med/dental

20. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Residents #1 and #6 utilize a bedside mobility device. The Assessment and Support Plans for Resident #1 dated [redacted] and for Resident #2 dated [redacted] do not include the specific need for the device, the intended use of the device, any risks associated with the use of the device, the resident's ability to use the device safely, identification of the specific device being used and if a cover is required to meet FDA guidelines.

Repeat Violation 2/21/24

Plan of Correction ***Accept [redacted] 09/05/2024)***

19. 2800. 227.d.
Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.
Description of Violation Resident
 # 2, #3, and #4 had fall in May 2024. None of the falls were documented in the ASP nor the safeguards the home put in place to ensure their ongoing safety. Resident # 1 and #6 uses a bedside mobility devices. Resident # 1's Assessment Support Plan dated [redacted] and Resident # 2's Assessment Support Plan dated [redacted] does not reflect the specific need for the device, the intended use, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, identification of the specific device to be used and if a cover is required to meet FDA guidelines.
POC: All ASP were reviewed while updated to reflect their care needs, mobility with and without assistive devices, and to promote ongoing safety and why the cover was necessary.
Completion Date: 8/9/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: ADON and DON will review and update the ASP monthly and as needed to ensure proper updates are being documented.
(Resident #2 does not have an enabler bar)

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

Not Implemented [redacted] 10/16/2024)

227g Support plan - signatures

21. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The Assessment and Support Plan for Resident #7 dated [redacted] was not signed by the resident. The boxes indicating if the resident refused or was unable to sign were also left blank.

Plan of Correction ***Accept [redacted] - 09/05/2024)***

20. 2800. 227.g.
Individuals who participate in the development of the support plan shall sign and date the support plan.
Description of Violation
Resident #7 ASP dated [redacted] was not signed by the resident. It was not indicated that the resident refused or was unable to sign.
POC: All ASP were reviewed to ensure all signatures were on the last page of the ASP. Moving forward, the ED will receive and go through all ASP and check for signatures after they're completed.
Completion Date: 8/6/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: ADON and DON will look over the ASP for signatures as they're completed.
**Documents attached*

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

Implemented [redacted] - 10/16/2024)

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

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *10/19/2024*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *83* **Waking Staff:** *62*

Inspection Information

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

Reason: *Complaint, Provisional, Incident, Interim* **Exit Conference Date:** *09/25/2024*

Inspection Dates and Department Representative

08/27/2024 - On-Site [redacted]
09/24/2024 - On-Site
09/25/2024 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served:** *71*

Special 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:** *71*

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

Have Mobility Need: *12* **Have Physical Disability:** *0*

Inspections / Reviews

08/27/2024 - Full

Lead Inspector [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/28/2024*

12/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/01/2024*

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

5a1 DHS access

1. Requirements

2800.
5.a. The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:
1. Agents of the Department.

Description of Violation

On 8/27/24 at approximately 9:30am a list of current residents was requested from staff. At approximately 10:30am resident records were requested from staff after the lists were provided to Licensing Representatives. Resident records were not provided to licensing representatives until 11:50am.

Plan of Correction ***Directed (JH - 11/05/2024)***

POC: Administrator or designee will provide DHS surveyors immediate access to all resident records as required.

Completion Date: 9/25/2024
Who's responsible: Administrator will ensure the POC will be followed when surveyors are in the building at all times.

Proposed Overall Completion Date: 11/01/2024

Directed Plan of Correction:
The administrator will ensure that agents of the Department have immediate access to the home, records, and residents upon request. The home will designate a staff person to act as administrator designee at all times the administrator is not present in the home. The designee will have access to all staff and resident records. The staff schedule will indicate who is acting as administrator designee on all shifts.

Directed Completion Date: *12/01/2024*

60a Staffing/support plan needs

2. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

The home has a current census of 64 residents including 12 residents with mobility needs who require assistance for safe transfers during emergency evacuation. According to staff interviews 4 of the 12 residents with mobility needs require assistance of two staff persons for safe transfers. The home only scheduled two staff persons for the 3rd shift hours of 11pm to 7am for all dates in the month of September 2024. On 7/18/24 the home conducted a fire drill at 5:35am and fire drill logs indicate the evacuation time took 14 minutes with seven staff participating in the drill. At the time of the drill the home had 12 residents with mobility needs and 4 residents requiring assistance of two staff

60a Staffing/support plan needs (continued)

persons. The home's maximum safe evacuation time is currently 7 minutes according to the fire safety inspection letter dated 8/27/24. The home is not scheduling an adequate number of staff to safely evacuate all residents within the designated maximum safe evacuation time.

Plan of Correction ***Accept [redacted] - 11/05/2024)***

POC: Scheduler will ensure 3 or more staff are scheduled on 11-7 shift daily.
Completion Date: 9/26/ 2024
Who's responsible: DON or Administrator will ensure the POC will be followed and if staffing is short, agency will fill in..
How will it be maintained: Scheduler is responsible for scheduling clinical staff and reviewing the schedule daily with DON and Administrator.

Licensee's Proposed Overall Completion Date: *11/01/2024*

65g Initial direct care training

3. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff person A was hired [redacted] as a direct care worker. Staff person A did not complete the department's required direct care competency test until [redacted]

Plan of Correction ***Directed [redacted] 1/05/2024)***

POC: Human resources will incorporate the DHS required training for RA's into the orientation plan during week 1.

Completion Date: 10/1/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: HR and Administrator will review DHS training is happening the week of orientation.

Proposed Overall Completion Date: 11/01/2024

Directed Plan of Correction:
The administrator will develop a staff training plan that includes the following information:
(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly-scheduled volunteer
(2) The required training courses for each person identified in (1).
(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g.

Directed Completion Date: *12/01/2024*

101j7 Lighting/operable lamp

4. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident room #127 does not have a bedside lamp or other source of illumination.

Plan of Correction ***Accept (JH - 11/05/2024)***

POC: Maintenance staff will complete weekly rounds to check for light bulbs that are not functioning and replace immediately.
Completion Date: 11/1/2024-12/31/2024
Who's responsible: Maintenance Director
How will it be maintained: Maintenace Director will complete monthly light bulb audits and review with the Administrator/ED.

Licensee's Proposed Overall Completion Date: *11/01/2024*

132c Fire drill records

5. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

Fire drills recorded on the home's fire drill logs from January 2024 through August 2024 denote only the number of minutes for the time of the evacuation. The home is not documenting evacuation times with both minutes and seconds. The home's maximum safe evacuation time is 7 minutes according to the fire safety letters dated 11/15/23 and 8/26/24. Also, on 8/7/24 a fire drill was observed by a fire safety expert and the letter dated 8/26/24 from the fire safety expert indicates the evacuation was completed in 3 minutes and 50 seconds. The home's fire drill logs incorrectly indicate the fire drill took 5 minutes on 8/7/24. Repeated violation 2/21/24 et al.

Plan of Correction ***Directed [redacted] 11/05/2024)***

POC: Maintenace will document minutes and seconds on fire drill log.

Completion Date: 10/31/2024
Who's responsible: Administrator will ensure the POC is being followed.
How will it be maintained: Maintenace and Administrator will review after each fire drill.

Proposed Overall Completion Date: 11/01/2024

Directed Plan of Correction:
The home will use the Department's model fire drill log to record fire drill information. The log will be completed in its entirety.

132c Fire drill records *(continued)*

Directed Completion Date: *12/01/2024*

132d Evacuation

6. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

On 7/18/24 the home conducted a fire drill at 5:38 am and the evacuation times was documented as 14 minutes on the fire drill logs. The Fire safety inspection letter dated 11/15/23 indicates that the maximum safe evacuation time is 7 minutes. Repeated violation 2/21/24 et al.

Plan of Correction ***Accept [redacted] - 11/05/2024)***

POC: Maintenace and Adminstartor will ensure residents are evacuated within the allowed timeframe given by the fire safety expert.
Completion Date: 10/31/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Maintenace will review fire drill log with Administrator monthly to ensure residents are evacuated within the desired timeframe.

Licensee's Proposed Overall Completion Date: *11/01/2024*

141a Medical evaluation

7. Requirements

2800.
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:
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Description of Violation

The Medical Evaluation dated [redacted] for resident #1 was missing information indicating their medication regimen, contraindicated medications, or medication side effects
The Medical Evaluation dated [redacted] for resident #2 was missing information indicating their medication regimen, contraindicated medications, or medication side effects.
The Medical Evaluation dated [redacted] for resident # 3 was missing information indicating their medication regimen, contraindicated medications, or medication side effects.

Plan of Correction ***Accept [redacted] - 11/05/2024)***

POC: Medical evaluations will be completed within 1 year or as needed.
Completion Date: 11/1/2024-12/31/2024
Who's responsible: DON or designee will ensure the POC will be followed.
How will it be maintained: Administrator or designee will audit DME's to ensure evaluations are being completed on time.

Licensee's Proposed Overall Completion Date: *11/01/2024*

184a Resident meds labeled

9. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4 has an order for Lorazepam .5mg one tablet every 4 hours as needed. The order is listed correctly on the Medication Administration Record (MAR) but on 9/25/24 the pharmacy label for the medication indicated the order is for one tablet every 6 hours as needed.

Resident #4 has an order for Novolog insulin at 9am to be administered on a sliding scale basis. The MAR indicates the sliding scale is as follows:
201-250 = 2 units
251-300 = 4 units
301-360 = 6 units
351-400 = 8 units
On 9/25/24 the pharmacy label incorrectly indicated the sliding scale is as follows:
201-250 = 4 units
251-300 = 6 units
301-350 = 8 units
351-400 = 10 units.

Plan of Correction ***Accept [redacted] 11/05/2024)***

POC: Audits will be completed to check for EMAR/labeling errors.
Completion Date: 11/1/2024-12/31/2024
Who's responsible: DON or designee will audit random EMARS to ensure the POC will be followed.
How will it be maintained: Administrator will ensure POC is being followed by reviewing the audit binders with the DON.

Licensee's Proposed Overall Completion Date: *11/01/2024*

185a Storage procedures

10. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #4's glucometer is not calibrated to the correct date and time.

Resident #4 has an order for Cal Gest antacid tablets, one tablet as needed for heartburn. The home did not have the antacid tablets on hand to administer if needed on 9/25/24.

185a Storage procedures (continued)

On 9/24/24 the glucometer and blood glucose readings were audited for resident #5's order for blood glucose monitoring before meals and the following errors were found:
On 8/19/24 the resident's blood glucose reading at 4pm was documented as 109 but was 106 in the glucometer.
On 8/20/24 the resident's blood glucose reading at 4pm was documented as 179 but was 172 in the glucometer.
On 8/22/24 the resident's blood glucose reading at 4pm was documented as 119 but was 112 in the glucometer.
On 8/24/24 the resident's blood glucose reading at 11:30am was documented as 87 but was 82 in the glucometer.
On 8/24/24 at 4pm the resident's blood glucose reading at 4pm was documented as 194 but was 192 in the glucometer.

Resident #6's Glucometer and Medication Administration Record (MAR) were reviewed.
On 8/16/24 at 5:00pm the meter indicates a blood sugar level of 263; 265 is documented on the MAR.
On 8/17/24 at 5:00pm the meter indicates a blood sugar level of 259; 249 is documented on the MAR.
Repeated violation 2/21/24 et al.

Plan of Correction ***Accept ([redacted] - 11/05/2024)***

POC: DON or designee will audit glucometers for calibration every month
Completion Date: 11/1/2024-12/31/2024
Who's responsible: DON or designee
How will it be maintained: Administrator will ensure the POC will be followed.

Licensee's Proposed Overall Completion Date: *11/01/2024*

187d Follow prescriber's orders

11. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #7 has an order for Guaifenesin 600 mg, one tablet every 12 hours for cough. On 9/20/24 the medication was administered at 8am and not again until 9/21/24 at 8 am.

Resident #8 has an order for Metoprolol 25mg one half tablet two times daily, to be held for systolic blood pressure (SBP) less than 100 or heart rate less than 60. From 9/1/24 through 9/24/24 the home did not measure the resident's heart rate before administering the medication.
Also, from 9/1/24 to 9/4/24 the medication was administered at 9am and 5pm but neither the SBP nor the heart rate were measured prior to administering the medication. On 9/21/24 and 9/22/24 the medication was administered at 9am but again neither the SBP nor the heart rate were measured prior to administering the medication.
Resident #8 also has an order for Acetaminophen, two capsules every 8 hours. On the following dates and times, the medication was not administered:
9/14/24 at 6am; 9/17/24 at 2pm and 9pm; 9/21/24 at 2pm; 9/23/24 at 2pm; 9/25/24 at 2pm.

Resident #9 has an order for Metoprolol 100 mg, one tablet two times daily, to be held if the SBP is less than 110 or heart rate is less than 55. On 9/2/24 and 9/7/24 the resident's SBP and heart rate were not measured prior to administering the medication at 5pm and 9am respectively. On 9/15/24 the resident's SBP was 109 but the

187d Follow prescriber's orders (continued)

medication was still administered.
The above medication errors were discovered on 9/25/24 during the medication cart audits.

Resident #10 is prescribed Oxygen continuously, 24 hours per day, 7 days per week. On 8/19/24 Staff failed to connect Resident #10 to their portable oxygen tank prior to taking them to the dining room for lunch.
Repeated violation 2/21/24 et al, 7/30/24.

Plan of Correction ***Accept [redacted] - 11/05/2024)***

POC: DON will provide an education to staff on the importance of 5 rights of medication administration and BP parameters will be reviewed.
Completion Date: 11/1/2024-12/31/2024
Who's responsible: DON or designee
How will it be maintained: DON or the Administrator will review training with staff.

Licensee's Proposed Overall Completion Date: *11/01/2024*

227d Support plan – med/dental

12. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident #11 has an enabler bar attached to their bed. The Assessment/Support Plan (ASP) dated 6/10/24 does not indicate the following: The specific need for the device; the intended use; any risks associated with the device; the resident's ability to use the device safely for the intended purpose; identification of the specific device to be used; and if a cover is required to meet FDA guidelines.

The Support Plan for Resident #12 dated [redacted] does not indicate that the resident receives home health care and wound care services.

The Support Plan for Resident #13 dated [redacted] does not indicate that the resident receives home health and wound care services.
Repeated violation 2/21/24 et al.

Plan of Correction ***Accept [redacted] - 11/05/2024)***

POC: DON or designee will review ASP for specialties before filing in the chart.
Completion Date: 11/1/2024-12/31/2024
Who's responsible: Administrator will ensure the POC will be followed.

227d Support plan – med/dental (continued)

How will it be maintained: ASP audits will take place for ASP monthly and as needed.

Licensee's Proposed Overall Completion Date: *11/01/2024*

252 Records – content

13. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

The resident record for resident #14 does not include a photograph of the resident that is no more than 2 years old. The most current photo on record for Resident #14 is dated [redacted]
Repeated violation 2/21/24 et al.

Plan of Correction ***Accept[redacted] - 11/05/2024)***

POC: The Admissions director will ensure all photos are up to date in the residents chart every year.
Completion Date: 11/1/2024-12/31/2024
Who's responsible: Administrator will ensure the POC will be followed.
How will it be maintained: Admissions Director or designee will complete yearly audits.

Licensee's Proposed Overall Completion Date: *11/01/2024*