pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **470 MANOR OPERATING LLC**
LEGAL ENTITY

To operate **ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING**
NAME OF FACILITY OR AGENCY

Located at **490 MANOR AVENUE, DOWNINGTOWN, PA 19335**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

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

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 35**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 27, 2024** until **June 27, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **141082**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 27, 2024

Administrator
470 Manor Operating, LLC
490 Manor Avenue
Downingtown, Pennsylvania 19335

RE: St. Martha Villa for Independent & Retirement Living
License #: 141082

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 29 and 30, 2024 and July 31 and August 1, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from December 27, 2024 to June 27, 2025.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
103(f)	III	37	$3	$111	15 calendar days from mailing date of this letter

141(a)(1-10)	III	37	$3	$111	15 calendar days from mailing date of this letter
252(2)	III	37	$3	$111	15 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a SECOND 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 SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14108* **License Expiration**: *06/08/2024*

Address: *490 MANOR AVENUE, DOWNINGTOWN, PA 19335*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *470 MANOR OPERATING LLC*
Address: *490 MANOR AVENUE, DOWNINGTOWN, PA, 19335*
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/24/2001* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *04/30/2024*

Inspection Dates and Department Representative

04/29/2024 - On-Site: [redacted]
04/30/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served**: *45*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Carlson* **Capacity**: *35* **Residents Served**: *23*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *45*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

04/29/2024 - Full

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

06/25/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/16/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *07/13/2024*

11/06/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/16/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

5a1 - DHS Access

1. 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

On 4/29/2024, at 9:13 a.m., an agent of the Department requested access to the residents list and records. However, the resident list was provided at 1:15 p.m. and the medical records at 1:40 p.m.

Plan of Correction ***Accept (- 06/10/2024)***

Administrator provided the Surveyors with access to resident charts during the survey on April 29, 2024.
Administrator ensured all resident charts are available at the nurses' stations on or by May,1 2024
Clinical Director educated the Staff on the importance of providing surveyors with information in a timely manner on or before July 13,2024.
Administrator or designee will audit once a week for 30 days any future survey visits to ensure information is related to the survey in a timely manner on or before June 30, 2024. The audit will be reviewed during monthly quality assurance

Proposed Overall Completion Date: 07/13/2024

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (- 08/19/2024)

17 - Record Confidentiality

2. Requirements

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

Description of Violation

On 4/30/2024, at 11:00 a.m., there were two books with information about the residents narcotics medications on top of the medical carts on the 2nd floor, unlocked, unattended, and accessible to all staff and residents.

Plan of Correction ***Accept (- 06/25/2024)***

1.Clinical director confirmed third floor nurses station door is capable of locking. Narcotic books were stored in a locked medication cart on or about May 1,2024.
2. Clinical Director audited the Medication doors to ensure they lock appropriately. All other medication were checked, and narcotics books were locked inside the carts on or about May 1,2024.
Clinical Director educated the clinical staff on the importance of confidentiality of resident information and locking of narcotic books within the medication cart on or before June 30,2024.
Director of nursing or design will audit med rooms, and med carts to ensure confidentiality is being maintained.

17 - Record Confidentiality (continued)

The audit will be once a week for 30 days on or before June 30,2024. Results of the audit will be reviewed at the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented (█ - 08/19/2024)

42s - Privacy

3. Requirements

2600.

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 4/29/2024, there were video cameras observed at the facility entrance. However, there were no signs posted indicating that images or video recording were in progress.

Plan of Correction ***Accept (█ - 06/25/2024)***

Administrator ensured video monitoring sign was displayed at the front door on or about May 1,2024.
Clinical Director audited resident exit doors for video monitoring sign. If a sign was not located, it was properly displayed on or about May 1,2024.
Administrator educated the Maintenance department on the importance of having video monitoring signs at resident exits on or before July 13,2024.
Administrator or designate will audit all exit doors once a week for 30 days to ensure video monitoring signs are displayed on or before July 13,2024. The results of the audit will be reviewed at the monthly quality insurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation, and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home’s smoking policy, and the location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors, fire alarms, and telephone use and notification of emergency services.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Clinical Director educated staff member B on general fire safety, and emergency preparedness on or before July 13,2024.
Clinical Director completed an audit of all Villa personnel files and any staff member who has not received general fire safety and emergency preparedness was educated on the content on or before July 13,2024.
Clinical Director educated clinical staff on the importance of first day orientation on or before June 30, 2024.
HR Director or design wall complete an audit of new employees once a week for 30 days to ensure they have completed orientation on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Proposed Overall Completion Date: 07/13/2024

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented ([redacted] - 08/19/2024)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

65b - Rights/Abuse 40 Hours *(continued)*

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed [redacted] 40th scheduled work hour on [redacted]. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § §10225.101—10225.5102) and reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Clinical director educated Employee B on resident rights, emergency medical plan, abuse, and neglect, training, and reporting of reportable incident and conditions on or before July 13,2024.
Clinical Director completed an audit of employee files to ensure they completed the necessary orientation training. If a staff member did not obtain the training, they were reeducated on or before July 13,2024.
Administrator educated the Clinical Director and HR Director on the importance of reviewing mandatory orientation content for Villa employees on or before July 13,2024.
HR Director or design audit files of new Villa staff to ensure they have the appropriate orientation content reviewed once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed at the monthly quality assurance meeting.?

Proposed Overall Completion Date: 07/13/2024

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented ([redacted] - 08/19/2024)

65d - Initial Direct Care Training

7. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.

65d - Initial Direct Care Training *(continued)*

viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

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

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Staff person C direct care certificate obtained.
Clinical Director completed an audit of direct care staff to ensure they have the appropriate training required. If the direct staff do not have the required training, the staff member was removed from the schedule until appropriate training has been completed on or before July 13,2024.
Administrator educated the Clinical Director was educated on the importance of having staff completing direct care training on or before July 13,2024.?
Clinical director or design well audit once a week for 30 days direct care staff files to ensure they have the appropriate training on or before July 13,2024. The results of the audits will be reviewed at the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented ([redacted] - 08/19/2024)

65e - 12 Hours Annual Training

8. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff members D, E, F, and G did not receive any hours of annual training in the training year 2023.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Clinical Director ensured Direct care staff members D, E, F, and G completed 12 hours of annual training on or before July 13,2024.?

65e - 12 Hours Annual Training (continued)

Clinical Director audited Direct care staff files for 12 hours of training. If a direct care staff member did not complete 12 hours of training, the training was completed on or before June 30,2024.
Administrator educated the Director of nursing was on the importance of having direct care staff complete 12 hours of training on or before July 13,2024.?
Director of nursing or design will complete an audit of direct care. Staff files once a week times 30 days to ensure 12 hours of training has been completed on or before July 13,2024.?The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

65f - Training Topics

9. Requirements

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

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

Description of Violation

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

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director ensured Direct care staff members D, E, F, and G completed the required training topics on or before July 13,2024.?
Clinical Director ensured Direct care staff files were reviewed for the required training topics. If a direct care staff member did not complete training, the training was completed on or before July 13,2024.?
Administrator educated the Director of nursing on the importance of having direct care staff complete the required training on or before July 13,2024.?
Director of nursing or design will complete an audit of direct care Staff files once a week times for 30 days to ensure required training has been completed on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

65f - Training Topics *(continued)*

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

65g - Annual Training Content

10. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

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

Description of Violation

Staff members D, E, F, and G did not receive training in fire safety completed by a fire safety expert or by a staff member trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert; emergency preparedness procedures and recognition and response to crises and emergency situations; resident rights; the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102); falls and accident prevention; and new population groups that are being served at the home that were not previously served, if applicable, during the training year 2023–2024.

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director ensured Direct care staff members D, E, F, and G completed the required annual training topics on or before July 13,2024.?
Clinical Director ensured Direct care staff files were reviewed for the required annual training topics. If a direct care staff member did not complete training, the training was completed on or before July 13,2024.?
Administrator educated Director of nursing on the importance of having direct care staff complete the required training which includes annual training Administrator educated on or before July 13,2024.?
Director of nursing or design will complete an audit of direct care Staff files once a week times 30 days to ensure required annual training has been completed on or before July 13, 2024.?
The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

65i - Training Record

11. Requirements

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

65i - Training Record *(continued)*

Description of Violation

The home does not have training records for staff members D, E, F, and G.

Plan of Correction ***Accept (- 06/25/2024)***

Clinical Director ensured Direct care staff members D, E, F, and G have training records on or before July 13,2024.?
Clinical Director completed a review of direct care staff training records. All direct care staff have a training record on or before July 13,2024
Administrator educated Director of nursing on the importance of having a training record for all direct care staff on or before July 13,2024.
Director of nursing or an audit of all direct care staff training records once a week times 30 days to ensure staff having trainings on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (- 08/19/2024)

66a - Staff Training Plan

12. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2024.

Plan of Correction ***Accept (- 06/25/2024)***

Clinical Director ensured the facility has a 2024 training plan on or before July 13,2024.?
2024 training plan was reviewed by the clinical director to ensure they meet state requirements. The training plan met the state requirements on or before July 13,2024.
Administrator educated Director of nursing on the importance of having a training plan each year on or before July 13,2024.
Director of nursing or design will review the yearly training plan once a week times 30 days to ensure the plan is being followed on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

66c - Training Documentation

13. Requirements

2600.
66.c. Documentation of compliance with the staff training plan shall be kept.

Description of Violation

The home does not maintain documentation of the completion of courses in the staff training plan.

66c - Training Documentation *(continued)*

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director ensured the facility has a 2024 training plan on or before July 13,2024.?
2024 training plan was reviewed by the clinical director to ensure they meet state requirements. The training plan met the state requirements on or before July 13,2024.
Administrator educated Director of nursing on the importance of having a training plan each year on or before July 13,2024.
Director of nursing or design will review the yearly training plan once a week times 30 days to ensure the plan is being followed on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

82c - Locking Poisonous Materials

15. Requirements

2600.

82c - Locking Poisonous Materials *(continued)*

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Calmoseptine Ointment with a manufacturer's label indicating "Keep out of reach of children. In case of accidental ingestion, get medical help or contact a poison control center immediately." was unlocked, unattended, and accessible to resident 4. Not all the residents of the home, including resident 4, have been assessed as capable of recognizing and using poisons safely.

Antibacterial hand soap with a manufacturer's label indicating "Keep out of reach of children. In case of accidental ingestion, get medical help or contact a Poison Control Center immediately." was unlocked, unattended, and accessible in the staff bathroom with the door not secured on the Memory Care Unit. Not all the residents of the home, including residents in the Memory Care Unit, have been assessed as capable of recognizing and using poisons safely.

A can of interior latex paint, multiple lotions, shampoos, and toothpastes were in the memory care unit kitchen with a manufacturer's label indicating "Keep out of reach of children. In case of accidental ingestion, get medical help or contact a Poison Control Center immediately." was unlocked, unattended, and accessible to all residents in the Memory Care Unit. Not all the residents of the home, including residents on the Memory Care Unit, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 06/25/2024)***

Nursing and maintenance staff removed all poisonous materials from resident's room and kitchen area as of May 1, 2024.
Administrator checked resident rooms and resident areas for poisonous materials and none found May 5, 2024.
Administrator educated the Nursing, Housekeeping, and maintenance staff on the importance of storing poisonous materials on or before July 13,2024.
Administrator or design will complete an audit once a week for 30 days to ensure no poisonous materials are not identified on or before July 13,2024. The results of the audit will be reviewed at the monthly quality assurance meeting.?

Proposed Overall Completion Date: 07/13/2024

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

85a - Sanitary Conditions

16. Requirements

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

Description of Violation

On 4/30/2024, there was spilled food on the refrigerator door shelf in the Memory Care Unit kitchen.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept (- 06/25/2024)***

Housekeeping cleaned the spilled food in the refrigerator as of May 1, 2024.
Administrator checked Facility refrigerators to ensure sanitary conditions were maintained. It was identified all refrigerators were in compliance as of May 5,2024.
Administrator educated Nursing, Housekeeping, and kitchen staff on the importance of maintaining sanitary conditions on or before July 13,2024.
Administrator designate will audit facility refrigerators to ensure they meet sanitary conditions. The audit will be completed once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed at the monthly quality meeting.?

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

88a - Surfaces

17. 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

Water stains were found on the ceilings of the dining room, activity room, and main entrance on April 30, 2024. Additionally, there was a vent in the dining room ceiling of the personal care unit that was not properly attached, as well as a ceiling tile with a hole in it near the activity room entrance.

Plan of Correction ***Accept (- 06/25/2024)***

Maintenance department changed the Ceiling tiles in the dining room, activity room, and main entrance. The vent was cleaned in the dining room by maintenance as of May 8, 2024.
A visual inspection was completed in the facility the administrator and if ceiling tiles were noted with water stains, they were changed. In addition, if vents were noted to be dirty, they were cleaned on or before July 13,2024.
Administrator educated Housekeeping and maintenance department on the importance of maintaining clean, ventilation vents, and changing ceiling tiles when noted to be stained on or before July 13,2024.
Administrator or designee will complete an audit of ceiling tiles and ceiling vents to ensure they are either cleaned and free of stains. The audit will be conducted once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.
95
Maintenance Department checked the spa door locking mechanism and fixed the lock as of May 8, 2024.?
Administrator ensured All spa door knobs were functioning correctly. All spa door knobs were functioning as designed on or before June 30,2024.
Administrator educated Maintenance department on ensuring locking door knobs function correctly Administrator educated on or before July 13,2024.
The administrator or design will audit spa door knobs to ensure they function correctly once a week for 30 days Administrator educated on or before June 30,2024. The results of the audit will be reviewed at the monthly quality insurance meeting.?
96a

88a - Surfaces (continued)

Proposed Overall Completion Date: 07/13/2024

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

95 - Furniture and Equipment

18. Requirements

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

Description of Violation

On 4/30/2024, the Memory Care Unit spa door knob lock was broken.

Plan of Correction ***Accept (█ - 06/25/2024)***

Maintenance department changed the Ceiling tiles in the dining room, activity room, and main entrance. The vent was cleaned in the dining room by maintenance as of May 8, 2024.
A visual inspection was completed in the facility the administrator and if ceiling tiles were noted with water stains, they were changed. In addition, if vents were noted to be dirty, they were cleaned on or before July 13,2024.
Administrator educated Housekeeping and maintenance department on the importance of maintaining clean, ventilation vents, and changing ceiling tiles when noted to be stained on or before July 13,2024.
Administrator or designee will complete an audit of ceiling tiles and ceiling vents to ensure they are either cleaned and free of stains. The audit will be conducted once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.
95
Maintenance Department checked the spa door locking mechanism and fixed the lock as of May 8, 2024.?
Administrator ensured All spa door knobs were functioning correctly. All spa door knobs were functioning as designed on or before June 30,2024.
Administrator educated Maintenance department on ensuring locking door knobs function correctly Administrator educated on or before July 13,2024.
The administrator or design will audit spa door knobs to ensure they function correctly once a week for 30 days Administrator educated on or before June 30,2024. The results of the audit will be reviewed at the monthly quality insurance meeting.?
96a

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

96a - First Aid Kit

19. Requirements

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.

96a - First Aid Kit *(continued)*

Description of Violation

The first aid kit in the Personal Care Unit does not include scissors, and the first aid kit in the Memory Care Unit does not include a thermometer or safety glasses.

Plan of Correction ***Accept (- 06/25/2024)***

Director of Nursing ensured the first aid kits were updated to include scissors thermometer, and safety glasses as of May 8, 2024.
Director of Nursing checked All first aid kits in the facility were to ensure they have the appropriate items on or before June 30,2024. If any items were missing, they were supplied to the kit.
Director of nursing or designee will educate the clinical staff on the importance of having the appropriate items in the first aid kits on or before July 13,2024.
Director of nursing or design will complete an audit once a week times 30 days to ensure first aid kits have the appropriate items on or before June 30,2024. The audit will be reviewed during the monthly quality assurance meeting.?

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (- 08/19/2024)

103g - Storing Food

20. Requirements

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

Description of Violation

On 4/30/2024, there were in the Memory Care Unit kitchen freezer popsicles that were opened and unsealed, and in the kitchen refrigerator, a container of pudding was opened and unsealed.

Repeat Violation: 11/10/22 et al, 1/31/23

Plan of Correction ***Accept (- 06/25/2024)***

The Popsicles and pudding were discarded by housekeeping by May 1, 2024.
Administrator ensured Items in the facility freezers and kitchens that were not dated were discarded by May 8, 2024.
Administrator educated the Nursing and kitchen staff for educate on importance of dating items in the refrigerator and freezers on or before July 13,2024.
The dietary manager will complete a weekly audit times 30 days of kitchen freezers and refrigerators to ensure items are dated on or before July 13,2024. The audit results will be reviewed during the monthly quality insurance meeting.?

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

103i - Outdated Food

21. Requirements

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

Description of Violation

There was an unlabeled, undated bag of food in the Memory Care Unit kitchen refrigerator.

Repeat Violation: 11/10/22 et al, 1/31/23

Plan of Correction ***Accept (- 06/25/2024)***

Dietary manager removed unlabeled food was discarded from the memory care unit refrigerator as of May 1, 2024.
Administrator ensured Facility refrigerators were checked for unlabeled or unsafe neared food. If any unable or undated food were noted, they were discarded as of May 8, 2024.
Administrator educated the Nursing and Dietary staff educated on the importance of labeling food in refrigerators and freezers on or before July 13,2024.
Dietary manager will audit freezers and refrigerators to ensure items are labeled or dated once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the quality assurance meeting.?

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

107b - Emergency Procedures

22. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include the contact information for each resident's designated person.

Plan of Correction ***Accept (- 06/25/2024)***

A list of resident contacts to the department of health by the administrator on April 30, 2024.?
Administrator ensured a review of the contact list was completed and all contact information was up-to-date as of May 8, 2024.
Administrator educated facility administration was on the importance of having emergency contact information for each resident on or before July 13,2024.
Admissions Director or designee will complete a weekly audit for 30 days of emergency contact information for

107b - Emergency Procedures (continued)

residents to ensure it is accurate on or before July 13,2024. The results of the audit will be reviewed at the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

107d - Procedure Emergency Management Agency Submission

23. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed, updated, and submitted annually to the local emergency management agency.

Plan of Correction ***Accept (█ - 06/25/2024)***

Emergency preparedness plan was provided to the local emergency management agency on or before July 13,2024.
Emergency preparedness plan was reviewed to ensure its accurate on or before July 13,2024. Document noted to be accurate
Administrator educated Facility administration on the importance of having an up-to-date emergency preparedness plan on or before July 13,2024.
Administrator or designate will audit weekly for 30 days the emergency preparedness plan to ensure it is accurate on or before July 13, 2024. The results of the audit will be reviewed at the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

141a - Medical Evaluation

24. 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.

Description of Violation

The medical evaluation was not complete within 60 days prior to admission or within 30 days after admission of the residents 5 and 6.

Repeat Violation: 11/10/22 et al

Plan of Correction ***Accept (█ - 06/25/2024)***

Director of Nursing ensured Resident number 3 and 5 had the medical evaluations updated to include missing documentation on or before July 13,2024.
Medical evaluations were reviewed for each PCU resident the director of nurse for PCU resident on or before July 13,2024. If information was missing from the medical evaluation, the doctors were requested to update.
Administrator educated the clinical director was educated on the importance of having medical evaluation

141a - Medical Evaluation (continued)

completed per regulations on or before July 13,2024.
Clinical director or designee will complete a weekly audit for 30 days to ensure medical evaluations are completed per regulations on or before July 13,2024. Results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

141a 1-10 Medical Evaluation Information

25. 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 3 medical evaluation, dated █, did not include the special health or dietary needs of the resident.

Resident 7 medical evaluation dated █ did not include medical information pertinent to diagnosis and treatment in case of an emergency, allergies, Immunization history, body positioning, or movement stimulation for residents, if appropriate.

Repeat Violation: 8/03/23

Plan of Correction ***Accept (█ - 06/25/2024)***

Director of Nursing ensured Resident number 3 and 7 had the medical evaluations updated to include missing documentation on or before July 13,2024.
. Medical evaluations were reviewed for each PCU resident the director of nurse for PCU resident on or before July 15,2024. If information was missing from the medical evaluation, the doctors were requested to update.
3. Administrator educated the clinical director was educated on the importance of having medical evaluation completed per regulations on or before July 13,2024.
Clinical director or designee will complete a weekly audit for 30 days to ensure medical evaluations are completed per regulations on or before July 15,2024. Results of the audit will be reviewed during the monthly quality assurance meeting.

Proposed Overall Completion Date: 07/13/2024

141a 1-10 Medical Evaluation Information *(continued)*

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

141b1 - Annual Medical Evaluation

26. Requirements

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

Description of Violation

Resident 8's missing most recent medical evaluation was completed on █.

Plan of Correction ***Accept (█ - 06/25/2024)***

Director of nursing ensured Resident 8 has a current medical evaluation form completed by the provider on or before July 13,2024.
Director of Nursing evaluated PCU residents for medical evaluations on or before July 13,2024. If a resident does not have a current medical evaluation completed the provider completed the form.
Administrator educated the Clinical Director on the importance of providers completing annual medical evaluation forms on or before July 13,2024.
Clinical Director or design will complete an audit once a week for 30 days to ensure providers are completing annual medical evaluation forms on or before July 13,2024. The results of the audit will be reviewed during monthly quality assurance meeting.

Proposed Overall Completion Date: 07/13/2024

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

162c - Menus Posted

29. 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

The home's menu stating the specific food being served at each meal for the week of April 27 to May 4 was not posted in a conspicuous and public place in the Personal Care Unit.

Plan of Correction ***Accept (- 06/25/2024)***

Menu was posted one week in advance in the PCU by the dietary manager by May 1, 2024
An evaluation of the facility was completed by the dietary manager to ensure menus were posted. Menus were posted in designated areas on or before July 13,2024.
Administrator educated Dietary manager on the importance of posting menus one week in advance on or before July 13,2024.
Dietary manager or designee will audit placement of menus once a week times for 30 days on or before July 13,2024. Results of the audit will be reviewed at the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

171b4 - Staff Training

30. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff person H who transported residents to appointments has not completed the initial new hire direct care staff person training, nor has any staff person who accompanied residents on the trip.

Plan of Correction ***Accept (- 06/25/2024)***

Administrator confirmed the facility vehicle driver will be accompanied by a healthcare provider when transporting residents on May 29,2024.
Administrator or designee reviewed personnel files of all staff that operate facility vehicles for residents on or

171b4 - Staff Training (continued)

before June 30,2024. It was determined all staff members have the appropriate training.
Administrative staff was educated by the administrator on the importance of having drivers for the facility van with the correct credentials on or before June 30,2024.
Administrator or designee will complete an audit of drivers' credentials once a week for 30 days to ensure credentials meet DOH requirements on or before June 30,2024. The results of the audit will be reviewed at the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

171c - Home's Vehicle Documents

31. Requirements

2600.
171.c. The home shall maintain current copies of the following documentation for each of the home's vehicles used to transport residents:

1. Vehicle registration.
2. Valid driver's license for vehicle operator.
3. Vehicle insurance.
4. Current inspection.
5. Commercial driver's license for vehicle operator if applicable.

Description of Violation

The home does not have a copy of the current vehicle registration for the bus used to transport residents. The most current registration expiration date was 10/31/2023.

Plan of Correction ***Accept (█ - 06/25/2024)***

Administrator obtained a copy of the current vehicle registration on or before June 30,2024.
Administrator obtained current registration for the facility vehicle and insured a copy of the registration is located within the facility on or before June 30,2024.
Administrator educated maintenance department on monitoring vehicle registration expiration dates on or before June 30,2024.
Administrator or design with audit vehicle registration once a week for 30 days to ensure vehicle registration is current on or before June 30,2024. Results of the audit will be reviewed during monthly quality insurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

183e - Storing Medications

35. Requirements

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

Description of Violation

Alprazolam Tab 1 mg, prescribed for resident 9, was in a blister card. The foil on the back of pill #1 has an opening in it.

Plan of Correction ***Accept (- 06/25/2024)***

Clinical Director removed the medication that was exposed due to the foil being open on the blister pack as of May 1, 2024.
Clinical Director completed an audit of all blister packs and no other packaging was a concern?on or before July 13,2024.?
Clinical Director educated the clinical team on the importance of blister pack integrity on or before July 13,2024.
Clinical Director will complete a weekly audit times 30 days to ensure blister packs of medication's are intact on or before July 13,2024. The results of the audit will be reviewed at the monthly quality meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

185a - Implement Storage Procedures

36. 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 5 has various glucometer readings that do not match with the MAR readings to include the following:
On 4/29/2024, at 4:22 p.m., resident 5's glucometer had a reading of 304. However, the reading on the MAR was 305.
On 4/28/2024, at 8:16 p.m., resident 5's glucometer had a reading of 297. However, the reading on the MAR was 293.

Repeat Violation: 11/10/2022, et al

Plan of Correction ***Accept (- 06/25/2024)***

Clinical director checked the glucometers to ensure they are functioning correctly as of May 8,2024. Clinical Director also educated the nurses involved in the deficiency on how to document properly blood sugars on or before July 13,2024.
Clinical Director reviewed the Mars of resident who utilize blood sugars. If there was a discrepancy at the time of the review, the Director informed the doctor on or before July 13,2024.
Clinical Director, educated the staff on the importance of documenting blood sugars in the resident records/ EMR on or before July 13,2024.

185a - Implement Storage Procedures (continued)

Clinical Director or designee will audit once a week for 30 days residents who have blood sugars to ensure the MARs and glucometer information matches on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

37. 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 8 is prescribed Milk of Magnesia, and Tylenol Extra Strength tab 500 mg as needed.
On 4/30/24 these medication(s) were not available in the home.

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director obtained the medications that that were not available for resident 8 as of May 8, 2024
Clinical Director reviewed residents' medication inventory on or before July 13,2024. If a medication was not on hand, the clinical Director worked with the family and doctor to obtain the medication.
Clinical Director educated the staff on the importance of having medications on hand to dispense to residents on or before July 13,2024.?
Clinical Director or designee will complete once a week audit for 30 days on medication inventory of residents to ensure medications are on hand on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

187a - Medication Record

39. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 10 is prescribed Clonazepam 0.5 mg tab. However, the resident's April 2024 medication administration records do not indicate drug allergies, dosage, route of administration, frequency of administration, administration times, duration of therapy, if applicable, special precautions, if applicable, diagnosis, or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director updated resident 10 Clonazepam orders to include the appropriate documentation as of June 8, 2024.
Clinical Director reviewed resident MARS who are prescribed clonazepam to ensure appropriate documentation was noted on the all resident had the appropriate documentation on or before July 13, 2024.
Clinical Director educated clinical staff on the importance of having appropriate documentation for medications on the MAR on or before July 13, 2024.
Clinical Director will audit MARs To ensure appropriate documentation is noted?for each medication audited. The audit will be conducted once a week for 30 days on or before July 13, 2024. The results of the audit will be reviewed during the monthly quality source meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

187a - Medication Record *(continued)*

Not Implemented (█ - 08/19/2024)

190b - Insulin Injections

40. 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

On April 1, 4, 5, 12–15, 18, 19, 26–29, at 4:30 p.m., staff person I, who has not successfully completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to resident 8.
On April 4, 5, 12, 15, 18, 19, 26, and 29 at 8:00 p.m., staff person I, who has not successfully completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to resident 8.

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director has confirmed employee 1 has obtained diabetic training as of May 29, 2024.?
By June 4, 2024 the clinical Director will have had all full-time clinical employees will have had diabetic training.
Clinical Director will educate clinical team on the importance of having diabetic training for residents on or before June 30, 2024.
Clinical director or designee Will audit clinical files once a week for 30 days to ensure diabetic training is noted for each employee's personal file on or before June 30, 2024. The results of the audit will be reviewed at the monthly quality insurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

190c - Record of Training

41. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training records for staff persons C and I do not include a record of the training, including the staff person trained, the date, source, name of the trainer, and documentation that the course was successfully completed.

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director, updated personal files for C and I with the completed medication administration training on or before July 13,2024.
Clinical Director, checked all clinical status to ensure medication training was completed for staff members who require the training on or before July 13,2024. Staff members completed the medication training.
Clinical director educated the clinical staff on the importance of having routine medication training on or before July 13,2024.
Clinical Director or designee will audit employee files to ensure medication training has been completed. The audit

190c - Record of Training (continued)

will be once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly assurance meeting.?

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (- 08/19/2024)

224a - Preadmission Screen Form

42. Requirements

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

Description of Violation

Resident 3 was admitted to the home on however, the resident's preadmission screening form was not completed.

Resident 5 was admitted to the home on however, the resident's preadmission screening form was not completed.

Resident 6 was admitted to the home on ; however, the resident's preadmission screening form was not completed.

Repeat Violation: 11/10/2022, et al

Plan of Correction ***Accept (- 06/25/2024)***

Clinical Director updated resident 3,5,6 pre-screen forms on or before July 13,2024.
Clinical Director audited, prescreen forms to ensure they were completed correctly on or before July 13,2024. If any prescreen was not completed correctly, the clinical Director updated the form.
Clinical Director, educated the staff on completing prescreen forms accurately on or before July 13,2024.
Clinical Director or designee will audit prescreen forms to ensure that they are completed accurately once a week for 30 days on or before July 13,2024. The result of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

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 3 was admitted on ; however, the resident's assessment was not completed until

225a - Assessment 15 Days (continued)

Resident 11 was admitted on ; however, the resident's assessment was not completed until .

Plan of Correction ***Accept (- 06/25/2024)***

Clinical Director reviewed resident 3 and 11 assessments and determined the information completed was accurate on or before July 13,2024.
Clinical director reviewed assessment of resident who were admitted within the last 10 days from May 30, 2024 to ensure they were completed on time. The assessments were completed on time.
Clinical Director, educated the clinical team on the importance of completing assessments within the allotted timeframe on or before July 13,2024.
Clinical Director or designee will audit resident charts to ensure assessments are completed within the allotted timeframe once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

44. 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

An assessment was not completed for resident 5, who was admitted to the home on

An assessment was not completed for resident 6, who was admitted to the home on

Plan of Correction ***Accept (- 06/25/2024)***

Resident five and six had new assessments completed by the clinical Director on or before July 13,2024.
Clinical Director audited all PCU resident charts to ensure an assessment was completed recently on or before July 13,2024. If an assessment was not completed recently, the clinical Director completed a new assessment.
Clinical Director, educated the staff on the importance of having an admission assessment on or before July 13,2024.
Clinical director will audit resident charge to ensure an assessment is completed on admission. The audit will be completed once a week times 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

225c - Additional Assessment

45. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

225c - Additional Assessment *(continued)*

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 4's current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Clinical director was educated on the time frames in which annual assessments are to be completed for PCC residents by the administrator on or before July 13,2024.
Clinical Director reviewed the calendar of assessments to ensure they meet the standard time deviation to be completed on or before July 13,2024.
Clinical Director educated the clinical team on the importance of completing assessment and a timely manner based upon intervals prescribed by regulations on or before July 13,2024.
clinical Director will audit resident assessments to ensure they are completed within an allotted timeframe once a week for 30 days on or before July 13,2024. The audits will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented ([redacted] - 08/19/2024)

227a - Support Plan 30 Days

46. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 5 was admitted on [redacted]; however, the resident's initial support plan was not completed.

Resident 11 was admitted on [redacted]; however, the resident's initial support plan was not completed until 12/13/2023.

Plan of Correction ***Accept ([redacted] - 06/25/2024)***

Clinical Director was educated on completing support plans timely by the administrator on or before July 13,2024.
Resident five had a support plan completed by the clinical Director on or before July 13,2024. Resident 11 had a support plan completed on 12/23/2023.?
Clinical director review PCU resident support plans to ensure all had one completed. All residents had a support plan completed on or before July 13,2024.
Clinical Director, educated clinical staff of completing support plants timely on or before June 30,2024.
Clinical Director or designee will audit PCU resident charts to ensure support plans are completed timely. The audit

227a - Support Plan 30 Days (continued)

will be completed once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

227g -Support Plan Signatures

48. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 8 participated in the development of his/her support plan on 6/23/2023. However, the resident did not sign the support plan. The signature page included with the support plan was from a previous year, 6/17/2022.

Repeat Violation: 1/31/23, 11/10/22, et al

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director completed a new support plan for resident 8 and resident 8 signed the plan on or before July 13,2024.

227g -Support Plan Signatures (continued)

Clinical Director audited Support plans to ensure they were signed by either the resident or POA. If a signature was not noted the clinical Director obtain the signature by either the resident or POA on or before July 13,2024.
Clinical director educated staff on the importance of having signature, signed by either the resident or POA for service plans on or before July 13,2024.
Clinical Director will audit service plans to ensure a signature has been completed by either the resident or POA. The order will become completed once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

231c - Preadmission Screening

49. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 7 was admitted to the Secure Dementia Care Unit (SDCU) on 6/05/2023. However, resident 7's written cognitive pre-admission screening was not completed.

Repeat Violation: 11/10/22, et al

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director completed a new cognitive pre-admission screening tool for resident 7 on or before July 13,2024.
Clinical Director audited charts of resident on the dementia unit to ensure they had a cognitive pre-admission screening on or before July 13,2024. If a screening was not completed the clinical Director completed the form.
Clinical director educated the staff on the importance of having a pre-cognitive form completed on or before July 13,2024.
Clinical Director will audit once a week for 30 days of resident on the dementia unit to ensure cognitive prescreen tool has been completed on or before July 13,2024. The audit results will be reviewed at the monthly quality source meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (█ - 08/19/2024)

234b - Support Plan Needs Elements

50. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated 6/05/2023, for resident 7 does not address the fact that the resident is in Hospice.

234b - Support Plan Needs Elements *(continued)*

Plan of Correction ***Accept (█ - 06/25/2024)***

Resident 7 support plan was updated to include hospice by the clinical Director on or before July 13,2024.
Clinical Director audited service plans of residents who are on hospice. If the service plan did not include the hospice the clinical Director completed a new service plan on or before July 13,2024.
Clinical Director, educated staff on the importance of adding hospice to service plans on or before July 13,2024.
Clinical Director will audit chart resident on hospice to ensure their service plan includes hospice services. The audit will be completed once a week times 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality assurance meeting.?

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

236 - Staff Training

51. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person G, who works in the Secure Dementia Care Unit (SDCU), had 0 hours of training in dementia care during the 2023–2024 training year.

Plan of Correction ***Accept (█ - 06/25/2024)***

Clinical Director provided dementia training for staff member G on or before July 13,2024.
Clinical Director audited charts of staff that work on the dementia unit and if they were missing dementia training, the clinical Director provided the training on or before July 13,2024.
Clinical director, educated staff on the importance of having dementia training if a staff member works on the dementia unit on or before July 13,2024.
Clinical Director will audit staff education who work on the dementia unit to ensure dementia. Training has been completed once a week for 30 days on or before July 13,2024. The results of the audit will be reviewed during the monthly quality insurance meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Implemented (█ - 08/19/2024)

252 - Record Content

52. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

252 - Record Content *(continued)*

5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Residents 3 and 11 records do not include race, color of hair, or color of eyes.

Repeat Violation: 11//10/22, et al

Plan of Correction ***Accept (- 06/25/2024)***

Admission Director, updated resident 3 and resident 11 files to include the appropriate demographic information by May 5, 2024.
Admissions Director audited all PCU charge to ensure demographic information was accurate on resident chart May 5,2024.
Administrator educated staff on the importance of having accurate demographic information on resident charts on or before June 30,2024.
Administrator or designee will audit resident charts once a week times 30 days to ensure demographic information is accurate on the charts on or before July 13,2024. The results of the audit will be reviewed during the monthly quality short meeting.

Licensee's Proposed Overall Completion Date: *07/13/2024*

Not Implemented (- 08/19/2024)

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

Facility Information

Name: *ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14108* **License Expiration**: *06/08/2024*

Address: *490 MANOR AVENUE, DOWNINGTOWN, PA 19335*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *470 MANOR OPERATING LLC*

Address: *490 MANOR AVENUE, DOWNINGTOWN, PA, 19335*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/24/2001* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *88* **Waking Staff**: *66*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *08/01/2024*

Inspection Dates and Department Representative

07/31/2024 - On-Site:
08/01/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *35* **Residents Served**: *26*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *51* **Have Physical Disability**: *0*

Inspections / Reviews

07/31/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/26/2024*

09/03/2024 - POC Submission

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

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

09/11/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/14/2024*

11/06/2024 - Document Submission

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

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

17 - Record Confidentiality

1. Requirements

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

Description of Violation

On 7/31/2024, at 9:00 am, a task log for the resident care and information concerning the meals were unlocked, unattended, and accessible on a cart near the front desk of the main entrance of the facility.

Plan of Correction ***Accept (█ - 09/11/2024)***

17
Administrator removed log of information from the area on or before September 23, 2024.
Administrator toured the facility, and no other confidential information was found on or before September 23, 2024.
Dietary and nursing staff were educated by Administrator on the importance of resident confidentiality on or before September 23, 2024.
Director of nursing or designee will complete an audit to ensure resident confidentiality is maintained on or before September 23, 2024. Audits will be completed once a week for four weeks on or before September 23, 2024. Results of the audit will be reviewed during the quality assurance on or before September 23, 2024 meeting.

Proposed Overall Completion Date: 09/23/2024

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

53c - Administrator Duties

2. Requirements

2600.
53.c. The administrator shall be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

Description of Violation

The resident list provided by the facility administration was not current and did not include the residents date of admission.

Plan of Correction ***Accept (█ - 09/11/2024)***

53c
Administrator obtained a list of PCU residents that was provided to the DOH with admission dates on or before September 23, 2024.
Receptionist reviewed and updated PCU List and ensured the list had admission dates on or before September 23, 2024.

53c - Administrator Duties (continued)

Receptionist was educated on the importance of having a resident list with admission dates available at the front desk by the Administrator on or before September 23, 2024.
Clinical director or designee will audit the resident list once a week times four weeks to ensure the list is accurate with admission dates on or before September 23, 2024. The audit will be reviewed at the facility quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

82c - Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A container of Super Sani Cloth Wipes was in the cabinet above the stove, and a Santec Plum disinfectant cleaner was in the cabinet under the sink in the memory care unit pantry with a manufacturer's label indicating "Keep out of reach of children. In case of accidental ingestion, get medical help or contact a poison control center immediately." unlocked, unattended, and accessible to residents in the Memory Care Unit pantry. Not all the residents of the home, including the residents in the Memory Care Unit, have been assessed as capable of recognizing and using poisons safely.

A cleaning cart was left with an Original Kitchen cleanser in the memory care unit hallway with a manufacturer's label indicating "Keep out of reach of children. In case of accidental ingestion, get medical help or contact a poison control center immediately." unlocked, unattended, and accessible to residents in the Memory Care Unit pantry. Not all the residents of the home, including the residents in the Memory Care Unit, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept (█ - 09/11/2024)***

82C. Next
Clinical director ensured all hazardous materials were removed from cabinets on or before September 23, 2024.
All cabinets utilized in resident areas were examined, and no hazardous materials were identified on or before September 23, 2024.
Housekeeping and nursing departments were educated on the importance of having hazardous materials under lock and key by Administrator on or before September 23, 2024.
Clinical Director or designee will audit once a week for four weeks to ensure hazmat's are under lock and key on the units on or before September 23, 2024. Results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Proposed Overall Completion Date: 09/23/2024

82c - Locking Poisonous Materials *(continued)*

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 7/31/2024, at 10:40 a.m., staff member A did not sanitize their hands in between medication administrations from one resident to the next.

Plan of Correction Accept (█ - 09/11/2024

85a
Housekeeping Director had rug steam cleaned on or before September 23,2024. Staff member was educated on importance of hand, sanitizing or washing of hands during medication administration by Clinical Director on or before September 23, 2024.
Carpets in general areas of the first floor of the facility were steam cleaned on or before September 23, 2024.
Medication administration observation was completed by the clinical Director and no concerns noted for infection control on or before September 23, 2024.
Housekeeping staff were educated on the importance of maintaining clean carpets on or before September 23, 2024.
Nurses and techs were educated on the importance of handwashing during medication administration on or before September 23, 2024.
The Clinical Director or designee will monitor medication administration for one-week times four weeks to ensure handwashing is being completed on or before September 23, 2024. In addition, the Clinical Director or designee will monitor the cleanliness of carpets for one-week times four weeks to ensure they are clean on or before September 23, 2024. Results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

86b - Bathroom

5. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathrooms on bedrooms 9, 11, 26, 29, 33, and 39 do not have an operable window or ventilation fan. The

86b - Bathroom (continued)

ventilation fan is inoperable, and there is no window in the bathroom.

Plan of Correction ***Accept (█ - 09/11/2024)***

86b
Maintenance ensured Rooms 9, 11, 26, 29, 33, and 39 had fans operational in bathrooms on or before September 23, 2024.
Maintenance Director or designee evaluated all resident vent fans in bathrooms to ensure they are operational on or before September 23, 2024. All fans were operational on or before September 23, 2024.
Maintenance was educated on the importance of having proper functioning ventilation fans by Administrator on or before September 23, 2024.
Maintenance Director or designee will audit resident ventilation fans to ensure their functioning once a week for four weeks on or before September 23, 2024. The audit will be reviewed during the quality insurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Implemented (█ - 10/02/2024)

88a - Surfaces

6. Requirements

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

Description of Violation

On 7/31/2024, there were electrical wires hanging out in two separate locations of the Memory Care Unit ceiling.

Plan of Correction ***Accept (█ - 09/11/2024)***

88a
Maintenance Department ensured electrical wires were removed from the locations on or before September 23, 2024.
Maintenance Director completed an evaluation of the facility to ensure no other electrical wires were hanging in the facility on or before September 23, 2024.
The maintenance department was educated on the importance of completing environmental rounds to ensure the safety of the physical plant by the Administrator on or before September 23, 2024.
Maintenance Director or designee will audit once a week for four weeks to ensure electrical wires are not hanging or causing a safety concern in the facility on or before September 23, 2024. The audit results will be reviewed during the qualities source meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

88a - Surfaces *(continued)*

Not Implemented (█ - 10/02/2024)

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 7/31/2024, the hot water temperature in bedroom 9 measured 122.2, bedroom 11 measured 122.1, and bedroom 26 measured 122.3 degrees Fahrenheit.

Plan of Correction ***Accept (█ - 09/11/2024)***

89b
1.. Mixing valve was adjusted by Maintenance director to ensure hot water on or before September 23, 2024. Temps are below 120 on or before September 23, 2024.
2.. Maintenance Director completed facility evaluation for hot water on September 23, 2024. All temperatures were under 120 on or before September 23, 2024.
3.. Maintenance department was educated on the importance of having water temperature temperatures below 120 by Administrator on or before September 23, 2024.
4.. Maintenance Director or designee will complete water temperature audit once a week for four weeks to ensure temperatures of below 120 on or before September 23, 2024. Audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Implemented (█ - 10/02/2024)

92 - Windows

8. Requirements

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

Description of Violation

On 7/31/2024, there were no window screens in bedroom 26. The resident stated that █ has been waiting for years to get the window screen replaced.

There are no window screens in the 3rd floor pantry area of the facility.

Plan of Correction ***Accept (█ - 09/11/2024)***

92.
Window screens were replaced in room 26 and on the third-floor pantry area by the maintenance department on

92 - Windows (continued)

or before September 23, 2024.
Maintenance completed a facility check of screens and no other screens were noted to be missing on or before September 23, 2024.
The maintenance department was educated on the importance of maintaining screens throughout the physical plant by Administrator on or before September 23, 2024.
Maintenance Director or designee will audit once a week for four weeks facility screens to ensure they are in place throughout the physical plant on or before September 23, 2024. Results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Implemented (- 10/02/2024)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.
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 7/31/2024, the temperature in the 3rd floor pantry freezer was 8 degrees Fahrenheit.

Plan of Correction ***Accept (- 09/11/2024)***

103f 9.
Freezer controls were adjusted by Dietary manager to ensure a temperature of zero or below on or before September 23, 2024.
Maintenance department checked all freezers to ensure they are functioning correctly on or before September 23, 2024. All freezers were working correctly and tempting below zero on or before September 23, 2024.
Dietary staff were educated on the importance of maintaining freezer temps at a desired temperature by the Administrator on or before September 23, 2024.
Dietary manager or designee will audit freezer temps once a week for four weeks to ensure that they are meeting required temperatures on or before September 23, 2024. Results of the audit will be reviewed during quality review meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (- 10/02/2024)

10. Requirements

2600.
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

There were no thermometers in the main kitchen ice cream freezer and in the Memory Care pantry refrigerator.

103f - Refrigerator/Freezer Temps (continued)

Repeat Violation: 11/10/22, et al

Plan of Correction ***Accept (█ - 09/11/2024)***

103f 10.
The thermometer was placed in the ice cream freezer by Dietary manager on or before September 23, 2024.
The Dietary manager checked all freezers to ensure a thermometer was in the freezer on or before September 23, 2024. All freezers had a thermometer on or before September 23, 2024.
Dietary was educated on the importance of maintaining thermometers and freezers by the Administrator on or before September 23, 2024.
Dietary manager or designee will audit freezers to ensure a thermometer is located in each one once a week times four weeks on or before September 23, 2024. Results of the audit will be reviewed during quality assurance meeting on or before September 23, 2024

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

103g - Storing Food

11. Requirements

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

Description of Violation

There was an ice cream container in the main kitchen freezer that was opened and unsealed.

Repeat violation: 11/10/22, et al; 1/31/23

Plan of Correction ***Accept (█ - 09/11/2024)***

103g
Dietary manager ensured Ice cream container was removed from the kitchen freezer on or before September 23, 2024.
Dietary staff checked all freezers for any opened items on or before September 23, 2024. If items were open, they were discarded on or before September 23, 2024.
Dietary staff was educated on the importance of food storage and sealing of food containers by the Administrator on or before September 23, 2024.
Dietary manager will audit freezers to ensure items are sealed correctly once a week for four weeks on or before September 23, 2024. The results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

103g - Storing Food (continued)

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

103i - Outdated Food

12. Requirements

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

Description of Violation

There was a dented can of vanilla pudding in the main kitchen.
There was an unlabeled, undated bag of pepperoni and a bag of hashbrowns in the main kitchen freezer.

Repeat violation: 11/10/22, et al; 1/31/23

Plan of Correction ***Accept (█ - 09/11/2024)***

103i
Dented can of vanilla pudding was removed by Dietary manager on or before September 23, 2024. Unlabeled pepperoni and hashbrowns were removed from the freezer on or before September 23, 2024.
Dietary manager checked freezers for outdated or spoiled food on or before September 23, 2024. No outdated or spoiled food were noted in the freezers on or before September 23, 2024.
Dietary staff was educated on the importance of not having outdated or spoiled food and freezers by the Administrator on or before September 23, 2024
Dietary manager will audit freezers once a week for four weeks to ensure no outdated or spoiled foods are in the freezer on or before September 23, 2024. The audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

107d - Procedure Emergency Management Agency Submission

14. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed, updated, and submitted annually to the local emergency management agency.

107d - Procedure Emergency Management Agency Submission *(continued)*

Plan of Correction ***Accept (- 09/11/2024)***

107d
Administrator verified emergency procedures were delivered to the local emergency management agency on or before September 23, 2024.
Local emergency management agency reviewed and commented on facility emergency procedures on or before September 23, 2024.
Maintenance Director or designee was educated on the importance of providing emergency procedures to local emergency management agencies by the Administrator on or before September 23, 2024.
Maintenance Director or designee to audit once a week the emergency procedure plans to ensure they are being utilized once a week for four weeks on or before September 23, 2024. Results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (- 10/02/2024)

123c - Evacuation Diagrams

15. Requirements

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

Description of Violation

The home currently serves 36 residents. However, the emergency evacuation diagram posted does not show the line of travel.

Plan of Correction ***Accept (- 09/11/2024)***

123c
Evacuation diagrams were updated to include lines of travel on or before September 23, 2024.
Maintenance Director or designee checked all evacuation diagrams in the facility to ensure they have lines of travel on or before September 23, 2024. If diagrams were missing line of travel were missing the maintenance Director replaced with new diagram on or before September 23, 2024.
Maintenance department was educated on the importance of having evacuation diagrams with lines of travel by the Administrator on or before September 23, 2024.
Maintenance Director or design will audit evacuation diagrams once a week times four weeks to ensure lines of travel are on the diagrams on or before September 23, 2024. Result of the audit will be reviewed during facility Quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Implemented (- 10/03/2024)

141a - Medical Evaluation

16. Requirements

2600.

141a - Medical Evaluation *(continued)*

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

Description of Violation

Residents 1, 2, 3, and 4 did not have a medical evaluation by a physician, physician's assistant, or certified registered nurse practitioner documented on a form specified by the Department.

Repeat violation: 11/10/22, et al

Plan of Correction ***Accept (- 09/11/2024)***

141a
Resident one, two, three, four had medical evaluations completed on specific forms on or before September 23, 2024.
Director of nursing checked all medical evaluation forms to ensure they were on specific forms on or before September 23, 2024. If any form was not on the required format, the physicians were requested to complete on the required format on or before September 23, 2024.
Clinical Director was educated on the importance of utilizing department issued forms for medical staff by the Administrator on or before September 23, 2024.
Clinical director or designee will audit medical forms to ensure they are completed on the correct format once a week times four weeks on or before September 23, 2024. The results of the audit will be reviewed during quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (- 10/02/2024)

141a 1-10 Medical Evaluation Information

17. 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 5's medical evaluation dated did not include special health or dietary needs of the resident, allergies, or health status.

141a 1-10 Medical Evaluation Information (continued)

Repeat violation: 3/4/24

Plan of Correction ***Accept (█ - 09/11/2024)***

141.a.
Resident five medical evaluation form was updated to include the necessary health and dietary requirements on or before September 23, 2024.
The Clinical Director evaluated medical evaluation forms for residents on or September 23, 2024. If a form required completion, the clinical Director utilized providers to complete on or September 23, 2024.
Clinical Director was educated on the importance of having completed medical evaluation forms by the Administrator on pr before September 23, 2024.
Clinical Director or designee to audit medical evaluation forms to ensure the appropriate information is completed once a week for four weeks on or before September 23, 2024. The audit will be reviewed at the quality assurance meeting on or before September 23, 2024

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

182c - Medication Administration

19. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 7/31/2024, staff member A did not follow the medication administration procedure and signed the EMAR prior to administering medications to a resident who requires this assistance to take medication

Plan of Correction ***Accept (- 09/11/2024)***

182c

1. Director of nursing spoke to staff member who was educated on signing for medication's once resident has taken them on or before September 23, 2024.

Clinical Director completed an evaluation of nursing staff to ensure they signed off on medications after the resident has accepted on or before September 23, 2024. No concerns noted from the evaluation on or before September 23, 2024.

Clinical staff were educated on importance of signing for medication after resident has accepted or declined the medications by Clinical Director on or before September 23, 2024.

Clinical director or designee while audit medication observation to ensure staff are signing after medication's either except or declined the medication on or before September 23, 2024. The audit will be completed once a week for four weeks. The results will be reviewed during the facility meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (- 10/02/2024)

183e - Storing Medications

20. Requirements

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

Description of Violation

Lorazepam Tab 0.5 mg, prescribed for resident 5, was in a blister card. The foil on the back of pill #6 has an opening in it.

Two bottles of levothyroxine were prescribed to resident 6. However, one bottle expired on November 9, 2023, while the second one expired on February 3, 2024.

The following medication, Loperamide 2 mg, belonging to resident 7, was observed on the medication cart with a

183e - Storing Medications (continued)

discard date of 2/01/2024.

Plan of Correction ***Accept (█ - 09/11/2024)***

183.e
Director of nursing checked lorazepam medication for resident 5 it was counted, and the count was correct on or before September 23, 2024. Levothyroxine and loperamide were destroyed on or before September 23, 2024.
Clinical Director completed a house audit of medications on or before September 23, 2024. Any medication's that were expired were destroyed on or before September 23, 2024.
Clinical staff was educated on the importance of maintaining correct medication counts for controlled substances and the importance of discarding expired medications by Clinical Director on or before September 23, 2024.
Clinical Director or designee will audit medication cards to ensure narcotic counts are correct and medications are discarded if expired on or before September 23, 2024. The audit will be completed once a week for four weeks. The results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

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185a - Implement Storage Procedures

22. 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 5 is prescribed Milk of Magnesia, Dextromethorphan and Sunblock as needed. On 7/31/24 these medication(s) were not available in the home.

Resident 8 is prescribed Sunblock as needed. On 7/31/24, this medication was not available in the home.

Repeat Violation: 11/10/22, et al

Plan of Correction ***Accept (- 09/11/2024)***

185a
Resident 5 and 8 medications were obtained if ordered on or before September 23, 2024.
Clinical Director reviewed med carts to ensure PRN medications were available for residents on or before September 23, 2024. If medications were not available, the medications were obtained on or before September 23, 2024.
Clinical staff educated on the importance of having PRN medications as part of resident inventory of medication on hand in the facility by the Clinical director on or before September 23, 2024.
Clinical Director will audit PRN medications to ensure they are on hand in the facility on or before September 23, 2024. The audit will be completed once a week times four weeks on or before September 23, 2024. The results of the audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (- 10/02/2024)

187a - Medication Record

23. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident’s name.
2. Drug allergies.
3. Name of medication.

187a - Medication Record *(continued)*

4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 9 is prescribed Morphine 100 ml and Lorazepam 0.5. However, the July 2024 medication administration record do not indicate route of administration, frequency of administration, diagnosis, or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Accept (█ - 09/11/2024)***

187a
Resident 9 had morphine and lorazepam orders updated to include the route, frequency, diagnosis, and the purpose of the medication by the Director of nursing on or before September 23, 2024.
Clinical director checked all PRN orders to ensure they were written correctly on or before September 23, 2024. Any orders not written correctly were updated o n or before September 23, 2024.
Clinical staff educated on the importance of physician orders written correctly to include root of administration, frequency of administration, diagnosis, and the purpose of the medication by the Clinical Director on or before September 23. 2024.
Clinical Director or designee will audit PRN medications to ensure that they are written correctly on or before September 23, 2024. The audit will be conducted once a week for four weeks on or before September 23, 2024. The audit results will be reviewed during the facility quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

224a - Preadmission Screen Form

25. Requirements

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

Description of Violation

Resident 10's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Residents 1, 2, 3, and 4 were admitted to the home; however, the residents don't have the preadmission screening form completed.

Repeat Violation: 11/10/22, et al

Plan of Correction ***Accept ([redacted] - 09/11/2024)***

224a
Administrator had Resident 10's prescreens updated to include determination needs on or before September 23, 2024. Residents 1,2,3 and 4 prescreening admission form could not be retro actively corrected on or before September 23, 2024.
All prescreen forms that were completed within the last 30 days were reviewed to ensure they were accurate on or before September 23, 2024. If the form was not accurate, the clinical Director updated the form on or before September 23, 2024.
Clinical Director was educated on the importance of completing prescreen forms by Administrator on or before September 23, 2024.
Clinical Director or design will audit prescreen forms for accuracy once a week times four weeks on or before

224a - Preadmission Screen Form (continued)

September 23, 2024. The audit will be reviewed during the quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)

225a - Assessment 15 Days

27. 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

An assessment was not completed for residents 1, 2, 3, and 4.

225a - Assessment 15 Days (continued)

Plan of Correction ***Accept (█ - 09/11/2024)***

225a
Residents 1,2,3, and 4 had assessments completed on or before September 23, 2024.
Administrator insured all resident who are PCU resident have an assessment on or before September 23, 2024. If assessment was not completed the clinical Director completed on or before September 23, 2024.
Clinical Director was educated on the importance of having residence who dwell on a PCU has assessments completed by the Administrator on or before September 23, 2024.
Clinical Director or designee will audit PCU charts to ensure assessments are completed on or before September 23, 2024. The audit will be completed once a week times four weeks on or before September 23, 2024. Results of the audit will be reviewed during the facility quality assurance meeting on or before September 23, 2024.

Licensee's Proposed Overall Completion Date: *09/23/2024*

Not Implemented (█ - 10/02/2024)