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

January 7, 2025

THOMAS SMITH

RE: COMFORTS OF HOME
1619 LISTONBURG ROAD
CONFLUENCE, PA, 15424
LICENSE/COC#: 33113

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2024, 07/17/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *COMFORTS OF HOME* **License #**: *33113* **License Expiration**: *05/21/2025*

Address: *1619 LISTONBURG ROAD, CONFLUENCE, PA 15424*

County: *SOMERSET* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *THOMAS SMITH*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *09/17/1986* **Issued By**: *Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *19* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *07/17/2024*

Inspection Dates and Department Representative

07/16/2024 - On-Site: [redacted]
07/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **Residents Served**: *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *13*
Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *5*
Have Mobility Need: *2* **Have Physical Disability**: *2*

Inspections / Reviews

07/16/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/09/2024*

08/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/02/2024*
Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/22/2024*

Inspections / Reviews *(continued)*

08/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted**: *10/02/2024*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *10/02/2024*

01/07/2025 Document Submission

Submitted By: [redacted] **Date Submitted**: *10/02/2024*

Reviewer: [redacted] **Follow Up Type**: *Not Required*

3c Post Current License

1. Requirements

2600.
3.c. The personal care home 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 personal care home.

Description of Violation

On , the home did not have the most recent license certificate posted conspicuously in the home. The most recent license certificate posted expired on

Repeated Violation - 11/01/2022

Plan of Correction ***Accept (- 08/23/2024)***

• On 7/17/24, the Administrator printed a copy of the most resent license certificate and posted it in the residents dining area.
• Staff will receive education by 9/1/24, instructing them to notify the Administrator if the current license certificate and other required posting are observed to be missing from the resident dining area. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24, monthly audits will be completed by the Administrator or designee to ensure that the current license certificate and other required postings are in the dining area.
• Documentation of staff education and monthly audits will be kept by the home and available for review by the department.

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

Implemented - 01/07/2025)

5a1 DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

At approximately 11:17AM on , the agents of the department informed Staff Member A of the staff record sample to be reviewed during the inspection, full staff records for Staff Member B, Staff Member C, and Staff Member D. The staff record information requested included: medication trainers' certificates, annual staff training records to include training hours and specific regulatory trainings for the annual training year, any trainings staff have completing in the current year, 2 years of completed medication training for all staff, current insulin administration training for all staff, current Trulicity training for all staff, FA/CPR training for all staff, qualifications for direct support staff and administrator, At 12:30PM on , agents of the Department requested again, the employee files, training records, and qualifications for Staff Members B and C. At 2:11PM, information was again requested which included the employee files, training records, and qualifications for Staff Members B and C
.
At approximately 10:30AM on , the home was asked to provide the home's emergency procedures and documentation of this being sent to local emergency management. Again at 2:11PM on , the home was asked to provide the notification letter sent to the local emergency management to include the home's emergency procedures.

5a1 - DHS Access (continued)

At approximately 10:30AM on [redacted], the home was asked to provide documentation of the refund provided after residents' deaths, including Resident [redacted] and Resident [redacted] At approximately 9:45 AM on [redacted], the home was again asked to provide documentation of the refund provided after residents' deaths in 2024. By 7:00PM on [redacted], the home had not provided documentation of the refunds.

At approximately 11:17AM on [redacted], the administrator's qualifications were requested. As of 5:00PM on [redacted] the administrator's qualifications were not provided.

At approximately 10:30AM on [redacted], the home was instructed to produce all staff's annual medication training documents for the previous two years to show annual compliance. At approximately 11:17AM on [redacted], all medication training, for all staff was requested. As of 5:00PM on [redacted], the home had not produced all medication trainings for staff. Requested items were still not produced by 1:00PM on [redacted], training for Staff Member B.

Repeated Violation - 11/01/2022

Plan of Correction ***Accept [redacted] - 08/14/2024)***

- *A written policy regarding record storage and access will be reviewed and updates will be made as necessary by 9/1/24.*
- *The administrator or designee will provide education to all staff who have access to resident records on the policy by 9/1/24.*
- *Quarterly audits of the home's resident and staff records, policies and procedures, quality management meeting minutes, and fire safety documents will be completed by the administrator or designee starting 9/1/24 to ensure the records are present, accurate and readily available.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented [redacted] - 10/31/2024)

16c - Written Incident Report

3. 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 [redacted] at 10:00AM, Staff Member A reported to agents of the Department that four residents had passed away in the home in 2024: Resident [redacted], Resident [redacted] Resident [redacted], Resident [redacted]-[redacted]. As of [redacted], the home had not reported these incidents to the Department.

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

- *On 8/23/24 a Reportable will be submitted to the Department for the identified residents death by the Administrator.*
- *On [redacted] the Administrator and Staff person A completed an initial audit of resident records who passed away*

16c - Written Incident Report (continued)

in the home to ensure the home obtained a copy of those residents death certificates.
• Beginning 7/18/24 the Administrator and designee now understand this regulation and will report any incidents of a resident passing away to the department.

(Directed)
In addition to the above plan of correction:

- *The Administrator or designee will complete an audit of all other resident deaths that occurred from December 2023 through current date to ensure the deaths have been reported to the Department. Audit will be completed by 9/5/24. An Incident Reporting Form will be completed and submitted to the Department for any deaths found not to have been reported. All incidents will be submitted by 9/10/24, as applicable.*
- *The Administrator or designee will provide education to the appropriate staff titles on reporting any death while the home is the resident's place of residence to the Department by 9/10/24.*
- *Beginning 9/10/24, the Administrator or designee will review resident records within 24 hours of a resident passing away while the home is the resident's place of residence to ensure the Department has been notified via Incident Reporting Form.*
- *Documentation of staff education, completed audits and submitted Reportable(s) will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/10/2024*

Implemented [redacted] - 01/07/2025)

19 - Review Waiver

5. Requirements

2600.
19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

On [redacted] the home was granted a waiver relating to 55 Pa. Code § 2600.22(1)-(2), 55 Pa. Code § 2600.141(a), and 55 Pa. Code § 2600.224(a), indicating the home shall use Tabula Pro in lieu of using the department's documentation of medical evaluation and preadmission screening forms. At the time of the [redacted], the home is using Tabula Pro forms, in lieu of the department's forms. A copy of the waiver request and the Department's written decision was not posted in a conspicuous and public place within the home.

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

• On 7/17/24, the Administrator printed a copy of the waiver and posted it in the residents dining area.
• Staff will receive education by 9/1/24, instructing them to notify the Administrator if the waiver and other required posting are observed to be missing from the resident dining area. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24, monthly audits will be completed by the Administrator or designee to ensure that the waiver and other required postings are in the dining area.
• Documentation of staff education and monthly audits will be kept by the home and available for review by the department.

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

19 - Review Waiver *(continued)*

Implemented (█ - 01/07/2025)

44g - Telephone Number

7. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

At 9:38 AM on █, the telephone numbers of the Department's personal care home regional office, the local protective services unit in the area agency on aging, Pennsylvania Protection and Advocacy Inc, the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline were not posted conspicuously and publicly in the home.

Repeated Violation - 11/01/2022

Plan of Correction ***Accept (█ - 08/23/2024)***

- *On 7/23/24, the Administrator printed a copy of the required telephone numbers and posted it in the residents dining area.*
- *Staff will receive education by 9/1/24, instructing them to notify the Administrator if the required telephone numbers and other required posting are observed to be missing from the resident dining area. Staff training will be provided by the Administrator and Staff Member A.*
- *Beginning 9/1/24, monthly audits will be completed by the Administrator or designee to ensure that the required telephone numbers and other required postings are in the dining area.*
- *Documentation of staff education and monthly audits will be kept by the home and available for review by the department.*

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

Implemented (█ - 01/07/2025)

64c - Annual Training

8. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

The Department allows for 12 of the required 24 hours to be completed online annually. Per Staff Member C's training record, all Staff Member C's training for training year 2023 (37 hours) has been completed online.

Plan of Correction ***Accept (█ - 08/23/2024)***

- *The Administrator received 7.5 hours of in person training in the training year of 2023.*
- *On 8/19/24 the Administrator completed an audit for the 2024 training year for the Administrators continuing education. As of 8/19/24 the Administrator has completed a 4 hour in person CPR/First Aid Training on 1/25/24*

64c Annual Training (continued)

and a 1 hour in person Fire Safety/Fire Extinguisher Training on 8/22/24. An in person 1.5 hour Diabetic Education Training is scheduled on 09/12/24. The Administrator will ensure to have a minimum of 17.5 more continuing education hours completed in the 2024 calendar year, with a minimum of 5.5 of those hours being in person trainings.
• The Administrator will ensure to schedule at least 24 hours annually of continuing education and only 12 hours of that time will be completed online.
• Beginning 8/19/24 the Administrator will keep a log of training hours scheduled to ensure all training hours are completed and in the appropriate manner.
• Please see attachments.

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

Implemented (- 10/31/2024)

82b - Poisonous Material Storage

10. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

Two large bottles of Fabuloso and four bottles of PineSol were stored on the bottom shelf area of the home's dry storage food closet which contains packages of food and drinks.

Plan of Correction ***Accept (- 08/23/2024)***

• The Fabuloso and Pine Sol were moved out of the food storage area on 7/17/24 by the designee.
• Education will be provided to all staff by 9/1/24 informing them that poisonous materials cannot be kept in the food storage areas. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24 the Administrator or designee will do monthly audits to ensure that poisonous materials are not located in the food storage areas.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented (- 10/31/2024)

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

On at approximately 9:38AM, a home made trap to catch fruit flies was witnessed directly next to the silverware tray in the dining room containing silverware that residents use to eat with. The home made trap contained a greenish liquid and many dead fruit flies in the liquid.

On at approximately 11:30AM, an uncovered bathroom trash can, approximately 36" high, contained soiled adult briefs, soiled wipes, and used paper items.

85a Sanitary Conditions (continued)

The toilet in the first bathroom on the right side of the resident hallway was not equipped with a toilet seat and the home was using a portable, adaptive toilet seat. The toilet seat was cracked on most of one side of the seat and held together by thick, white tape that can not be properly cleaned and sanitized. The front part of the toilet seat was almost entirely covered in rust.

On [redacted] at approximately 11:40AM, a portable, an uncovered, handheld urinal was sitting on Resident #5's bedside table, directly next to a drinking water cup. The urinal contained approximately 16 ounces (half full) of a dark yellow urine. Staff were not clear when the last time the urinal was emptied and cleaned nor how long it was sitting on the resident's bedside table.

On [redacted] at approximately 12:00PM, Resident [redacted] had a portable, handheld urinal on the floor next to their bed. Resident [redacted] reports using this urinal occasionally but could not recall the last time it was used. The portable urinal had approximately ¼" of dark urine still in the container.

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

• On [redacted] the home made trap for fruit flies was discarded and the silverware tray was moved from the area. The silverware was washed and placed in a cupboard away from any fruit flies.
• On [redacted] the bathroom trashcan lid was shut.
• On [redacted] a new toilet seat was installed.
• On [redacted] Resident [redacted] & Resident [redacted] urinals were emptied and cleaned.
• Staff were all spoken to individually regarding this regulation and sanitary conditions. Formal education will be provided to all staff by the Administrator and Staff Member A on [redacted]. After speaking with the residents who use the urinals, it was mutually decided to only use the urinals during the night. Residents will use [redacted] bathrooms throughout the daytime. Urinals will checked at a minimum of every two hours at each bed check. If used, the urinals will be emptied, cleaned and sanitized. Beginning [redacted] the Administrator or designee will perform weekly audits to ensure that sanitary conditions are maintained throughout the home.
• Documentation of education and completed audits will be kept by the home for review by the Department.

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

Implemented ([redacted] - 10/31/2024)

85d - Trash Receptacles

12. Requirements

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

Description of Violation

On [redacted] at approximately 11:30AM, there was an uncovered, unattended trash can in the first bathroom on the right side of the resident hallway containing soiled briefs.

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

• On [redacted] the bathroom trashcan lid was shut.

85d Trash Receptacles (continued)

- *Staff were all spoken to individually regarding this regulation and keeping all trash can lids shut. Formal education will be provided to all staff on or before 9/1/24. Staff training will be provided by the Administrator and Staff Member A. Beginning 9/1/24 the Administrator or designee will perform weekly audits to ensure that all trash can lids are shut throughout the home.*
- *Documentation of education and completed audits will be kept by the home for review by the Department*

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

Implemented (- 10/31/2024)

88a - Surfaces

13. Requirements

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

Description of Violation

At the time of the inspection, the home had at least 4 residents that use a wheelchair, walker, or cane to ambulate in the home. On at approximately 11:30AM, the second bathroom on the right side of the resident bedroom hallway was missing an approximate 8" X 24" portion of the linoleum flooring on the right hand side of the bathroom, running from the threshold of the bathroom towards the toilet. The linoleum floor was curling up and exposing the subfloor. Tape had been used to secure the flooring down but due to it curling back up, the flooring had a raised edge that posed a potential tripping hazard.

On , a hole that measured approximately 4" in diameter was observed on the ceiling of the second floor of the home, directly above the top landing of the stairs. When looking through the hole into the attic, light from the outside of the home could be seen through a slatted attic vent plate. A black substance was visible around the entirety of the hole's edge and dried rings indicating previous water damage further extended around the hole. The entire damaged part of the ceiling was approximately 12"+ in diameter.

The floor around the base of the toilet in the first bathroom on the right hand side of the resident hallway had dark yellow and brown stains around the base of the toilet and dark colored matter exposed between the floor and the wall behind the toilet. Part of the floor and baseboard was missing from behind the toilet, exposing the floorboards to any potential wet overflow from the toilet.

Plan of Correction ***Accept (- 08/23/2024)***

- *The Administrator will ensure that all items listed above will be completed on or before 10/1/24. The work will be completed by a private individual.*
- *Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify area where maintenance is required.*
- *Documentation of the weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.*

Proposed Overall Completion Date: 08/22/2024

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

88a Surfaces *(continued)*

Implemented (- 10/31/2024)

89d Contaminant Level

14. Requirements

2600.
89.d. If the water is found to be above maximum contaminant levels, the home shall conduct remediation activity to reduce the level of contaminants to below the maximum contaminant level. During remediation activity, an alternate source of drinking water shall be provided to the residents.

Description of Violation

The home is not connected to a public water source and uses well water. The home's most recent water testing, completed on , indicated coliform contamination above the maximum-allowed contaminant level. At the time of the inspection, the home had not conducted remediation activity to reduce the level of contaminants to below the maximum contaminant level. The home had not provided an adequate, alternate source for drinking water to the residents. Staff Member B reported to the agents of the Department that five 5-gallon jugs of Culligan Water were delivered from Stoner Quality Water on and nothing has been delivered for drinking water since then. On Resident was observed with a cup of drinking water, reportedly from the bathroom sink and reported drinking the water from the tap. The resident stated that no one from the home had prevented them from drinking from the tap nor instructed them not to drink from the tap.

Plan of Correction ***Accept (- 08/15/2024)***

• The home DID conduct remediation activities to reduce the level of contaminated water to the residents.
• The home had water delivered on numerous occasions for residents to drink. Water for the residents to drink was delivered from Culligan on: & . Staff either boiled water or used some of the delivered water for preparing meals. There were also 35 gallons of water present in the home for use if needed.
• Resident along with all residents were informed not to use the tap water for drinking. All residents were told and educated of the importance of getting water from staff from the kitchen. Unfortunately, Resident did get water from the tap, but there are 8-10 residents each day with water bottles and they all knew to see staff in the kitchen to get their drinking water.
• On residents were all educated that they should not use the tap water and signs were hung at all sinks reminding residents not to use the tap water for drinking.
• On the water was retested and the coliform was absent.
• Administrator will continue to have the water checked and if any contaminants are above maximum levels, the Administrator or designee will immediately educate staff and residents not to use the water for drinking purposes, hang reminder signs at all sinks stating that the tap water should not be used for drinking purposes and continue to purchase water for the homes use until the water is tested and there are not any contaminants above maximum levels.
• Please see attachments.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented (- 10/31/2024)

92 Windows

15. Requirements

2600.

92 - Windows *(continued)*

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

Description of Violation

On [redacted] at approximately 11:45AM, the window to Bedroom [redacted] was observed to be opened and the window's screen was ripped approximately 7" in length along the bottom, allowing the penetration of insects and rodents.

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

• The Administrator will ensure that the screen is removed from the window and repaired or replaced by 9/1/24. The work will be completed by a private individual.
• An audit of all windows and screens will be completed by the Administrator and designee on 8/23/22. Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify area where maintenance is required.
• Documentation of the weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.

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

Implemented ([redacted] - 10/31/2024)

94b - Non-Skid Surface

16. Requirements

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

Description of Violation

On [redacted] at approximately 11:40 AM, the wooden ramp off the rear exterior exit of the home did not have a non-skid surface.

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

• The Administrator will ensure that a non-skid surface be placed on the wooden ramp off of the rear exterior exit by 9/15/24. The work will be completed by a private individual.
• An audit of all interior and exterior steps and ramps will be completed by the Administrator and designee on 8/23/24. Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify area where maintenance is required.
• Documentation of the weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.

Proposed Overall Completion Date: 08/22/2024

Licensee's Proposed Overall Completion Date: *08/23/2024*

Implemented ([redacted] - 10/31/2024)

96a - First Aid Kit

17. Requirements

96a First Aid Kit *(continued)*

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On [redacted], the home's first aid kit did not contain a working thermometer.

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

• On 7/18/24 a new, working thermometer was placed in the first aid kit.
• Education will be provided to all staff by 9/1/24 informing reminding them to be sure all items are in the first aid kits and that they are in working order. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24 the Administrator or designee will do monthly audits to ensure that all items are in the first aid kits and working properly.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented ([redacted] - 10/31/2024)

101c Bedroom Mobility Needs

18. Requirements

2600.
101.c. Each bedroom for one or more residents with a mobility need must have at least 100 square feet per resident, to allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space. A legal entity with a personal care home license for the home as of October 24, 2005, that has one or more bedrooms serving a resident with physical mobility needs as of October 24, 2005, shall be exempt from the requirements specified in this subsection for the bedroom. If a bedroom is exempt in accordance with this subsection, additional square footage may be required sufficient to accommodate the assistive devices of the resident with mobility needs.

Description of Violation

Resident [redacted] requires total assistance with mobility and shares a bedroom with Residents [redacted] and [redacted], requiring a minimum total of 220 square feet. However, their bedroom only measures 181.72 square feet.

Resident [redacted] has mobility needs and shares a bedroom with Residents [redacted] and [redacted] requiring a minimum total of 280 square feet. However, their bedroom only measures 273.43 square feet.

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

• On 8/20/24 the Administrator and designee evaluated each resident with their mobility needs. Please see the attached medical orders for Resident's [redacted] & [redacted]
• In the future if a resident has a mobility need the home will either obtain a medical order from their attending physician or staff will move resident bedrooms to accommodate each resident with their mobility needs.
• Administrator or designee will continue to monitor residents with mobility needs as they are admitted to the facility or if their mobility needs change to ensure that there is enough space for them with their medical equipment.

(Directed)

- *On 8/20/24 the Administrator and designee evaluated each resident with their mobility needs.*
- *On 8/22/24, medical orders for Resident's [redacted] & [redacted] were obtained indicating each resident can maneuver*

101c - Bedroom Mobility Needs (continued)

around the room with the space provided.

- *Beginning 9/1/24, if a resident's mobility needs change or a new resident moves into the home with a mobility need, the home will either obtain a medical order from their attending physician or staff will move resident bedrooms to accommodate each resident with their mobility needs.*

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

Implemented (- 10/31/2024)

102i - Soap Dispenser

19. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

For the duration of the inspection on , the second bathroom on right side of the resident bedroom hallway was observed to have an empty soap dispenser.

On at approximately 2:00PM, there were 4 bars of soap in an unlabeled, clear cup in the laundry room, next to the laundry sink that is used by all staff. Staff Member D reported that Staff Member B uses those bars of soap to provide bed baths to Resident .

On at approximately 2:15PM, there were two used bars of soap accessible to everyone, sitting in an unlabeled, open container on the top of the dresser next to Resident bed. Resident shares a bedroom with Residents and

Plan of Correction ***Accept (- 08/23/2024)***

• Liquid soap was placed in the second bathroom on the right side on 7/18/24 by the designee.
• Education was provided to all staff by 7/22/24 that liquid soap is always required in all bathrooms. Liquid soap needs to be filled as it gets low to ensure the bathrooms do not run out. Staff training was provided by the Administrator and Staff Member A.
• The bar soap was removed from the laundry room and Resident dresser top on 7/18/24.
• On 7/18/24 all residents were reminded by the Administrator and Staff member A that they are not permitted to keep bars of soap unless they are in a labeled container stored in their bedroom with their personal belongings.
• Beginning 9/1/24 the Administrator or designee will do weekly audits to ensure that there is liquid soap available in all bathrooms at all times and that there is not any bar soap in the home unless it is in a labeled container.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented (- 10/31/2024)

103c - Food Protected

20. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

103c Food Protected *(continued)*

Description of Violation

On [redacted] at approximately 9:30AM, there was uncovered butter sitting on the kitchen counter in a crock. The butter remained in the uncovered crock, on the kitchen counter, for the duration of the inspection from [redacted] [redacted].

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

• The butter on the kitchen counter in the crock was covered on 7/18/24.
• On 7/18/24 the Administrator educated the staff that all food items must be covered.
• The Administrator or designee will continue to educate and remind staff of this and will go over it again formally during a staff training held on or before 9/1/24. Staff training will be provided by the Administrator and Staff Member A. Beginning 9/1/24 the Administrator or designee will conduct weekly audits to ensure that all food items are protected.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented ([redacted] - 10/31/2024)

103h - Thawing Food

21. Requirements

2600.
103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

On [redacted] at approximately 9:30AM, a package of chicken was being thawed in standing water filled in the kitchen sink. It was not observed to be under cool running water nor submerged in a sealed container. It had been thawing in the sink since agents of the Department arrived at 9:00AM.

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

• Staff were all spoken to individually regarding this regulation and the correct procedures for thawing food. Formal education will be provided to all staff on or before 9/1/24. Staff training will be provided by the Administrator and Staff Member A. Beginning 9/1/24 the Administrator or designee will perform weekly audits while the staff are preparing foods to ensure that they are thawing food in the correct way.
• Documentation of education and completed audits will be kept by the home for review by the Department.

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

Implemented ([redacted] - 10/31/2024)

107c - Food/Water 3 Day Supply

22. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

107c Food/Water 3 Day Supply *(continued)*

Description of Violation

On [redacted] the home served [redacted] residents, requiring 48 gallons of emergency drinking water. However, the home had only 35 gallons of water available. The home does not have a contract with a local bottled water supplier that includes emergency delivery of water.

Repeated Violation 11/1/2022

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

• Water was purchased on 7/23/24 by Staff Member B to ensure that there is enough water in the home for a 3 day supply for all residents.
• The Administrator or designee will continue to educate and remind staff that a 3 day water supply must remain in the home at all times and they must inform us if the supply has been used. Administrator and designee will go over it again formally during a staff training held on or before 9/1/24. Beginning 9/1/24 the Administrator or designee will conduct weekly audits to ensure that there is always a 3 day water supply and that the water is not outdated.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented ([redacted] - 01/07/2025)

123b - Emergency Procedures Posted

23. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On [redacted], the written emergency procedures for the home's municipality were not posted in a conspicuous and public place in the home.

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

• On 7/18/24 the designee posted copy of the municipality's emergency procedures in the resident dining area.
• Education will be provided to staff members on this regulation and to inform the Administrator or designee if the procedures are no longer posted so a new copy can be provided. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24 the Administrator or designee will complete monthly audits to ensure the Emergency Procedures for the municipality remain posted in the dining area.
• Documentation of education and completed audits will be kept in the home and available for review by the Department.

(Directed)
In addition to the above plan of corrections:

- *Education will be provided to staff members on this regulation and to inform the Administrator or designee if the procedures are no longer posted so a new copy can be provided. Staff training will be provided by the Administrator and Staff Member A by 9/1/24.*

Directed Completion Date: *09/01/2024*

123b - Emergency Procedures Posted *(continued)*

Implemented (█ - 10/31/2024)

123c - Evacuation Diagrams

24. Requirements

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

Description of Violation

On █████, the home served 16 residents. However, there were no emergency evacuation diagrams posted that showed the location of pull stations.

The evacuation diagram posted in the dining/rec room was curling in on itself and unable to be easily read by all residents, including those with disabilities and unable to get close to the diagram. This evacuation diagram was different than the evacuation diagram posted down the hallway where all the main residents' bedrooms were located.

The evacuation diagram posted in the main hallway did not include the residents' bedroom location on the other side of the home.

Neither diagram includes a proper layout of the home. They are missing half of the dining room floor plan, half of the front living room of the house, and the left front egress door is not listed on the evacuation diagram.

Repeated Violation - 11/2/2022

Plan of Correction ***Accept (█ - 08/23/2024)***

• On or before 9/15/24 new diagrams will be created and hung in all areas of the home by the Administrator or designee.
• Education will be provided to staff members on 8/29/24 that diagrams must be present in the home and to inform the Administrator or designee if the diagrams are missing. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/15/24 the Administrator or designee will complete monthly audits to ensure the diagrams are posted throughout the home.
• Documentation of education and completed audits will be kept in the home and available for review by the Department.

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

Implemented (█ - 10/31/2024)

124 - Notice to Fire Department

25. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

124 - Notice to Fire Department *(continued)*

Description of Violation

The home does not have updated documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency. The most recent letter sent on 8/26/19 reads there are ██ residents residing at the home, no immobile residents, a resident who is blind; the floor plan attached to the letter describe rooms that are no longer in the home and includes identification of residents who are no longer residing at the home.
At the time of the inspection, the home had ██ residents, █ residents requiring full assistance with evacuation, a bathroom that used to be a furnace room, and a bedroom that used to be a living room.

Plan of Correction ***Directed (██ - 08/23/2024)***

• On or before 9/1/24 the Administrator will update the fire department in writing with the address of the home, location of the bedrooms, and assistance needed to evacuate in an emergency.
• The Administrator and Staff Member A reviewed Regulation 2600.124.
• On 8/23/24 the Administrator will add this item to an annual checklist to ensure that it is completed as the homes needs change.

(Directed)
In addition to the above plan of correction:

- *The Administrator and Staff Member A reviewed Regulation 2600.124 by 8/23/24.*
- *Documentation of education and updates will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented (██ - 10/31/2024)

132c - Fire Drill Records

27. Requirements

2600.
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 home 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

According to fire drill records from June 2023 through June 2024, the home documents using the "back side" and "front side" exit routes. The home only has one egress door on the back of the home, and not a back side egress. The home has two egress doors off the front of the home and an egress door off the side of the home. Per staff interviews, residents can and have used all egress doors for fire drills, but all egress doors used were not documented. Additionally, the field to indicate any problems encountered during the monthly fire drills for the above-mentioned time frame was left blank.

Plan of Correction ***Accept (██ - 08/23/2024)***

• On 8/19/24 the Administrator and designee reviewed Regulation 2600.

132c Fire Drill Records (continued)

132(c) and will be more specific when filling out fire drill logs and ensure the use of all exit routes and documenting them accordingly. We will also be sure to fill out all sections of the fire drill logs not leaving any sections blank.
• The Administrator will begin quarterly audits of the fire drill logs starting 9/1/24 to ensure that fire drill logs are documented correctly.
• Documentation of the audits will be kept by the home and available to the Department for review.

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

Implemented (- 10/31/2024)

141a 1-10 Medical Evaluation Information

28. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

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

Description of Violation

Resident initial medical evaluation dated did not include the resident's medication regimen, contraindicated medications, and medication side effects.

Plan of Correction ***Accept (- 08/23/2024)***

• Office staff received a training on 8/13/24 by the Administrator on the information required to be included on the medical evaluation.
• The Administrator or designee will audit all resident records by 9/15/24 to ensure all resident medical evaluations contain all of the required information on them.
• Beginning September 2024, (with the first audit being completed by 9/15/24) the Administrator or designee will conduct quarterly audits of resident records and ensure that all requires information is contained in the medical evaluation.
• Documentation of these audits will be kept by the home for review by the Department.

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

Implemented (- 01/07/2025)

143a - Emergency Medical Plan

29. Requirements

2600.

143a Emergency Medical Plan *(continued)*

143.a. The home shall have a written emergency medical plan that includes the following:
3. An emergency-staffing plan.

Description of Violation

The home's written emergency medical plan does not include an emergency staffing plan.

Plan of Correction ***Accept (- 08/23/2024)***

• On 8/13/24 office staff will be reminded by the Administrator that it is required for an emergency staffing plan to be included in the emergency medical plan.
• The Administrator or designee will update the emergency medical plan to include the emergency staffing plan by 9/15/24.
• Starting 9/1/24, the Administrator or designee will conduct quarterly audits of the emergency medical plan to ensure that all required information is contained in the medical evaluation.
• Documentation of these audits will be kept by the home for review by the Department.

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

Implemented (- 10/31/2024)

144b - Policy on Smoking

30. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The Clean Indoor Air Act requires that the home post a sign at each entrance that states, "Smoking Permitted in Designated Areas Only" or "No Smoking." On signs were not posted at the home's entrances to the building.

Plan of Correction ***Accept (- 08/23/2024)***

• "No Smoking" signs will be purchased and hung by the Administrator on the outside entrances of the home on or before 9/15/24.
• On 8/29/24 staff will be educated that "No Smoking" signs be posted at all outside entrances and asked to inform the Administrator or designee if they notice a sign missing.
• Starting 9/15/24, the Administrator or designee will conduct quarterly audits of the homes outside entrances to ensure the "No Smoking" signs are present at all outside entrances to the home and intact.
• Documentation of the staff training and these audits will be kept by the home for review by the Department.

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

Implemented (- 01/07/2025)

144c1 - Smoking Area Guidelines

31. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 - Smoking Area Guidelines *(continued)*

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is the back covered patio area. On [redacted] at 12:10PM a large, plastic trash can approximately 4' high was observed in the smoking area with contents including a tissue box, multiple crumbled up papers, and approximately 20 cigarette butts.

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

• The cigarette butts in the trash can were butts that were previously extinguished and were not hot or warm when put into the trash can.
• The trash can was removed from the smoking area on 7/18/24.
• Staff and residents were educated on the proper safeguards regarding smoking on 8/19/24. A formal staff training will be provided by the Administrator and Staff Member A on 8/29/24.
• Starting 9/1/24, the Administrator or designee will conduct quarterly audits of the homes outside smoking area to ensure that the trash can remains out of the smoking area.
• Documentation of the staff training and these audits will be kept by the home for review by the Department.

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

Implemented ([redacted] - 01/07/2025)

162c - Menus Posted

32. 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 [redacted] at approximately 9:38 AM, the home did not have the current nor next week's menu posted in a conspicuous and public place in the home. The most recent week's menu that was posted was for the week of [redacted]. All other menus posted were for weeks prior to that week.

Repeated Violation - 11/2/2022

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

• Menu's were updated and hung in the resident dining area by the Administrator or designee on 8/19/24.
• All staff were informed that menus must be current and posted one week in advance and hung in the resident dining area. A formal training will be conducted by 9/1/24. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24, the Administrator or designee will complete weekly audits to ensure a current weekly menu and a menu for one week in advance are posted in the resident dining area.
• Documentation of the training and completed audits will be kept by the home and available for review by the Department.

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

162c - Menus Posted *(continued)*

Implemented (- 10/31/2024)

171b5 - First Aid Kit

33. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On at approximately 3:00PM, the first aid kit in the home's , used to transport residents, did not include eye coverings.

Plan of Correction ***Accept (- 08/14/2024)***

• On 7/18/24 eye coverings were placed in the first aid kit in the Subaru..
• Education will be provided to all staff by 9/1/24 reminding them to be sure all items are in the first aid kits and that they are in working order.
• Beginning 9/1/24 the Administrator or designee will do monthly audits to ensure that all items are in all first aid kits and working properly.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented (- 10/31/2024)

182b - Prescription Medication

34. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Residents and have prescribers orders for and have been administered weekly for at least a year as per Staff Member D. The home does not have a waiver for the administration of medications and staff are not
qualified to administer this medication.

Plan of Correction ***Accept (- 08/23/2024)***

• The family physician for Resident and Resident was contacted on by Staff Person A and the physician decided the to discontinue the on . Please see attached orders.
• Staff will be educated at a staff training as to which medications they are permitted to administer. This education will be conducted on 8/29/24. Staff training will be provided by the Administrator and Staff Member A.
• An audit of the MARS was completed 7/23/24 by the Administrator and designee to ensure that all staff are

182b - Prescription Medication (continued)

appropriately trained for all prescribed medications given to residents. Beginning 9/1/24, the Administrator or designee will complete monthly audits of the MARS to ensure that all staff are appropriately trained to give all medications prescribed to residents.
• Administrator and designee will continue to be mindful of this regulation and will not allow staff to administer Trulicity or any other medication unless the home obtains a waiver or staff is properly trained to give that type of medication.

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

Implemented (- 10/31/2024)

183b - Meds and Syringes Locked

35. 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 at approximately 9:10AM, the following medications were observed to be unlocked, unattended, and accessible in the kitchen/medication area:
- solution on top of the medication cart.
- on top of the medication cart.
- on top of the medication cart.
- in a pitcher on the kitchen table.
- solution on the kitchen counter.

On at approximately 11:40AM, additional medications were observed to be unlocked, unattended, and accessible including:
- vials on Resident nightstand.
- vials in an open Ziplock bag on the dining room table.

On at approximately 11:50AM, a bag of Dollar General Health Cough Drops was unlocked, unattended, and accessible on the dresser in Resident s bedroom.

On at approximately 2:40 PM on , Resident was unlocked, unattended, and accessible under the left-side bathroom sink in the resident bedroom hallway.

Plan of Correction ***Accept (- 08/23/2024)***

• on 7/23/24 Medications were removed from the home and secured and locked in the medication cart. by Staff person A.
• Education was provided on an individual basis to all staff and a formal staff training will be held on or before 9/1/24, informing staff that all medication must only be kept in the locked medication cart. Staff training will be provided by the Administrator and Staff Member A.
• An initial audit of all resident rooms and the entire home was conducted on 7/18/24 to ensure medications are not unlocked or unattended.
• Beginning 9/1/24, the Administrator or designee will complete monthly audits to ensure all medications in the home are kept in an area or container that is locked.

183b Meds and Syringes Locked (continued)

- *Documentation of the trainings and completed audits will be kept by the home for review by the Department.*

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

Implemented (- 10/31/2024)

183d - Prescription Current

36. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident by mouth twice a day for breathing was discontinued on at 1:00PM. However, this medication was administered on at 8:00 AM.

Plan of Correction ***Accept (- 08/23/2024)***

- *Resident was discarded by Staff Member D on*
- *Education was provided on an individual basis to all staff and a formal staff training will be held on or before 9/1/24, informing staff that all discontinued medications must be removed from the medication cart immediately when discontinued. Staff training will be provided by the Administrator and Staff Member A.*
- *The Administrator and Staff member A conducted an initial audit of med cart on 7/23/24 to ensure all medications in the med cart are current.*
- *Beginning 9/1/24, the Administrator or designee will complete monthly audits of the med cart to ensure that only current medications are in the med cart.*
- *Documentation of the trainings and completed audits will be kept by the home for review by the Department*

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

Implemented (- 10/31/2024)

184a - Resident's Meds Labeled

37. Requirements

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

On , at approximately 9:10AM, medications were observed in the kitchen/medication area that were not labeled with the resident’s name, the date the prescription was issued, the prescribed dosage and instructions for administration, and the name and title of the prescriber, including:

-
-

184a - Resident's Meds Labeled (continued)

Plan of Correction ***Accept (- 08/23/2024)***

- *On , all medications listed were put into their original labeled containers.*
- *Education was provided on an individual basis to all staff and a formal staff training will be held on or before 9/1/24, informing staff that all medications must remain in their original labeled containers. Staff training will be provided by the Administrator and Staff Member A.*
- *An initial audit of med cart was conducted by the Administrator and Staff member A on 7/23/24 to ensure all medications in the med cart are in their original labeled containers and include all of the required information on the container.*
- *Beginning 9/1/24, the Administrator or designee will complete monthly audits of the med cart to ensure that all medications are in their original labeled containers.*
- *Documentation of the trainings and completed audits will be kept by the home for review by the Department.*

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

Implemented (- 10/31/2024)

185a - Implement Storage Procedures

38. Requirements

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

Description of Violation

Resident is prescribed tablets - take 1 tablet by mouth every 12 hours as needed. On at approximately 2:50PM, this medication was not available in the home.

On at 8:00 PM, Resident had a level of recorded on the Medication Administration Record (MAR). The for this timeframe was

On at 7:40 PM, Resident had a blood glucose level of recorded on the MAR. This reading was not documented in the

On at 1:36PM, Resident r documented a reading of – this reading was not documented on the MAR.

On at 12:55PM, Resident documented a reading of – this reading was not documented on the MAR.

Plan of Correction ***Accept (- 08/23/2024)***

- *On Resident missing medication was ordered from the pharmacy, it just had not been delivered from the pharmacy yet.*

185a - Implement Storage Procedures (continued)

• The Administrator and Staff Member A conducted an initial audit of med cart on 7/23/24 to ensure all medications were available.
• Staff were educated individually on being mindful and to make sure they are ordering medications when it is getting low so that it is always available for the residents. A formal staff training will be conducted on 8/29/24 by the Administrator and Staff Person A. Staff will also be updated on the homes policy for ordering medications.
• Beginning 9/1/24, the Administrator or designee will complete monthly audits of the med cart, MARS and Glucometers to ensure that all medications are available to residents and that all blood sugar readings match between the MARS and Glucometers. If the Glucometer readings does not match the MARS or if a reading is missing on the Glucometer or MARS the Administrator or Staff Member A will immediately report this to the resident family physician and the staff person responsible will not be permitted to continue to perform any diabetic medication tasks until re-educated. Documentation will be kept by the home for review by the Department.

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

Implemented (- 01/07/2025)

187b - Date/Time of Medication Admin.

39. 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 is prescribed , and daily. Resident Medication Administration Record does not include the initials of the staff person who administered these medications on and at 8:00 PM.

Plan of Correction ***Accept (- 08/23/2024)***

• Staff were educated individually on being mindful and to make sure that they are documenting medication administration correctly. A formal staff training will be conducted on or before 9/1/24. Staff training will be provided by the Administrator and Staff Member A.
• Beginning 9/1/24, the Administrator or designee will complete monthly audits of the MARS to ensure that all medications administered and include the staff persons initials on the MARS.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department

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

Implemented (- 01/07/2025)

187d - Follow Prescriber's Orders

40. Requirements

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

Description of Violation

Resident was prescribed . Resident did not receive this medication as ordered on and as the medication was documented as not available in the home. On at 7:27AM, Staff Member B used the exception reason "physically unable to take" when the medication was, in fact,

187d - Follow Prescriber's Orders (continued)

not available.

Resident has physician's orders to receive , and Resident did not receive this medication as ordered on and at 8:00PM.

Resident is prescribed once a day. Resident did not receive this medication as ordered after it was ordered on as evidenced by exception notes on , , and .

Resident has physician's orders to receive , and . Resident did not receive this medication as ordered on , and at 8:00PM.

Resident has a physician's order to receive once a week on Mondays. Resident did not receive this medication as ordered on and at 8:00AM.

Resident has physician's orders to receive and . Resident did not receive these medication as ordered on , nor at 8:00PM.

Resident has a physician's order to receive blood sugar testing weekly on Mondays. Resident did not have tested on at 8:00AM and no reading was documented in the for this timeframe.

Resident has a physician's order to receive once a week on Wednesdays. Resident did not receive this medication as ordered on and at 8:00AM.

Resident has a physician's order to receive . Resident did not receive this medication as ordered on at 8:00PM

Resident has physician's orders to receive , Resident did not receive these medications as ordered on the following days:
- on 7/3/2024, 7/8/2024, 7/10/2024 at 8:00AM
- on 7/8/2024, 7/10/2024 at 8:00AM
- on 7/3/2024 at 8:00AM
- on 7/8/2024, 7/10/2024 at 8:00AM
- on 7/3/2024 at 8:00AM

Repeated Violation - 11/2/2022

Plan of Correction **Directed (- 08/23/2024)**

• Staff were educated individually on being mindful and be certain that they are following the directions of the prescriber. They were also informed to notify the Administrator or designee if there are any circumstances preventing them from being able to follow the orders from the prescriber and to also to make sure they are documenting the medications being given as prescribed. A formal staff training will be conducted on 8/29/24 by the Administrator and Staff person A. This training will include information to ensure medications are always available as ordered as

187d - Follow Prescriber's Orders (continued)

well as how to properly document missed medications on the exceptions report.
• An audit of the MARS was completed 7/23/24 by the Administrator and designee to ensure that all medications are given correctly.
• Beginning 8/13/24 the Administrator or designee will perform a weekly review of all residents who have their blood glucose levels checked to ensure blood glucose levels are being checked per the physician orders. Beginning 9/16/24, Administrator or designee will review all residents who have their blood glucose levels checked monthly to ensure blood glucose levels are being checked per the physician orders.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

(Directed)
In addition to the above plan of corrections:

- *Beginning 9/1/24, weekly MAR reviews will be completed to also ensure medications are being administered per the physician's orders in addition to the blood glucose levels being checked.*

Directed Completion Date: *09/16/2024*

Implemented (- 10/31/2024)

190b - Insulin Injections

41. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff Member B, who has not completed a Department-approved diabetes patient education program within the past 12 months, completed testing using a for Resident on and at 8:00AM.

Plan of Correction ***Accept (- 08/23/2024)***

• Staff Person B did not give insulin injections, therefore, we do not believe this was a violation of the regulation.
• Staff Person B was informed 7/19/24 that could not perform blood sugar testing using a glucometer on a resident until completes a department approved Diabetic Education scheduled on 09/12/24 at 2pm.
• On 8/20/24 the Administrator and designee audited all staff training records to ensure their Diabetic Education is current for all employees administering medication.
• Beginning 9/1/24, the Administrator or designee will complete monthly audits of the Diabetic Education to ensure all staff administering medications are current with their Diabetic Education.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department

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

Implemented (- 10/31/2024)

221b - Activity Types

42. Requirements

2600.

221b Activity Types *(continued)*

221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

On [redacted] at approximately 9:51AM, Residents [redacted] and [redacted], confirmed that the home did not provide any activities on the previous day, [redacted]. The activity calendar indicated "bird houses" as the planned activity. Both residents also confirmed that the home does not and has not recently conducted any group activities with residents in the home. Agents of the Department did not observe any staff nor residents engaging in any planned, coordinated or structured activities as per the activity calendar during the course of the inspection.

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

• Administrator and Designee have been working with the residents and staff throughout the week of 8/5/24 8/9/24 to create an Activity Schedule that the residents will enjoy and participate in.
• The Activity Schedule will include activities that provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.
• On 7/29/24 the home has began to have a daily interactive activity with the residents. The finalized official Activity Schedule along with supplies, ect. will begin 9/1/24 and will continue daily.
•A staff training will be conducted 8/29/24 instructing staff of the mandatory daily activities to be completed with the residents. Staff training will be provided by the Administrator and Staff Member A.
• All staff will be responsible for completing daily activities with residents per the posted Activity Calendar.
• The Administrator or Staff Member A will review the Activity Calendar monthly, have resident and staff interviews monthly to ensure the Activity Calendar is being followed and the residents are provided an interactive activity daily.

(Directed)
In addition to the above plan of corrections:

- *Beginning 9/1/24, the Administrator or Staff Member A will review the Activity Calendar monthly, have resident and staff interviews monthly to ensure the Activity Calendar is being followed and the residents are provided an interactive activity daily.*
- *Documentation of staff education and resident interviews will be kept by the home and available for review by the Department.*

Directed Completion Date: *09/01/2024*

Implemented ([redacted] - 10/31/2024)

225a - Assessment 15 Days

43. Requirements

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

Description of Violation

Resident [redacted] most recent assessment, dated [redacted], does not include the resident's need for a portable, handheld urinal nor staff support needed to empty and sanitize the urinal.

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

• Resident [redacted] updated information was added to the assessment on [redacted] by the Office Staff.

225a Assessment 15 Days (continued)

• Office staff received a training on 8/13/24 by the Administrator on the information required to be included on the assessment.
• On 8/13/24 Office staff were reminded and trained that all significant changes must be updated on the assessment form by the Administrator.
• Beginning 9/1/24 the Administrator and designee will perform monthly audits of resident records to ensure that all assessments are up to date with current information that may have needed to be added for the resident.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented (- 01/07/2025)

225c - Additional Assessment

44. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident s most recent assessment, dated , was not updated to include the resident's diagnosis and support for following a discharge from a hospital in May 2024.

Plan of Correction ***Accept (- 08/23/2024)***

• Resident updated information was added to the assessment on 8/13/24 by the Office Staff.
• Office staff received a training on 8/13/24 by the Administrator on the information required to be included on the assessment.
• On 8/13/24 Office staff were reminded and trained that all significant changes must be updated on the assessment form by the Administrator.
• Beginning 9/1/24 the Administrator and designee will perform monthly audits of several randomly chosen resident records to ensure that all assessments are up to date with current information that may have needed to be added for the resident.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department

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

Implemented (- 01/07/2025)

252 - Record Content

45. Requirements

2600.
252. Content of Resident Records - Each resident’s record must include the following information:
23. If the resident dies in the home, a copy of the official death certificate.

252 Record Content *(continued)*

Description of Violation

The records for Residents [redacted] and [redacted], who died in the home in March 2024, do not include a copy of the official death certificate.

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

• On 7/18/24 the Administrator and Staff person A completed an initial audit of resident records who passed away in the home to ensure the home obtained a copy of those residents death certificates.
• The Administrator and designee did receive death certificates for Residents [redacted] & [redacted] (please see the attached death certificates). The Administrator and designee have been trying extremely hard to get a copy of the death certificates for Resident's [redacted] and [redacted] The following is the attempts the home had made to obtain death certificates for Resident [redacted] & [redacted]
Initial call to Coroner: 4/11/24
Called Coroner to tell them we never received them: 4/15/24
Called Coroner to inform them we still did not receive them, they told us they had faxed them, we did not receive them so they said they would mail them to us: 5/6/24
Still hadn't received anything, called the Hospice Physician, [redacted], trying to obtain a copy the nurse said [redacted] would talk to the doctor and call us back: 6/3/24
Never heard back from the doctor, so we called them back, they told us that they did not have copies, they would try to get copies but to also try to obtain a copy from Viaquest Hospice: 6/9/24
Called Viaquest Hospice, they did not have copies: 6/9/24
Called [redacted] office to see if they ever obtained any copies of our residents death certificates. They did in fact have a copy of Resident [redacted] death certificate: [redacted]
[redacted] office faxed us Resident [redacted] death certificate: [redacted]
Called [redacted] Home to ask for a copy of Resident [redacted] death certificate: [redacted]
Called Coroner once again, said they would fax them for Resident [redacted] & [redacted] still never received them.
Called the [redacted] Courthouse, they informed us that we could apply for copy of Death Certificates thru Vital Records: [redacted].
Faxed our request for the death certificates: [redacted]
Called [redacted] again to ask for a copy of Resident [redacted] death certificate: [redacted]
Received Resident [redacted] death certificate: [redacted]
Still have not received death certificates for residents [redacted] & [redacted] On 8/23/24 the Administrator or Designee will file for a copy thru Vital Records.
• The administrator and designee will continue to follow up until we get a copy of the death certificates, and we will submit them to the department as soon as we receive them.
• Beginning 8/22/24 the Administrator and designee will ensure to obtain death certificates for any residents who passed away in the home.

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

Implemented ([redacted] - 01/07/2025)