pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **KAYMARIE BRIDDELL**
LEGAL ENTITY

To operate **VINE STREET MANOR**
NAME OF FACILITY OR AGENCY

Located at **230 NORTH 65TH STREET, PHILADELPHIA, PA 19139**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **84**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **April 18, 2025** until **April 18, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142340**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing date: April 18, 2025

[redacted]
President
KayMarie Briddell
[redacted]
[redacted]

RE: Vine Street Manor
230 North 65th Street
Philadelphia, Pennsylvania 19139
License #: 142340

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on August 7 and 8, 2024 and November 6 and 7, 2024, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Facility Information

Name: *VINE STREET MANOR* **License #**: *14234* **License Expiration**: *11/14/2024*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

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

Administrator

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

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *09/07/2018* **Issued By**: *Phila L&(*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *08/08/2024*

Inspection Dates and Department Representative

08/07/2024 - On-Site: [redacted]

08/08/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *60*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *42* **Are 60 Years of Age or Older**: *38*

Diagnosed with Mental Illness: *58* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

08/07/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/05/2024*

Inspections / Reviews *(continued)*

10/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2024*

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

10/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/21/2024*

03/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 8/8/2024, a copy of the 55 Pa. Code 2600 chapter regulations was not posted in a conspicuous and public place in the home.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

The home's interim administrator has posted the latest violation report and was retrained on 8/28/24 by the consultant on 2600 3.c. pertaining to the posting of chapter regulations and licenses. The administrator immediately printed out and posted a copy of the 55 Pa. Code 2600 chapter regulations on 8/8/24. In addition, the home has purchased a shadow box on 9/9/24 to prevent residents from removing posted documents from the wall.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

The home's administrator will conduct monthly audits to ensure that all required items are posted in a conspicuous and public place in the facility. This will start on October 7th and last for three months, unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *10/07/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

20b1 - Financial Records

2. Requirements

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

Description of Violation

The home manages the finances for resident #1. However, the home did not provide a record of financial transactions with the resident.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

Request to be withdrawn: *The home is not the representative payee for resident #1 nor does it manage resident #1's funds. ("Financial management is defined in § 2600.4 as follows: (i) A personal care service provided whenever the administrator serves as representative payee or as a guardian or power of attorney assigned prior to December 21, 1988, for a resident, or when a resident requests and receives assistance in budgeting and spending of the personal needs allowance. (Note – § 2600.20(b)(7) prohibits the home from being power of attorney or guardian of a resident or a resident's estate.) (ii)* ***The term does not include solely storing funds in a safe place as a***

20b1 - Financial Records (continued)

convenience for a resident.").

Resident #1 asked the facility to store allowance funds for [redacted] convenience and spends [redacted] funds as [redacted] sees fit. That transaction is recorded and a ledger is and always has been available for review. Resident #1 has now requested that the home apply for a representative payee appointment after she met with the state inspectors. The inspectors never asked to see the record of these transactions during the inspection or exit review.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please develop a plan of correction for this violation.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

The home has a record of resident 1's transactions in a binder just to make sure they were keeping track however the facility did not believe it was "managing" that resident's funds. The home has been in contact with state inspectors and subsequent to that conversation the home will enter all resident's funds transaction regardless of their rep payee status or the resident's capacity/desire to handle their funds into the new financial management system in the TabulaPro software. The administrator and the facility's consultant will reconcile the existing binder to the online TABULA PRO financial system over the next two weeks. The consultant and administrator will then perform weekly checks on the system for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

20b8 - Quarterly Account

3. Requirements

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

Description of Violation

Resident #2 has not received a quarterly account of financial transactions since 3/31/2024. The home's quarterly financial summary had no entry for the second quarter of the year.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

Request to be withdrawn*: A quarterly statement was recorded and was available during the inspection. The facility has gone through great pains to create a digital financial recording system. Resident #2 was one of the first residents to be fully integrated into the system and offered a copy of the available statement. Unlike the compliance regulation for financial transactions, the quarterly statement regulation does not require the resident's signature ("(20b8 2600.20(b)(8) - The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis. Discussion: A model (not mandatory) quarterly financial summary is available on the Department's website. Accounts and documentation of the transmittal of the accounts to both the resident and designated person are required to be maintained in accordance with § 2600.253(a). This information may be managed electronically, provided that the electronic system is capable of producing a resident-specific report for the purposes of complying with § 2600.20(b)(9)").*
In addition, the inspectors viewed the report for this resident and stated that there was no issue with this quarterly

20b8 - Quarterly Account (continued)

report during the exit review.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please develop a plan of correction for this violation.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

The quarterly statement was available however resident 2 refuses to sign most financial transactions. This has been noted in the resident's RASP. Going forward, the home will continue to offer the resident these documents however when resident refuses to sign, administrator will write "refuse to sign" and have a staff person "witness" the transaction. The administrator and consultant will check quarterly for compliance.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

65f - Training Topics

4. 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 person A did not receive training in meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, or in care for residents with mental illness or an intellectual disability, during training year 2023.

Direct care staff person B did not receive training in care for residents with mental illness or an intellectual disability during training year 2023.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

Staff person A did in fact receive training in meeting the needs of the residents during the 2023 training year. Staff person B also received the necessary training in 2023. The interm administrator will download all training certificates for 2023 and 2024 and place them in a file. These training certificates will be reviewed by the administrator and consultant beginning 10/1/24. Annual staff training plan will be created and reviewed by the administrator and consultant 12/2/24.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Update: *10/01/2024*

Please indicate the immediate action that was taken to correct the violation. How did the home identify that

65f - Training Topics (continued)

both staff persons completed the required training topics?

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

The online file where staff training certificates are kept was immediately opened and the certificates where available. Going forward, access to the online folder has been verified and granted to the administrator, building supervisor and consultant. The online folder and binder will be reconciled over the next two weeks. The consultant and administrator have created a new annual staff training plan together that accurately reflects ALL staff training needs. This plan will be followed, and the status checked monthly.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

65g - Annual Training Content

5. 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:

Description of Violation

Staff person B did not receive training in fire safety from a fire safety expert during training year 2023.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

Fire safety training was completed on August 9th, 2024. Starting 12/1/24 the home's consultant and administrator will review the latest training requirements on an annual basis to ensure that the home remains in compliance.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please indicate the immediate action that was taken to correct the violation. How did the home identify that the staff person completed the required training topic?

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

Staff person's fire safety training for 2023 was found to be unacceptable to the inspectors because it was an online fire safety course with fire safety testing that followed in order to receive the certificate. This inspection was conducted in August 2024 therefore the facility was unable to rectify this for Calander year 2023. The facility however immediately brought in an in person fire safety expert on August 9th to train all staff properly and in compliance. The administrator and consultant will monitor training status and requirements monthly.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.
ADD FIRE SAFETY EXPERT ON AUG 9TH

85a - Sanitary Conditions

6. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 8/7/2024 at 9:02 am, there were red stains, resembling blood or gravy, dotting the wall and ceiling along the first-floor stairwell. At 9:07 am, there were bloodlike stains on the floor of room B-9. At 9:17 am, similar stains were on the ceiling at the top of the stairs, in front of the medication area, between two storage closets. At 12:43 pm, there were live flies and dead bugs in the downstairs kitchen.

On 8/8/24 at 10:38 am, the floor of room C-8 was sticky with a clear, shiny substance. In room C-13 at 10:41 am, there was a large, white bucket containing a resident's urine next to the closet. At 3:23 pm, a locked closet in room C-13 was opened, revealing an odor of urine, scattered mouse droppings, a yellow washcloth, and various smoking paraphernalia.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

Starting 9/10/24 the home's staff supervisor will be directed to walk the building once a day during their shift specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed. The acting administrator and staff supervisor will be training the rest of the maintenance staff and direct care staff on appropriate cleaning practices to maintain safe and compliant conditions. This training will take place on or before 10/1/24.
In addition, the facility has contacted a commercial cleaning service for quarterly deep cleaning beginning 10/1/24.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

85b - Infestation

7. Requirements

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

Description of Violation

On 8/7/2024 at 9:13 am, there was a bedbug on the bedroom floor in room B-14. There was another bedbug on the floor in B-10, and the sheets on the bed were stained with the remains of bedbugs. At 12:35 pm and other times, there were flies in several hallways and a swarm of gnats in a corner. At 12:43 pm, there were live flies and dead bugs in the downstairs kitchen.

On 8/8/24 at 10:52am, there were about two dozen dead wasps trapped in a ceiling light fixture in the C hallway.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

The home currently has a contract with [redacted] Pest Control to treat the building once a month. The home has reached out to increase the areas of the facility that are treated to prevent any infestations from occurring.
In addition, the facility has contacted a commercial cleaning service for quarterly deep cleaning beginning 10/1/24.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Update: *10/01/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

85b - Infestation (continued)

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

In addition to the steps outlined in the original POC answer, the administrator will perform a weekly pest control walk through the entirety of the building to ensure compliance.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

85e - Trash Outside Home

8. Requirements

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

Description of Violation

On 08/7/2024 at 1:08 pm, there was a black trash bag lying under a fire escape. At 1:10 pm, there were twenty or more cigarette butts under a tree between the main residence and the detached office area.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

Starting 9/10/24 the home's staff supervisor will be directed to walk the building once a day during their shift specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed. The acting administrator and staff supervisor will be training the rest of the maintenance staff and direct care staff on appropriate cleaning practices to maintain safe and compliant conditions. This training will take place on or before 10/1/24. In addition, the facility has contacted a commercial cleaning service for quarterly deep cleaning beginning 10/1/24.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

86b - Bathroom

9. 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

On 8/8/2024 at 10:47 am, the powder room in the C hall did not have a window and the ventilation fan did not work.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

The home has scheduled to have the ventilation fan repaired on 9/13/24. Starting 9/10/24 the home's staff supervisor will be directed to walk the building twice a day during their shift specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed. The acting administrator and staff supervisor will be training the rest of the maintenance staff and direct care staff on appropriate cleaning practices to maintain safe and compliant

86b - Bathroom (continued)

conditions. This training will take place on or before 10/1/24. In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/9/24.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

88a - Surfaces

10. 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 8/8/2024, wallpaper was peeling from multiple walls on the third floor and the wall on the second floor "main room." There was swelling from water damage on the wall along the staircase. At 10:55 am, when an emergency door on the third floor was opened, a dusty debris fell from the ceiling.

On 8/7 and 8/8/24, the edge of the tile step inside the home's front door has a crack of roughly eighteen inches in length. The tile has worn away at the edge, presenting a jagged slope which creates a tripping hazard for those entering and exiting the vestibule.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

The edge of the tile step inside of the home's front door was immediately repaired on 8/9/24.
The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary. In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/12/24.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

95 - Furniture and Equipment

11. Requirements

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

Description of Violation

On 8/8/2024 at 12:35 pm, the railing outside the elevator was broken and covered in duct tape. Several of the buttons in the elevator were confusingly marked and didn't light up when pushed. In room C-17 at 10:32 am, the dresser was broken with handles missing and drawers falling out.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary. In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/9/24. Railing repair will be completed by 9/19/24. In addition, Otis

95 - Furniture and Equipment (continued)

elevator has been contacted to do maintenance on or before 9/24/24.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

96a - First Aid Kit

12. 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.

Description of Violation

The home's first aid kit is mounted on the wall of the nursing station and not portable as required.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

***Request to be withdrawn**: the regulation cited doesn't specifically say that the home's first aid kit needs to be portable. The regulation states that "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". The home has all of the required items that can easily be transported throughout the building as necessary.*

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please develop a plan of correction for this violation.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

The home has ordered a portable first aid kit to comply with the state's compliance discussion. The kit will be audited weekly by the health and welfare check to maintain compliance.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

101j1 - Mattress Fire Retardant

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 8/8/2024 at 10:32 am, the mattress on the left side of room C-17 was sinking, lacking a sturdy foundation.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

The home has replaced the mattress on the left side of room C-17. The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary. In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/9/24.

101j1 - Mattress Fire Retardant *(continued)*

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

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

Description of Violation

On 8/8/2024 at 10:32 am, the bed on the right side of room C-17 had dirty sheets with holes in them. There was a black debris on the pillow and bed.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

New linen has been ordered and will be installed by 9/27/24. Also, the sheets referenced in room C-17 were immediately replaced with clean linen on 8/8/24. The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024* [redacted]

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

101j4 - Bedroom Storage Area

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

On 8/8/2024, resident # [redacted] did not have access to a closet in room C-13. The closet was locked, and the resident did not have the key.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

The closet was unlocked on the same day during the inspection for resident access. A new lock will be installed by a newly hired additional part time maintenance person by 9/13/24. A spare key will kept in the administrators office. In addition, the facility has hired an additional part time maintenance person to perform preventative maintenance checks and repairs starting 9/9/24.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Update: *10/01/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

101j4 - Bedroom Storage Area *(continued)*

Plan of Correction ***Accept (- 10/07/2024)***

In addition to the steps outlined in the original POC answer, the daily health and welfare check will include resident's closets and storage. The administrator and consultant will monitor checks on a weekly basis.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

101j6 - Mirror

16. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

On 8/8/2024 at 10:41 am, there was no mirror in room C-13 for resident #

Plan of Correction ***Do Not Accept (- 10/01/2024)***

Resident # has requested that no mirror be inside room. As per request, RASP has been updated to reflect wishes. Beginning on 9/10/24 the home's administrator and consultant will conduct monthly audits of resident files. The administrator and consultant will conduct monthly reviews of all resident files to ensure that they are current and reflect any significant changes in resident behavior or condition. This includes immediate updates as needed and will take place for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (- 10/07/2024)***

In addition to auditing resident files for accuracy and reconciliation with their needs as stated in original POC, the administrator's weekly audit will include monitoring the rooms for compliance with physical site needs.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

101j7 - Lighting/Operable Lamp

17. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

On 8/7/2024 at 9:07am, resident # did not have access to a source of light that could be turned on/off at bedside in room B-9. At 9:10 am, the resident who sleeps on the right side of room B-10 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction ***Accept (- 10/01/2024)***

A lamp has been placed in the room for resident access. In addition, the home purchased wall mounted sconces to be installed in resident rooms as needed by our newly hired additional part time maintenance staff person on or before 9/20/24.The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary. Also, the facility has hired an additional part time maintenance person to perform preventative maintenance checks and repairs starting 9/9/24.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

101o - Walls, Floors, Ceilings

18. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 8/7/2024 at 9:07 am, the wallpaper on the right side of room B-9 was torn. On 8/8/24 at 10:32 am, the walls in room C-17 were spotted with dirt. At 10:41 am, the floor in room C-13 was sinking and wet.

Plan of Correction ***Accept (- 10/01/2024)***

The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary. The home has also contacted an outside maintenance company to guarantee quality assurance within the facility. In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/9/24. All repairs will be completed by 9/20/24.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

101r - Bedroom - shades/drapes/window covering

19. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 8/7/2024 at 9:10 am, the window in room B-10 was not covered. A drape partially covered the window but was falling off. On 8/8/24 at 10:41 am, the window in room C-13 was not covered.

Plan of Correction ***Accept (- 10/01/2024)***

The home has appointed a direct care staff member to do weekly walk throughs of the facility and report any

101r - Bedroom - shades/drapes/window covering (continued)

issues to the administrator. Walk throughs started 9/3/24 and will continue for three months unless an extension is found to be necessary.

In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/9/24. All repairs will be completed by 10/1/24.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

103f - Refrigerator/Freezer Temps

20. 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 8/7/2024 at 12:51 pm, the temperature in the freezer behind the kitchen was 19 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

As of 9/9/24, Atlantic Refrigeration has repaired the freezer in question. The home has added temperature logs to document the thermometer on the freezer behind the kitchen. Starting 9/10/24 the home appointed a staff supervisor who will be responsible for checking the temperature logs on a monthly basis. Reviews of the temperature logs will begin on 9/10/24 and will continue for 2 months unless an extension is found to be necessary. In addition, the staff supervisor's duties will include temperature logs, expiration dates, appropriate a/c and heating throughout the building, first aid supplies and reviewing staff training compliance with consultant and the administrator .

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

104b - Dishes/Glassware/Utensils

21. Requirements

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

Description of Violation

On 8/7/2024 at approximately 1:05 pm, residents in the basement dining room were eating off Styrofoam plates and drinking from Styrofoam cups. Some residents were using clear plastic cups.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

Request to be withdrawn*: Styrofoam plates and cups are not used on a regular basis at Vine Street Manor. The inspectors happened to come on a day where disposable dishes were being used, however that is not normally the case.*

Licensee's Proposed Overall Completion Date: *09/07/2024*

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

Update: *10/01/2024*

Please develop a plan of correction for this violation.

Why were disposable dishes being used on that day?

Plan of Correction ***Directed ([redacted] - 10/07/2024)***

In light of staffing challenges experienced on that day (the staff person who normally assists in the kitchen was monitoring their area during the state inspection) the team opted to utilize disposable paper plates and cups for the residents' lunch service. This decision was made to ensure that we could still provide a timely and efficient meal for the residents without compromising on quality or service.

Proposed Overall Completion Date: 10/06/2024

Directed POC:

Within 3 days of receipt of this plan of correction: *All staff persons involved in food preparation and serving shall be educated that plastic and paper plates, utensils and cups may not be used on a regular basis. Documentation of education shall be kept in accordance with 2600.65i.*

Within 5 days of receipt of this plan of correction: *The administrator shall monitor at least two different meal times per week for the next 4 weeks to ensure that plastic and paper plates, utensils and cups are not being used on a regular basis. Documentation of monitoring shall be kept for Department review.*

Directed Completion Date: *10/12/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

104c - Condiments

22. Requirements

2600.
104.c. Condiments shall be available at the dining table.

Description of Violation

At lunch time, on 8/7/2024 at approximately 1:05 pm, condiments were not available at the dining tables in the basement. Macaroni and beef was served at this meal.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

The home will purchase condiments and condiment holders and they will be put into use on or before 9/13/24. The home's staff supervisor will check in on a daily basis to ensure that the home remains in compliance. The home will create a log that will be utilized through the groupme app .

Licensee's Proposed Overall Completion Date: *09/07/2024*

104c - Condiments *(continued)*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

125b - Combustible Restrictions

23. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 8/7/2024 at 12:44pm, there were more than a dozen oxygen tanks left unlocked, unattended, and accessible to residents in a basement closet and in room 4 of the basement. On 8/8/24 at 10:45am, there were two more unsecured oxygen tanks in room C-11.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

All oxygen tanks have been moved to a secure location within the home behind a locked door. In addition, the facility has hired an outside maintenance service to perform preventative maintenance checks and repairs starting 9/9/24. All repairs will be completed by 9/20/24.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Update: *10/01/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

Following DHS's response, all of the empty oxygen tanks have been removed from the facility. Starting Monday Oct 7, administrator/health and welfare will perform daily checks of all storage to ensure they are either appropriately secure and/or devoid of combustible dangerous materials.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

141b1 - Annual Medical Evaluation

24. Requirements

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

Description of Violation

Resident #5's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

Beginning on 9/10/24 the home's administrator and consultant will conduct monthly audits of resident files. The administrator and consultant will conduct monthly reviews of all resident files to ensure that they are current and reflect any significant changes in resident behavior or condition. This includes immediate updates as needed and

141b1 - Annual Medical Evaluation (continued)

will take place for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

144c1 - Smoking Area Guidelines

25. Requirements

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

Description of Violation

On 8/7/2024, there were twenty or more cigarette butts under a tree between the main residence and the detached office space, outside of the designated smoking area.

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

The area in question has been cleaned. The home's administrator will walk the property twice per day to maintain compliance. In addition, the facility has hired an outside maintenance service to perform deep cleaning on a quarterly basis beginning 10/1/24. In addition, the home's landscaper has been instructed to provide additional cleaning in these outside areas.

Licensee's Proposed Overall Completion Date: *09/08/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

183b - Meds and Syringes Locked

26. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 8/7/2024 at approximately 9:38 am, there was a round white pill in the bottom of the storage section of a medication cart, lying loose among documents and residents' insurance cards.

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

The loose white pill was removed from the medication cart and discarded into the Drug Buster. All med techs were counseled on 8/8/2024 by the medication supervisor regarding all compliance requirements for medications. Starting 9/9/24 the home's administrator will be responsible to monitor all medication carts and train med techs if necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please indicate the frequency for the medication cart monitoring.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

In addition to the steps outlined in the original POC, the med cart will be monitored daily by the administrator/med supervisor.

Licensee's Proposed Overall Completion Date: *10/06/2024*

183b - Meds and Syringes Locked *(continued)*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

183d - Prescription Current

27. Requirements

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

Description of Violation

Resident #6 has been missing from the home since . On 8/7/2024 at about 9:38 am, the medicine cart still contained medications, including Symbicort, nicotine gum, Albuterol, Oxcarbazepine, and Risperidone.

Plan of Correction ***Do Not Accept (- 10/01/2024)***

Request to be withdrawn*: Resident #6 was not missing. The resident was in the hospital. All medications were current as of the time of hospitalization. No medications were missing or improperly stored. The home's E-MAR system properly reflected the resident's hospitalization status. To avoid future confusion for the the state inspectors, all medication for hospitalized residents will be removed from the general medication cart.*

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Resident #6 was not in the home.

Please develop a plan of correction for this violation.

Plan of Correction ***Accept (- 10/07/2024)***

Hospitalized resident's medication will be monitored to ensure they are appropriately removed, returned to the pharmacy or destroyed. The administrator and med supervisor will check daily for compliance.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

183e - Storing Medications

28. 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

On 8/7/2024 at approximately 9:40 am, there was an Incruse Ellipta inhaler for resident #7 which was marked as having been opened on 3/24/24. According to the manufacturer's instructions, the inhaler should be discarded six weeks after opening.

183e - Storing Medications *(continued)*

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

The inhaler in question was discarded immediately and the administrator called the pharmacy for a refill. In the future the med techs will put the expiration date on the box upon opening. Starting 10/1/24 the administrator will audit all resident inhalers on a monthly basis. This will continue for 1 month unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please include a step to educate staff.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

Med Supervisor will provide a memo and in person reminder October 7th.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Update: *10/07/2024*

Documentation of education shall be kept in accordance with 2600. 65i.

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

185a - Implement Storage Procedures

29. 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 one 250-MG Carisoprodol tablet twice daily. The home has two logs which provide contradicting information on when and how this medication was given. The home states that both logs are tracking doses dispensed from the same blister pack. According to sheet one of the home's narcotic logs, 30 tablets were received on 7/17/2024, but no doses were administered until 7/20/24. Sheet one shows directions as "take one tablet by mouth daily" and tracks the medication administered at 9 am from 7/20/2024 to 7/29/2024, with a pill count that numerically decreases in order daily from 29 to 20. Sheet one is signed off by the staff member that administered the medication and shows a range of handwriting. Sheet one shows that as of 7/29/24 at 9am The home had 20 pills left. Sheet 2 in the narcotics log does not show the date the medication was received, or how much of the medication was received. It states, "take 1 tablet by month twice daily". Sheet two tracks the medication being administered twice daily from 7/25/2024 at 5pm to 7/29/2024 at 8am with the pill count that numerically decreases in order daily from 24 to 17. Sheet two does not name the person who administered the medication on 7/25/24, 7/26/24, or 7/29/2024 and does not include the signature of the staff persons administering this medication from 7/25-7/29/2024. The handwriting on this sheet is consistent. On 7/29/24 at 8 am the home shows that 17 pills were remaining.
The blister pack itself has a hand written note "directions change twice daily" and has 17 pills remaining with pills slots 20-18 circled. There are no notes about why these slots were circled on the blister pack.

Resident #9 has a prescription for 1-MG tablet of lorazepam. This medication was received by the home on 8/1/2024, but the home did not keep a narcotics log to ensure a correct pill count.

185a - Implement Storage Procedures (continued)

Plan of Correction ***Do Not Accept (- 10/01/2024)***

The home's narcotics log was confusing to the inspectors however, all necessary action was taken to ensure that no narcotics were missing and all 5 rights were followed. All med techs were verbally trained on August 9th, 2024 to make sure that this confusing situation does not happen again and that documentation continues to occur properly. Most importantly, all residents got their medications as prescribed. Starting 10/1/24 the home's administrator will check the narcotics log on a weekly basis and will audit the log on a monthly basis. This will continue for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please indicate the immediate action that was taken to correct the violation.

What steps were taken to determine all narcotics were accounted for?

Plan of Correction ***Accept (- 10/07/2024)***

In addition to the steps outlined in the original POC answer, the med supervisor immediately performed a narcotics count and verified the appropriate log.

Licensee's Proposed Overall Completion Date: *10/07/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

191 - Resident Right to Refuse

30. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #5, admitted 5/27/2021, did not give a signature on the residency contract indicating they were educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 10/01/2024)***

Beginning on 9/10/24 the home's administrator and consultant will conduct monthly audits of all resident files. The administrator and consultant will conduct monthly reviews of all resident files and assessments to ensure that they are current and reflect any significant changes in resident behavior or condition. This includes immediate updates as needed and will take place for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented (- 03/03/2025)***

See attached.

226a - Mobility Assessment

31. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #2's assessment, dated [redacted], said that the resident needed no assistance with ambulation. In fact, the resident has a prosthetic leg that the resident was not wearing on 8/7/2024

Plan of Correction ***Do Not Accept ([redacted] - 10/01/2024)***

Resident #2's RASP was updated on 9/6/24. Resident #2 does not wear [redacted] prosthetic leg because [redacted] says it is uncomfortable. However, beginning on 10//24 the home's administrator and consultant will conduct monthly audits of resident assessments and conditions. The administrator and consultant will conduct monthly reviews of all resident assessments to ensure that they are current and reflect any significant changes in resident behavior or condition. This includes immediate updates as needed and will take place for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *09/07/2024*

Update: *10/01/2024*

Please include the begin date for monthly audits.

Plan of Correction ***Accept ([redacted] - 10/07/2024)***

In addition to the steps outlined in the original POC answer, monthly audits will begin 10/15/24.

Licensee's Proposed Overall Completion Date: *10/06/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

252 - Record Content

32. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #5's record does not include a photo of the resident taken in the last two years. The photo of resident #5 was taken on [redacted]

Plan of Correction ***Accept ([redacted] - 10/01/2024)***

Resident #5's photo was updated on 9/6/24. Beginning on 10/1/24 the home's administrator and consultant will conduct monthly audits of resident files. The administrator and consultant will conduct monthly reviews of all resident files to ensure that they are current and reflect any significant changes in resident behavior or condition. This will take place for three months unless an extension is found to be necessary.
ADD

Licensee's Proposed Overall Completion Date: *09/07/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

Facility Information

Name: *VINE STREET MANOR* **License #**: *14234* **License Expiration**: *11/14/2024*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

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

Administrator

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

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *09/07/2018* **Issued By**: *Phila. L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *63* **Waking Staff**: *47*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *11/07/2024*

Inspection Dates and Department Representative

11/06/2024 - On-Site: [redacted]

11/07/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *59*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *41* **Are 60 Years of Age or Older**: *38*

Diagnosed with Mental Illness: *59* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

11/06/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/30/2024*

12/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/09/2024*

Inspections / Reviews *(continued)*

12/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/29/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/29/2025*

03/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/29/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.

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

Description of Violation

On 8/28/2024, resident 1 called resident 2 "pregnant" and grabbed resident 2's walker resulting in a pain in resident 2's hand. Resident 2's called the police and filed a report. A copy of this report was given to staff person A on an unknown date. However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

All staff members have been reminded about the necessity to report all incidents. Staff training on Older Adult Protective Services has been scheduled for December 13, 2024. In addition, the facility has implemented one on one, hourly monitoring of resident #1 for the next two months to promote improved behavior and interactions. The one on one monitoring began on 11/30/24 and will be done by direct care staff members.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please indicate what is being done to avoid another incident in the future.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

This regulation is important because timely reporting of incidents is essential for the safety and protection of all residents. The regulation was violated when the incident involving resident 1 and resident 2, which occurred on August 28, 2024, was not reported to the local area agency on aging as required.
Immediate action taken to address this violation included reminding all staff members of the critical importance of reporting all incidents without delay. To further reinforce this protocol, staff training on Older Adult Protective Services has been scheduled for December 13, 2024. This training aims to ensure that all staff members are well-informed about their responsibilities regarding incident reporting.
To prevent future incidents, the facility has implemented one-on-one, hourly monitoring of resident 1 for the next two months, starting on November 30, 2024. This monitoring will be conducted by direct care staff members to promote improved behavior and positive

15a - Resident Abuse Report (continued)

interactions. On December 7th, 2024, all staff members received a memo regarding the requirements for reporting incidents.
Additionally, a monthly audit of incident reports will be conducted beginning in December 2024. This audit will be the responsibility of the Administrator, who will review all reported incidents to ensure compliance with reporting protocols and to identify any areas in need of improvement. All staff members will be held accountable for following these protocols to ensure the safety and well-being of all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

16c - Written Incident Report

2. Requirements

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

Description of Violation

On 8/28/2024, resident 1 called resident 2 "pregnant" and grabbed resident 2's walker resulting in a pain in resident 2's hand. Resident 2's called the police and filed a report. A copy of the police report was given to staff person A on an unknown date. The home did not report this incident to the department.

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

The incident was reported the day of the inspection, 11/7/24. All staff members have been reminded about the necessity to report all incidents. Staff training on Older Adult Protective Services has been scheduled for December 13, 2024. In addition, the facility has implemented one on one, hourly monitoring of resident #1 for the next two months to promote improved behavior and interactions. The one on one monitoring began on 11/30/24 and will be done by direct care staff members.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the steps that will be taken to address the specific violation related incident reporting.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

This regulation is important because timely reporting of incidents is essential for the safety and well-being of all residents. The regulation was violated by failing to report the incident involving resident 1 and resident 2 to the department. To address this violation, the following steps will be implemented:
All staff members have been reminded of the critical importance of reporting all incidents immediately. On

16c - Written Incident Report (continued)

December 7th, 2024, all staff members received a memo regarding the requirements for reporting incidents. A retraining session focused on incident reporting protocols will be conducted on December 13, 2024. This training will emphasize the procedures for documenting and reporting incidents to ensure compliance with regulatory requirements.

In addition to the retraining, the facility will implement a system of regular audits to monitor compliance with incident reporting. Starting on December 1, 2024, a designated staff member will conduct weekly reviews of incident reports to ensure all incidents are documented and reported appropriately. This review will continue for a period of three months.

To further promote improved behavior and interactions by Resident 1, the facility has initiated one-on-one, hourly monitoring of resident 1. This monitoring began on November 30, 2024, and will be conducted by direct care staff members for a duration of two months. The staff will document their observations and any incidents that occur during these sessions on the GroupMe company form.

Additionally, a monthly compliance audit will be conducted starting on January 15, 2025, to review incident reporting practices. This audit will include a review of all incident reports, documentation accuracy, and adherence to reporting timelines. The facility consultant will be responsible for overseeing this audit process and ensuring that any identified issues are addressed promptly.

By implementing these steps, the facility aims to ensure ongoing compliance with incident reporting regulations and enhance the safety and well-being of all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

CARE FACILITY CARBON MONOXIDE ALARMS STANDARDS ACT - ENACTMENT Act of Jun. 23, 2016 Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On 11/6/2024 at 11:31 AM The Carbon Monoxide detector installed in the basement near the boiler room was not functioning.

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

The detector in the boiler is non-operational, however to remain in compliance and provide the safest environment possible, the facility has replaced the batteries and instituted monthly safety checks by a maintenance person to maintain safety. In addition the facility has reached out to emergency response to install hard wired carbon monoxide detectors to prevent this from occurring again. We have confirmed the detectors in the kitchen and basement on each floor are operational.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate dates for each step.

18 - Compliance With Laws *(continued)*

Plan of Correction ***Accept (- 12/11/2024)***

This regulation is important because carbon monoxide alarms are essential for ensuring the safety of residents by detecting harmful gas emissions from fossil-fuel burning devices. The regulation was violated due to the non-functioning carbon monoxide detector located in the basement near the boiler room. The boilers have been shut for years and therefore there are no fossil fuels. However, to address this violation, the following steps will be implemented:

1. The batteries in the non-operational carbon monoxide detector were replaced on November 7, 2024, to restore its functionality.

2. To maintain ongoing safety, the facility has instituted monthly safety checks including the checking of all carbon monoxide detectors by a maintenance person. The first of these monthly checks will (took) take place on December 1, 2024, and will continue on the first of each month thereafter.

3. The facility has also reached out to emergency response services to arrange for the installation of hard-wired carbon monoxide detectors throughout the facility. This installation is scheduled to be completed by January 15, 2025.

4. A thorough inspection was conducted on November 7, 2024, to confirm that the carbon monoxide detectors in the kitchen and basement on each floor are operational.

By implementing these steps, the facility aims to ensure compliance with the Carbon Monoxide Alarms Standards Act and provide a safe environment for all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented (- 02/03/2025)***

See attached.

25b - Contract Signatures

4. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated for resident 2 was not signed by the administrator.

Plan of Correction ***Accept (- 12/04/2024)***

The administrator corrected the violation on site. The administrator reviewed all files for compliance on 11/29/2024. Starting November 29th, 2024, the administrator backed up by our consultant will be responsible for reviewing all files on a monthly basis to ensure compliance. This process will continue for 2 months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented (- 02/03/2025)***

See attached.

42b - Abuse

5. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse *(continued)*

Description of Violation

On 8/28/2024, resident 1 called resident 2 "pregnant" and grabbed resident 2's walker resulting in pain in resident 2's hand. Resident 2 called the police and filed a report. A copy of this report was given to staff person A on an unknown date. Resident 2 was never assessed for injuries.

Resident 2 stated that resident 1 calls resident 2 "The-b-word and other nasty names they do not say". On an unknown date, resident 1 threatened to punch resident 2 in the eye after an eye surgery and said "I hope you go blind and your service dog bites you". Resident 2 stated Resident 1 pounds on their bedroom door every morning, which was wearing resident 2 down emotionally.

On 10/3/24, Staff person B made a note in resident 2's record that read resident 1 was "calling [resident 2] names" and resident 2 is "tired of it". The home has not taken any action to address the behavior of resident 1. Resident 2, and resident 2's designated person were told by the home that nothing can be done unless resident 1 physically harms resident 2.

Repeat violation: 11/02/2023

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

Resident #2 was assessed for injuries and required no assistance. Resident #1's RASP has been updated to reflect the need for additional supervision by staff for behavioral problems. All Staff will be trained on December 13th on abuse reporting
policies. The facility has implemented direct one on one supervision on an hourly basis by staff for the next two months to encourage positive behavior. In addition, the facility has alerted the primary care physician to refer resident #1 for additional behavioral services and evaluation.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the steps that will be taken to address the specific violation related to resident rights.

Has resident 1 had a psych evaluation? Why are hourly checks happening instead of 24-hour 1 to 1 supervision?

Please indicate all steps that will be taken to ensure the safety of all residents.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

42b - Abuse *(continued)*

Plan of Correction ***Accept (- 12/11/2024)***

This regulation is important because it ensures the safety and well-being of all residents by protecting their rights and addressing any behavioral issues that may arise. The regulation was violated by failing to adequately address the concerning behavior of resident 1 towards resident 2, which has resulted in emotional distress and potential harm. To address this violation, the following steps will be implemented:
1. Resident 2 was assessed for injuries on November 7, 2024, and it was determined that no assistance was required.
2. Resident 1's Resident Assessment and Support Plan (RASP) has been updated to reflect the need for additional supervision by staff due to behavioral problems.
3. All staff members will receive training on abuse reporting policies on December 13, 2024, to ensure they are equipped to handle similar situations in the future.
4. The facility has implemented direct one-on-one supervision of resident 1 on an hourly basis for the next two months. This decision was made due to the facility's financial constraints, which prevent the allocation of a dedicated staff member for 24-hour supervision. Additionally, resident 1's insurance has denied coverage for bringing in outside staff for continuous monitoring.
5. The primary care physician for resident 1 is scheduled to evaluate resident 1 for a referral to psychiatric treatment on [redacted]. This evaluation is crucial for determining the appropriate behavioral interventions needed for resident 1.
6. To ensure the safety of all residents, the facility will conduct weekly reviews of the supervision logs and incident reports related to resident 1's behavior. These reviews will begin on December 1, 2024, and will be overseen by the Administrator to ensure compliance and address any emerging issues promptly.
7. A follow-up assessment of resident 1's behavior and the effectiveness of the implemented measures will be conducted on January 15, 2025, to determine if further actions are necessary.
By taking these steps, the facility aims to ensure the safety and rights of all residents while addressing the specific behavioral concerns related to resident 1.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented (- 02/03/2025)***

A follow-up assessment of resident 1's behavior has been pushed back due to the fact that resident #1 is in the hospital. Further actions will be conducted once resident #1 returns to Vine Street Manor.

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 11/6/2024 at 11:22 AM, there was food stuck to the wall behind the trash can in the downstairs dining room.

On 11/6/2024 at approximately 11:31 AM there were dead insects in the light fixture by the boiler room.

Plan of Correction ***Do Not Accept (- 12/04/2024)***

The housekeeping staff has addressed the unsanitary areas. The administrator has provided direct training to the

85a - Sanitary Conditions (continued)

housekeeping staff regarding their duties that were not necessarily in their job description. The administrator will monitor housekeeping's progress and compliance on a daily basis starting December 3rd, 2024. This process will last one month unless an extension is found to be needed.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

This regulation is important because maintaining a clean and sanitary environment is essential for the health and safety of all residents. The regulation was violated due to the presence of food stuck to the wall behind the trash can and dead insects in the light fixture by the boiler room.
To address this violation, the following steps will be implemented:
1. The housekeeping staff has thoroughly cleaned the unsanitary areas identified in the violation report as of November 7, 2024.
2. The administrator provided direct training to the housekeeping staff on November 8, 2024, regarding their duties, including tasks that may not have been explicitly outlined in their job descriptions. This training emphasized the importance of maintaining cleanliness and sanitation throughout the facility.
3. The administrator will monitor the progress and compliance of the housekeeping staff on a daily basis, starting December 3, 2024. This monitoring will include inspections of common areas, dining rooms, and other high-traffic locations to ensure cleanliness standards are met.
4. This monitoring process will last for one month, concluding on January 3, 2025, unless an extension is deemed necessary based on the observed performance of the housekeeping staff.
By implementing these steps, the facility aims to ensure ongoing compliance with sanitation regulations and provide a safe and clean environment for all residents.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

85b - Infestation

7. Requirements

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

Description of Violation

On 11/6/2024 at 10:41 AM there was a large number of gnats flying around room C3.

At 11:22 AM there were multiple dead bugs in the picture frame on the left side of the downstairs dining room. There were also gnats flying around the sink of the downstairs kitchen.

Repeat violation: 8/7/2024 et al

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

The kitchen staff has been instructed to clean the kitchen thoroughly using bleach where appropriate on a daily basis. The housekeeping staff has been instructed to thoroughly clean the dining room multiple times per day. The administrator will monitor these areas on a daily basis for one month to ensure compliance and ongoing habit

85b - Infestation (continued)

building. The administrator has been authorized to hire additional housekeeping staff. The home's consultant will provide housekeeping training on December 9th, 2024.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate who will be training staff on how to properly use bleach in the kitchen.

Does the trainer have Servesafe certification?

Please indicate the dates for each step.

Plan of Correction ***Accept (- 12/11/2024)***

This regulation is important because maintaining a clean and pest-free environment is essential for the health and safety of all residents. The regulation was violated due to the presence of gnats and dead bugs in the facility.
To address this issue, the kitchen staff was immediately instructed to clean the kitchen thoroughly and then continue to do so on a daily basis using standard sanitary products. The downstairs kitchen will be sealed off from usage, as it has led to neglected duties and is not necessary for our operations.
The housekeeping staff has been directed to clean the dining room multiple times each day to ensure a pest-free environment. The administrator will monitor these areas daily for one month to ensure compliance and foster the development of consistent cleaning habits among the staff.
The administrator is interviewing additional housekeeping staff to support these efforts. Furthermore, a training session for the housekeeping staff will be conducted by the home's administrator on December 9, 2024, focusing on effective cleaning practices and pest prevention. The home's administrator has Servesafe certification. All housekeeping staff will be responsible for adhering to these cleaning protocols to maintain a clean and safe environment. Regular assessments will ensure that cleanliness standards are consistently met.

Licensee's Proposed Overall Completion Date: *12/10/2024*

Evidence of Completion ***Implemented (- 02/03/2025)***

See attached.

95 - Furniture and Equipment

8. Requirements

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

Description of Violation

On 11/6/2024:
- The bed side tables in rooms B10, B20, B21, and C1 were missing a knob on the front drawer.
- The dressers in rooms C6 and C-15 were missing handles.

Plan of Correction ***Do Not Accept (- 12/04/2024)***

The knobs and handles will be installed on all of the furniture by Dec 9th, 2024. A list of necessary items has been posted on the interior of every bedroom door to assist and remind staff of compliance needs. The administrator and consultant will monitor compliance on a daily basis for one month. The administrator has also been authorized to hire additional housekeeping/maintenance staff.

95 - Furniture and Equipment *(continued)*

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

This regulation is important because all furniture must be in good repair to ensure the safety and comfort of residents. The regulation was violated due to missing knobs on the bedside tables in rooms B10, B20, B21, and C1, as well as missing handles on the dressers in rooms C6 and C-15.
Immediate action was taken to address the violation by switching out the non-compliant furniture with compliant furniture from storage on November 7, 2024. All missing knobs and handles will be installed on the remaining furniture by December 10, 2024.
To assist and remind staff of compliance needs, a list of necessary items was posted on the interior of every bedroom door on November 8, 2024. Starting November 9th, 2024 the administrator and the consultant will monitor compliance on a daily basis for one month to ensure that all furniture is in good repair. The administrator is interviewing additional housekeeping and maintenance staff to support ongoing compliance efforts.

Licensee's Proposed Overall Completion Date: *12/10/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

101j3 - Bed/Linens/Pillows/Blankets

9. Requirements

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

Description of Violation

On 11/6/2024 the following was observed:

At 10:41 AM in room C3 on the left bed there was a large wet mark that was slightly pink on a pillowcase, the bed's sheets had large holes and were stained with black residue. The right bed had a pillowcase that was full of holes and was stained.

At 10:44 AM in room C11 pillowcases on all beds were stained with black marks.

At 10:49 AM in room C6 the pillowcase on the right bed had holes in it.

At 10:58 AM in room B21, which had just been cleaned by staff person C, the pillowcase on the left side was stained with blood and black debris. Pillowcase on the right bed was covered in cigarette burns.

Repeat violation: 8/7/2024 et al

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

New pillowcases, sheets and quilts have been ordered by the facility. Housekeeping staff has been reminded of their duty to provide a safe, clean living space for the clients. The administrator has been authorized to hire additional housekeeping/maintenance staff. In addition, the administrator will monitor progress on a daily basis for one month to maintain compliance and encourage better housekeeping practices.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding maintaining a safe and clean living environment for clients is crucial for their health and well-being. The violation occurred due to inadequate housekeeping practices observed on 11/6/2024. In response to this violation, the facility has taken the following corrective actions:
On 11/7/2024, new pillowcases, sheets, and quilts were ordered to ensure that clients have access to clean bedding. Additionally, on the same day, housekeeping staff and direct care staff members were reminded of their responsibilities to provide a safe and clean living space for all clients.
To further address the issue, the administrator is interviewing additional housekeeping and maintenance staff, with the hiring process expected to begin by 1/15/2025.
The administrator will also monitor the progress of housekeeping practices on a daily basis for one month, starting from 11/8/2024, to ensure compliance and to encourage improved housekeeping standards.
These steps are being implemented to rectify the violation and to uphold the facility's commitment to providing a safe and clean environment for all clients.

Licensee's Proposed Overall Completion Date: *12/06/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

101j4 - Bedroom Storage Area

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

Resident 3 does not have access to the closet space in the bedroom because resident 4 has a padlock on the door of their shared closet, and only resident 4 has access to the key.

Repeat violation: 8/7/2024 et al

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

A wardrobe space has been added to accommodate the other resident in the bedroom. A list of necessary items and compliance issues has been placed on the inside each bedroom door to assist and promote staff knowledge of compliance for bedrooms.

101j4 - Bedroom Storage Area *(continued)*

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding residents' access to their personal belongings is essential for their comfort and autonomy. The violation occurred because Resident 3 did not have access to the closet space in the bedroom due to Resident 4 padlocking the shared closet, restricting access to only Resident 4.
In response to this violation, a wardrobe space has been added to the bedroom to ensure that Resident 3 has adequate storage for their personal items. This action was completed on 11/7/2024.
To further promote compliance and staff awareness regarding residents' rights and access to their belongings, a list of necessary items and compliance issues has been placed on the inside of each bedroom door. This list will serve as a reference for staff to ensure that all residents have appropriate access to their personal items.
To monitor ongoing compliance, the following steps will be implemented:
1. Weekly spot checks will be conducted by the administrator starting on 11/10/2024 to ensure that all residents have access to their personal belongings and that no padlocks are restricting access to shared spaces.
2. A monthly review of resident access issues will be documented by the staff supervisor and reported to the administrator, beginning on 12/13/2024.
3. Staff training sessions will be held quarterly to reinforce the importance of residents' rights to access their belongings, with the first session scheduled for 12/13/2024.
The staff supervisor will be responsible for conducting the spot checks, while the administrator will oversee the monthly reviews and staff training sessions. These measures are designed to ensure ongoing compliance and to uphold the residents' rights to access their personal items.

Licensee's Proposed Overall Completion Date: *12/13/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

101j7 - Lighting/Operable Lamp

11. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The resident in room C1 with the bed closest to the door does not have access to a source of light that can be turned on/off at bedside.

The resident in room B3 does not have access to a source of light that can be turned on/off at bedside because the light was not operable.

The residents in room B21 do not have access to a source of light that can be turned on/off at their bedsides because

101j7 - Lighting/Operable Lamp (continued)

the shared light was at least 3 feet from either bed.

The residents in room B20 do not have access to a source of light that can be turned on/off at their bedside because neither bed side lamp in the room was operable.

Repeat violation: 8/7/2024 et al

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

Lighting has been returned to the original position for compliance and extra lamps and nightstands have been ordered. All work will be completed by December 9th, 2024. A list of necessary items has been placed on the interior of the bedroom doors to assist staff in maintaining compliance. The administrator will monitor on a daily basis for one month to promote compliance and better maintenance practices. The administrator has also been authorized to hire additional housekeeping/maintenance staff.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding adequate lighting in resident bedrooms is essential for ensuring safety and comfort. The violation occurred because the lighting was not positioned correctly, impacting the residents' ability to see and navigate their space effectively.
In response to this violation, the lighting has been returned to its original position for compliance as of November 7, 2024. Additionally, extra lamps and nightstands have been ordered to enhance the living conditions for residents, with all work expected to be completed by December 9, 2024.
To assist staff in maintaining compliance, a list of necessary items has been placed on the interior of each bedroom door as of November 8, 2024. This list will serve as a guide for staff to ensure that all necessary items are available and properly maintained.
The administrator will monitor compliance on a daily basis for one month, starting from November 9, 2024, to promote better maintenance practices and ensure that all lighting and furnishings meet the required standards. Furthermore, the administrator is interviewing additional housekeeping and maintenance staff, with the hiring process expected to be completed by January 15th, 2025.
These actions are being implemented to rectify the violation and to ensure a safe and comfortable living environment for all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

101o - Walls, Floors, Ceilings

12. Requirements

101o - Walls, Floors, Ceilings *(continued)*

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The walls on both sides of the room in bedroom C6 had small splatters of blood or food on them.

The wall in bedroom B20 had a large hole behind the door.

Repeat violation: 8/7/2024 et al, 7/18/2024

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

All splatters were cleaned and housekeeping staff has been advised of their duty to provide safe, clean living spaces for our clients. Repair has been scheduled for December 9th, 2024. The administrator and consultant have been authorized to hire additional housekeeping/maintenance staff that can handle small repairs and advise administration of any larger repairs needed. The administrator will monitor daily for one month to maintain compliance and promote better housekeeping and maintenance practices.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding maintaining clean and safe living environments is critical for the health and well-being of our residents. The violation occurred due to the presence of small splatters of blood or food on the walls in bedroom C6 and a large hole behind the door in bedroom B20.In response to this violation, all splatters were cleaned immediately on November 7, 2024. Housekeeping staff have been reminded of their responsibility to provide safe and clean living spaces for our clients.
Repairs for the hole in bedroom B20 have been scheduled for December 9, 2024.
To enhance our maintenance capabilities, the administrator and consultant are interviewing additional housekeeping and maintenance staff who can handle small repairs and report any larger repair needs to administration. The hiring process for these additional staff members will begin on November 15, 2024 to be completed by January 15, 2025.
To ensure ongoing compliance, the administrator will monitor the cleanliness and maintenance of the living spaces on a daily basis for one month, starting from November 9, 2024. This monitoring will promote better housekeeping and maintenance practices throughout the facility. These actions are being implemented to rectify the violations and to ensure a safe and clean environment for all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

101q - Storage Space

13. Requirements

2600.
101.q. Space for storage of personal property shall be provided in a dry, protected area.

101q - Storage Space *(continued)*

Description of Violation

There is a basement storage area next to the downstairs dining area is that is filled with clothing and other belongings. On 11/6/2024 at 11:25 AM this area smelled damp and mildewy.

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

The storage area has been scheduled for painting on December 9th, 2024. Personal property and belongings have been relocated and a lock has already been installed. In the meantime, housekeeping has been advised of their duty to provide safe, clean living space and dry protected storage areas for our clients. The administrator has been authorized to hire additional housekeeping/maintenance staff. Administrator will monitor for one month to maintain compliance and promote better housekeeping/maintenance practices.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate what is being done about the dampness in the area.

Please indicate dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding maintaining clean and safe storage areas is essential for the health and well-being of our residents. The violation occurred due to the presence of dampness and a mildewy smell in the basement storage area next to the downstairs dining area, observed on 11/6/2024 at 11:25 AM.
In response to this violation, immediate action was taken on 11/7/2024 by removing all old unused clothes from the area. By December 9th, the home will place a dehumidifier in the storage room to address the dampness and improve air quality. Additionally, a lock will be installed by the same date to ensure secure storage.
The housekeeping staff has been reminded of their responsibility to provide safe, clean living spaces and dry, protected storage areas for our clients.
To support these efforts, the administrator is interviewing additional housekeeping and maintenance staff, with the hiring process expected to begin on November 15, 2024.
The administrator will monitor the storage area for one month, starting from November 9, 2024, to ensure compliance and promote better housekeeping and maintenance practices.
These actions are being implemented to rectify the violation and to ensure a safe and clean environment for all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

103i - Outdated Food

14. Requirements

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

103i - Outdated Food *(continued)*

Description of Violation

There was an uncovered half of an onion in the main kitchen refrigerator that was sprouting from the center.

Plan of Correction ***Accept ([redacted] - 12/04/2024)***

The kitchen staff has removed all food that may be potentially spoiled and cans that are dented. The kitchen staff will monitor food on a daily basis going forward to avoid future compliance issues and to maintain a safe and healthy living space for residents. This process will start December 3rd, 2024 and will continue for 1 month unless and extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

125a - Combustible Storage

15. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 11/7/2024, there was an unlocked oxygen tank in room C11. The door to room C11 was open and accessible to any resident. Agents of the Department observed evidence of smoking throughout the home in the form of holes burned in bed linens and discarded cigarette butts.

Repeat violation: 8/7/2024 et al

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

Resident will receive additional monitoring for smoking and a lock has been placed on the room. The resident's RASP has been updated to reflect the additional monitoring needed. The administrator will review on a weekly basis for compliance starting December 3rd,2024. This process will continue for one month unless and extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

This regulation is important because it ensures the safety and well-being of residents by preventing access to potentially hazardous items such as oxygen tanks and by addressing the dangers associated with smoking within the facility. The regulation was violated due to the presence of an unlocked oxygen tank in room C11 and the evidence of smoking in the home.
In response to this violation, the following actions will be taken:
The resident will receive additional monitoring for smoking, effective immediately on November 8, 2024. A lock has been installed on room C11 to prevent unauthorized access to the oxygen tank, and the resident's RASP was updated on November 8, 2024 to reflect the need for this additional monitoring.
The administrator will conduct a compliance review on a weekly basis, starting December 3, 2024. This review process will continue for one month, concluding on January 3, 2025, unless an extension is deemed necessary

125a - Combustible Storage (continued)

based on the resident's behavior and compliance with the established protocols.
All staff members are responsible for adhering to these measures to ensure the safety of all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

131f - Fire Extinguisher Inspection

16. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in downstairs kitchen does not have a tag showing it has been inspected by a fire safety expert.

Repeat violation: 11/02/2023

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

The tag for the extinguisher had fallen off and was place on the extinguisher, however Emergency Response, who handles all of our fire safety, has been notified to place tags more carefully and is scheduled to reinspect fire safety equipment by
January 15th, 2025. The home's administrator will monitor on a monthly basis starting December 3rd. The administrator has been authorized to hire additional housekeeping/maintenance staff and the new staff will assist hands-on with these types of issues.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the immediate action that was taken to correct the violation.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding the inspection and tagging of fire extinguishers is essential for ensuring the safety of all residents and staff. The violation occurred when it was noted that the fire extinguisher in the downstairs kitchen did not have a tag indicating it had been inspected by a fire safety expert.
In response to this violation, the tag for the extinguisher was immediately replaced on November 8, 2024. Additionally, Emergency Response, the company responsible for our fire safety equipment, has been notified to ensure that tags are placed more securely in the future. They are scheduled to reinspect all fire safety equipment by January 15, 2025.
To maintain ongoing compliance, the home's administrator will monitor the status of fire safety equipment on a monthly basis, starting December 3, 2024. Furthermore, the administrator is interviewing additional housekeeping and maintenance staff, who will assist with these types of safety issues.
These actions are being implemented to rectify the violation and to ensure a safe environment for all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

144d - Smoking Outside

17. Requirements

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

Description of Violation

On 11/7/2024 multiple cigarette burns were observed on the floor of the bedroom belonging to resident 5. There were burn holes observed in the bed sheet in room [redacted]. There were also cigarette butts and a lighter in the grass in front of the home which is not the home's designated smoking area. The home's designated smoking area is in the courtyard in the back of the building.

Repeat violation: 11/02/2023

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

A staff memo will be sent December 3rd, 2024. Room [redacted] and resident #5's roommate will be monitored hourly for one month to discern permanent long-term solutions and promote compliance and safety. The administrator will review on a weekly basis for one month starting December 3rd, 2024. Resident #5's roommate's RASP has been updated to reflect this behavior and monitoring. At the end of one month a determination will be made whether or not resident #5's roommate can remain in the home.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate the dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding smoking and the maintenance of a safe living environment is critical for the health and safety of all residents. The violation occurred on 11/7/2024 when multiple cigarette burns were observed on the floor of the bedroom belonging to Resident 5, along with burn holes in the bed sheet in room [redacted] Additionally, cigarette butts and a lighter were found in the grass in front of the home, which is not the designated smoking area.
In response to this violation, immediate action was taken on 11/8/2024. The bed sheets in room [redacted] were replaced, and the cigarette butts and lighter were cleaned up from the grass area.
To promote compliance and safety, a staff memo will be sent on December 3, 2024, to remind staff of the smoking policies and designated areas. Room [redacted] and Resident 5's roommate will be monitored hourly for one month, starting December 3, 2024, to assess behaviors and determine long-term solutions. The administrator will conduct weekly reviews during this monitoring period to ensure compliance.
Additionally, Resident 5's roommate's Risk Assessment and Support Plan (RASP) was updated on November 7, 2024 to reflect the need for this behavior monitoring. At the end of the one-month monitoring period, a determination will be made regarding whether Resident 5's roommate can remain in the home.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

Since the monitoring of resident #5's roommate, it has been determined that [redacted] is able to remain in the home.

185a - Implement Storage Procedures

18. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 6 is prescribed Hydroxyz Hel Tab 25 mg as needed. On 11/7/2024 this medication was not available in the home.

Resident 7 is prescribed Tussin DM Liquid 5-100 mg as needed. On 11/7/2024 this medication was not available in the home.

Resident 8 is prescribed Clonazepam .5mg tablet. On 9/17/24 at 3:37 PM this medication was administered as per the medication administration record but was not signed out on the controlled substance log.

Plan of Correction ***Accept ([redacted] - 12/04/2024)***

Staff had ordered the medication, but had not yet received them. Staff has been instructed to re-order these particular medications earlier in the process of delivery. The pharmacy has been contacted and notified of our need for prompt delivery for compliance.
Resident #8's Clonazepam was signed in the narcotics, but not the medication administration record as were the other medications in violation number 19. Please see violation #19 for corrective measures. Staff training will take place on December 13th, 2024.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

187b - Date/Time of Medication Admin.

19. Requirements

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

Description of Violation

Resident 8 is prescribed Clonazepam .5mg tablet. Resident 8's 09/2024 medication administration record does not include the initials of the staff person who administered Clonazepam .5mg on 9/4/24 at 8 PM, 9/9/24 at 9 PM, 9/16/24 at PM. 9/18/24 at 8 PM, 9/28/24 at 8 AM, 10/4/24 at 5 PM and 10/10/24 at 5 PM.

Plan of Correction ***Accept ([redacted] - 12/04/2024)***

Resident was originally on PRN narcotics only. [redacted] PCP then prescribed it for regularly scheduled meds. This led to confusion amongst the staff and to the deliveries being signed off in the narcotics log. The administrator and staff have discussed this situation to avoid further errors. Staff has been instructed to sign the medication administration and the narcotics log for these medications.
Staff training will take place December 13th, 2024 and the medication supervisor will monitor daily for compliance starting December 3rd, 2024. This will last one month unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

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

201 - Positive Interventions

20. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident 1 has continuously bullied resident 2. Resident 1 has a documented history of aggression towards residents that do not want to socialize with them and has become increasing vulgar and mean to other residents. Resident 2 states resident 1 pounds on resident 2's bedroom door in the morning. The home has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

Resident #1 now receives one on one hourly check-in by staff members. This will continue for two months to promote better behavior and safe living space for all residents. The primary care physician has been asked to refer resident #1 to behavioral evaluation. At the end of this two month process the administrator will make a determination whether resident #1 can remain in the facility.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the immediate action that was taken to correct the violation.

How was it determined that the resident only needs hourly checks?

What are staff duties when completing the hourly checks?

Please include a step to educate staff.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding the safety and well-being of residents is critical in maintaining a positive living environment. The violation was reported due to ongoing bullying behavior exhibited by Resident 1 towards Resident 2, along with a documented history of aggression.
In response to this violation, immediate action was taken by
implementing one-on-one hourly check-ins for Resident 1, starting on
November 8, 2024. This approach was chosen because the resident's insurance would not cover the cost of bringing in a dedicated staff member, and the facility cannot financially support a full-time staff person for Resident 1. The hourly checks will continue for two months to promote better behavior and ensure a safe living

201 - Positive Interventions (continued)

space for all residents. During these hourly checks, staff members are responsible for monitoring Resident 1's behavior, providing support, and documenting any incidents or interactions. Staff will also be educated on how to effectively engage with Resident 1 to encourage positive social interactions and discourage aggressive behavior. A staff training session will be held on December 13, 2024, to provide guidance on these strategies and reinforce the importance of maintaining a safe environment. Additionally, the primary care physician has been scheduled to see Resident 1 on December 13, 2024, at which time a referral for a psychiatric evaluation will be made. The effectiveness of the hourly checks will be assessed, and thus far, they have been successful, as Resident 1 has not been disruptive during this period. To ensure ongoing compliance and monitor the situation, the administrator will conduct weekly reviews of Resident 1's behavior and the effectiveness of the hourly checks, starting December 3, 2024. These reviews will continue for the duration of the two-month monitoring period. At the end of this period, the administrator will determine whether Resident 1 can remain in the facility based on the observed behavior and the outcomes of the psychiatric evaluation. These actions are being implemented to address the violation and to
foster a safe and supportive environment for all residents.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 03/03/2025)***

See attached.

224a - Preadmission Screen Form

21. 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 9'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.

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

This oversight has been corrected in the resident's record. The administrator has reviewed with the staff the regulatory compliance needs of the record. Staff training will take place December 13th, 2024. The administrator and consultant will monitor weekly for two months to maintain compliance and promote better record keeping habits.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

The regulation regarding the completion of preadmission screening forms is essential to ensure that the needs of residents can be met by the services provided by the home. The violation occurred because Resident 9's preadmission screening form, dated 9/27/2024, did not include a determination that the resident's needs could be met.
In response to this violation, the oversight has been corrected in Resident 9's record as of November 8, 2024. The administrator has reviewed the regulatory compliance needs of the record with the staff to ensure understanding and adherence to requirements.

224a - Preadmission Screen Form (continued)

To further address this issue, staff training will take place on December 13, 2024, to emphasize the importance of accurately completing preadmission screening forms and maintaining compliance with regulatory standards. Additionally, the administrator and consultant will monitor the records on a weekly basis for two months, starting December 3, 2024, to ensure ongoing compliance and to promote better record-keeping habits among staff. These actions are being implemented to rectify the violation and to ensure that all residents' needs are appropriately assessed and documented.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented (- 02/03/2025)***

See attached.

225c - Additional Assessment

22. Requirements

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

The assessment and support plan for resident 4, dated does not indicate the resident has a need for dental care or document how this need will be met. Resident 4's front tooth was black with decay and when interviewed they expressed a need to have it pulled. Staff person D stated that resident's teeth have been in the same condition since arrived.

Plan of Correction ***Do Not Accept (- 12/04/2024)***

The administrator will review and reconcile needs of the residents with records over the next two months. A mobile dental and additional medical services team has been contacted to schedule on site delivery of services. The home's administrator will monitor for two weeks starting December 3rd, 2024.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate the immediate action that was taken to correct the violation.

Please explain what will be monitored.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (- 12/11/2024)***

The regulation regarding the assessment and support plans for residents is crucial to ensure that all health needs are identified and addressed appropriately. A violation occurred because the assessment and support plan for Resident 4, dated did not indicate a need for dental care, despite the resident expressing a desire to have a decayed

225c - Additional Assessment (continued)

tooth pulled. In response to this violation, immediate action was taken on November 8, 2024, to update Resident 4's assessment and support plan to reflect the need for dental care.
The administrator will review and reconcile the needs of all residents with their records over the next two months, starting December 3, 2024. A mobile dental and additional medical services team has been contacted to schedule on-site delivery of services for residents in need of dental care. The administrator will monitor the implementation of these services and the overall health needs of residents for two weeks, beginning December 3, 2024.
To ensure ongoing compliance, the administrator will conduct weekly audits of the assessment and support plans for all residents throughout the two-month review period, verifying that all health needs, including dental care, are documented and addressed appropriately. The administrator will be responsible for these audits and will report findings to the management team. Additionally, quarterly reviews will be implemented to ensure sustained compliance and to address any emerging health needs of residents. These actions are being taken to rectify the violation and to ensure that all residents receive the necessary care and support for their health needs.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.

252 - Record Content

23. 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.
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.

252 - Record Content *(continued)*

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

Resident 10's record does not include a photograph of the resident that is no more than 2 years old.

Repeat violation: 10/2/2024 Et al, 8/7/24 et al

Plan of Correction ***Do Not Accept ([redacted] - 12/04/2024)***

The administrator has reviewed records and updated them as needed. The administrator will review on a monthly basis and insure compliance. Staff has been advised of regulatory compliance needs regarding photographs and record keeping. Staff training will take place December 13th, 2024.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Update: *12/04/2024*

Please indicate dates for each step.

Plan of Correction ***Accept ([redacted] - 12/11/2024)***

This regulation is important because it ensures that all residents' records are complete and up-to-date, including having a current photograph. The regulation was violated because Resident 10's record did not include a photograph of the resident that is no more than 2 years old. The administrator has reviewed the records and updated them as needed as of November 8, 2024.
To ensure ongoing compliance, the administrator will conduct monthly reviews of the records starting December 3, 2024, to verify that all residents have current photographs in their files. Staff has been advised of the regulatory compliance needs regarding photographs and record keeping. A staff training session will take place on December 13, 2024, to emphasize the importance of maintaining accurate and complete records, including the requirement for current photographs.
All staff members will be able to assist in ensuring that residents' records are kept up-to-date and compliant with regulations. The administrator will monitor compliance and address any issues that arise during the monthly reviews and going forward.

Licensee's Proposed Overall Completion Date: *12/09/2024*

Evidence of Completion ***Implemented ([redacted] - 02/03/2025)***

See attached.