



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SUGAR VALLEY LODGE INC**
LEGAL ENTITY

To operate **SUGAR VALLEY LODGE (SILVER OAK BUILDING)**
NAME OF FACILITY OR AGENCY

Located at **158 SUGAR VALLEY LANE, FRANKLIN, PA 16323**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **15**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

Restrictions: _____

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

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

and shall remain in effect from **April 10, 2025** until **April 10, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **447710**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
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.



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: April 10, 2025

[REDACTED]
Sugar Valley Lodge Inc.
[REDACTED]

RE: Sugar Valley Lodge (Silver Oaks Building)
158 Sugar Valley Lane
Franklin, PA 16323
License #: 44771

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspection on August 9, 2024 and the corrections you have made after our inspection, 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,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *SUGAR VALLEY LODGE (SILVER OAK BUILDING)* License #: *44771* License Expiration: *11/03/2024*
Address: *158 SUGAR VALLEY LANE, FRANKLIN, PA 16323*
County: *VENANGO* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *SUGAR VALLEY LODGE INC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *05/20/2016* Issued By: *Sugarcreek Borough*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *13* Waking Staff: *10*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Provisional* Exit Conference Date: *08/09/2024*

Inspection Dates and Department Representative

08/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *15* Residents Served: *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10* Are 60 Years of Age or Older: *7*
Diagnosed with Mental Illness: *6* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

08/09/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/03/2024*

Inspections / Reviews (*continued*)

09/24/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/01/2024

10/04/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/30/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 11/01/2024

03/26/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/01/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

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 8/9/24, at approximately 9:18 a.m., a copy of a regular license, dated 8/10/23-8/10/24, was posted on the living room wall; however, the home is currently issued a 1st provisional license, dated 5/3/24-11/3/24, which was not posted in a public and conspicuous place.

Plan of Correction

Accept [REDACTED] - 10/04/2024)

On 8/27/2024 [REDACTED] posted the provisional license in the lounge.

Starting on 9/2/2024 [REDACTED] will check monthly to ensure the license is posted in the correct area.

Starting on 9/2/2024 [REDACTED] will add license posted to quality management checklist.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 01/30/2025)

5a1 - DHS Access

2. Requirements

2600.

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

- 1. Agents of the Department.

Description of Violation

On 8/9/24, agents of the Department requested access to 4 resident records, including an itemized account of financial transactions made on the resident behalf on a quarterly basis (55 PA Code 2600.20(b)(8)). Staff person A, indicated at approximately 10:57 a.m., that the only person with access was on [REDACTED] until 8/15/24.

Plan of Correction

Accept [REDACTED] - 09/12/2024)

On 8/15/2024 [REDACTED] -Educated The Administrator/COO- Where these records are kept and how to gain access if this question is ever asked again.

On 8/28/24- [REDACTED] Asked Administrator/ COO for records on 2 people. [REDACTED] the records he requested.

As of 8/28/24- All administrators have keys to this office and are able to locate the records in question when needed.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [REDACTED] - 01/30/2025)

17 - Record Confidentiality

3. Requirements

2600.

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

17 - Record Confidentiality (continued)

Description of Violation

On 8/9/24, at approximately 9:38 a.m., multiple progress notes were unlocked and accessible, sitting in a wall file outside of the Administrators office to include a progress note, dated 8/2/24 at 12:30 p.m. that contained resident #1's name as well as information related to a fall sustained and potential injury.

Plan of Correction

Accept ([redacted] - 09/12/2024)

On 8/27/2024 [redacted] instructed staff to no longer place resident records in an open mailbox they are to be placed under the door.

Starting on 9/2/2024 [redacted] Lead will train all staff on the importance of confidentiality.

Starting on 9/9/2024 [redacted] will add confidentiality paperwork into the onboarding paperwork.

Licensee's Proposed Overall Completion Date: 08/27/2024

Implemented [redacted] - 01/30/2025)

26a - Quality Management Plan

4. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's quality management policy indicated that the home will have a quality management review annually; however, there was no documentation of a quality management review in the past year.

Plan of Correction

Accept [redacted] /04/2024)

On 8/27/2024 Administrators [redacted] and [redacted] went over quality management plan.

Starting on 9/3/2024 [redacted] will hold a Quality Management meeting monthly.

Starting on 9/3/2024 [redacted] will update the plan from annually to monthly meetings.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [redacted] 03/26/2025)

42e - Telephone Access

5. Requirements

2600.

42.e. A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

Description of Violation

The corded telephone intended for resident use was located in the living room near the nurses station and did not provide the residents with adequate privacy.

Plan of Correction

Accept [redacted] - 10/04/2024)

On 8/28/2024 [redacted] called changing times about moving the phone lines to more private area of the building.

Starting on 9/3/2024 [redacted] will check to ensure residents feel comfortable talking on the phone verbally.

[redacted] will also allow access to the administrators office for private phone calls upon request.

By 10/1/2024 [redacted] will have the phone lines moved to a better location for privacy of the residents.

Licensee's Proposed Overall Completion Date: 09/30/2024

42e - Telephone Access (*continued*)*Implemented* [REDACTED] - 01/30/2025)

54a - Direct Care Staff

6. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

On 8/9/24, direct care staff person B's staff record did not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Plan of Correction*Accept* [REDACTED] - 10/04/2024)

On 8/15/2024 [REDACTED] told Staff Person B they needed a copy of their high school diploma.

On 8/28/2025 [REDACTED] placed diploma in staff person B's personnel file.

Starting on 9/3/2024 [REDACTED] will go through all personnel files to ensure academic records are present these audits will take place monthly.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 01/30/2025)

63a - First Aid/CPR Training

7. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 8/1/24, there were 13 residents present in the home. Staff person C, who was not certified in first aid, obstructed airway techniques, or CPR worked alone in the home from 10:00 p.m.-7:00 a.m.

On 8/2/24, there were 13 residents present in the home. Staff person D, who was not certified in first aid, obstructed airway techniques or CPR worked alone in the home from 6:00 p.m.-6:00 a.m.

On 8/3/24, there were 13 residents present in the home. Staff person D, who was not certified in first aid, obstructed airway techniques or CPR worked alone in the home from 10:00 p.m.-6:00 a.m.

Plan of Correction*Accept* [REDACTED] - 10/04/2024)

On 8/28/2024 [REDACTED] got Sugar Valley Lodge affiliated with American Red Cross so staff members can be trained in house.

Starting on 9/3/2024 [REDACTED] will begin training new staff on CPR. First Training was completed 9/9/2024.

63a - First Aid/CPR Training (continued)

Starting on 9/3/2024 [REDACTED] update job description making CPR mandatory within the first month of hire.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 03/26/2025)

65a - FS Orientation 1st Day

8. Requirements

2600.

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

Description of Violation

Direct care staff person E, hired [REDACTED]/24, did not receive orientation training in any of the required topics under 2600.65(a).

On 8/9/24, direct care staff person F, hired [REDACTED] 22, did not receive orientation training in any of the required topics under 2600.65(a).

Plan of Correction

Accept [REDACTED] - 10/04/2024)

On 8/28/24- [REDACTED] - identified which trainings Staff Person E needed.

On 8/29/24- [REDACTED] sat with Staff Person E and went over required trainings and Staff Person E signed off on receiving these trainings.

By 9/9/24 [REDACTED] will have all staff have the required training and acknowledged in their employee files. We will add these trainings to the checklist to make sure they are documented correctly and filed.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 01/30/2025)

65b - Rights/Abuse 40 Hours

9. Requirements

2600.

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

Description of Violation

Direct care staff person F, hired [REDACTED]/22, did not receive training on resident rights as required under 2600.65(b).

Plan of Correction

Accept [REDACTED] - 10/04/2024)

On 8/28/24- [REDACTED] - identified which trainings Staff Person E needed.

On 8/29/24- [REDACTED] sat with Staff Person E and went over required trainings and Staff Person E signed off on receiving these trainings.

By 9/9/24 [REDACTED] will have all staff have the required training and acknowledged in their employee files. We will add these trainings to the checklist to make sure they are documented correctly and filed.

Licensee's Proposed Overall Completion Date: 09/30/2024

65b - Rights/Abuse 40 Hours (*continued*)*Implemented* [REDACTED] - 01/30/2025)

65f - Training Topics

11. 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 B, hired [REDACTED] 22, did not receive annual training in training year 2023 in the following areas:**Care for residents with dementia and cognitive impairments**Infection control**Personal care service needs of the resident**Safe management techniques***Plan of Correction***Accept* [REDACTED] - 09/12/2024)*On 8/29/2024 [REDACTED] created a spreadsheet to track which employees all received trainings.**On 9/3/2024 [REDACTED] provided all SVL employees who did not receive a certain training education to make up for the missed training.**Starting on 10/1/2024 [REDACTED] will update all employee trainings and keep them filed in their personnel files.***Licensee's Proposed Overall Completion Date: 08/29/2024***Implemented* [REDACTED] - 01/30/2025)

65g - Annual Training Content

12. Requirements

2600.

65g - Annual Training Content (continued)

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

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

Description of Violation

Staff person B, hired [REDACTED]/2022, and staff person G, hired [REDACTED]/1993, did not receive the following required training topics in the training year 2023:

Fire safety completed by a fire safety exit

Emergency preparedness

Plan of Correction

Accept [REDACTED] - 09/12/2024)

On 8/29/2024 [REDACTED] updated the staff training plan.

On 9/4/2024 [REDACTED] will provide education on the trainings staff member B and G missed.

Starting on 10/1/2024 [REDACTED] will make sure all employees trainings are up to date by tracking them. When a training is missed educational paperwork will be provided.

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

Implemented [REDACTED] - 01/30/2025)

86b - Bathroom

13. 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

At approximately 9:30 a.m., the single use common bathroom in hallway 100 did not have an operable window and the exhaust fan for ventilation was inoperable.

REPEAT VIOLATION: 7/27/23

Plan of Correction

Accept [REDACTED] - 10/04/2024)

On 8/28/2024 [REDACTED] contacted County Maintenance about the exhaust fan not working again.

Starting on 9/3/2024 [REDACTED] will track all maintenance requests through UPKeep Maintenance Manager application. The exhaust fan was repaired by County Maintenance on 9/5/2024.

Starting on 9/15/2024 [REDACTED] will through documentation audit the facility monthly catching any outstanding maintenance concerns.

Licensee's Proposed Overall Completion Date: 09/30/2024

86b - Bathroom (continued)

Implemented [redacted] - 03/26/2025)

87 - Lighting

14. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

At approximately 9:30 a.m., the overhead light in the single use common bathroom in hallway 100 was inoperable.

Plan of Correction

Accept [redacted] - 10/04/2024)

On 8/28/2024 [redacted] Submitted a request to County Maintenance to repair the light in the restroom.

On 9/3/2024 [redacted] will check to ensure the light is fixed. The Light was fixed on 9/5/2024 by County Maintenance.

Starting on 9/15/2024 [redacted] will through documentation audit the facility monthly catching any outstanding maintenance concerns.

Yes we regularly inspect the buildings since we have a quality management plan in place.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [redacted] - 01/30/2025)

103e - Left Overs

17. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 9:41 a.m., the following items in the walk-in freezer in the main kitchen were unlabeled and undated: what appeared to be hamburger meat, a bag of sliced ham, and a bag containing 1/3 loaf of bread.

At approximately 9:41 a.m., an unlabeled 1/4 full bag containing what appeared to be chopped chicken was in the walk-in freezer in the main kitchen.

At approximately 9:41 a.m., two packs of unlabeled cheese that were re-wrapped were in the walk-in freezer in the main kitchen.

At approximately 9:41 a.m., an unlabeled 1/3 bag of french toast sticks was observed in the walk-in freezer in the main kitchen.

At approximately 9:41 a.m., an opened and undated package of cookies was observed in the food storage/office in the main kitchen.

103e - Left Overs (continued)

Plan of Correction

Accept [redacted] - 09/24/2024)

On 8/9/24- [redacted] was made aware of the items listed above and immediately addressed nutrition staff on the issue at hand.

On 8/29/24- [redacted] educate Nutrition workers that handle any food that if it is taken out its original package or opened for any reason, it is to be dated and identified with the Date opened, what the item is and the expiration date along with the staff initials of who has written the documentation.

As of 9/9/24- [redacted] will do quality checks on fridges to make sure this is being completed monthly.

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

Implemented [redacted] - 01/30/2025)

103g - Storing Food

18. Requirements

2600.

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

Description of Violation

At approximately 9:41 a.m., the following were found to be open and not sealed in the main kitchen:

A package of cookies in the food storage/office

A ¼ full bag of chopped chicken, in the walk-in refrigerator

Two re-wrapped packages of cheese slices in the walk-in refrigerator

Plan of Correction

Accept [redacted] - 09/24/2024)

On 8/9/ [redacted] acknowledge the package of cookies that were opened and not put in a sealed bag as to prevent contamination.

On 8/29/24- All staff were instructed that if they opened a package, to put the item in a sealed container to prevent contamination. This package will be labeled with the date opened, expiration date and their initials.

By 9/9/24- [redacted] will have all staff sign a sheet stating that they were made aware. After this it will be included in the Dietary and Nutrition Workers trainings.

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

Implemented [redacted] - 01/30/2025)

103i - Outdated Food

19. Requirements

2600.

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

103i - Outdated Food (continued)

Description of Violation

At approximately 9:41 a.m., an open and undated bag of french toast sticks was observed in the walk-in freezer in the main kitchen.

Plan of Correction

Accept () - 09/24/2024)

On 8/28/2024 () met with Nutrition Group who handles the food for Sugar Valley Lodge on properly storing their food.

Starting on 9/3/2024 () will check the food storage to ensure proper storage of food.

Starting on 9/3/2024 () will meet with Nutrition Group monthly about any concerns in the kitchen areas.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented () - 01/30/2025)

126a - Furnace Inspection

20. Requirements

2600.

126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home had no documentation (record) of the last time the furnace was inspected.

Plan of Correction

Accept () - 09/24/2024)

On 8/28/2024 () contacted County Maintenance to obtain a copy of the most recent furnace inspection.

On 9/3/2024 () ensure furnace inspection records are filed correctly.

Starting on 9/4/2024 () will receive documentation from Venango County Maintenance whenever a furnace inspection takes place.

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

Implemented () - 01/30/2025)

132a - Monthly Fire Drill

21. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

A monthly unannounced fire drill was not conducted in March 2024 and July 2024.

Plan of Correction

Accept () - 09/24/2024)

On 8/9/24- () acknowledged that a monthly unannounced fire drill was not conducted in March 2024 and July 2024

On 8/29/24- () will provide staff with when the fire drills are to be conducted as well as what shift.

Starting on 10/1/2024 () train all SVL staff on conducting fire drills.

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

132a - Monthly Fire Drill (continued)

Implemented [REDACTED] - 01/30/2025)

132b - Safety Inspection/Fire Drill

22. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 7/17/23.

REPEAT VIOLATION: 7/27/23

Plan of Correction

Accept [REDACTED] 09/24/2024)

On 8/29/2024 [REDACTED] called Rocky Grove Fire Department to schedule the training.

On 9/4/2024 [REDACTED] will post training to make sure staff are all aware and able to be present.

Starting on 10/1/2024 [REDACTED] will make sure we have a planned training for the following year due to this being needed every year.

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

Implemented [REDACTED] - 03/26/2025)

132c - Fire Drill Records

23. Requirements

2600.

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

Description of Violation

On 8/9/24, the fire drill record for the following fire drills did not indicate the exit route used, number or resident evacuated, problems encountered, and whether the smoke detector or fire alarm was operable:

8/30/23 at 8:45

9/30/23 at 9:00

10/16/23 at 10:30 a.m.

11/30/23 at 4:00 p.m.

12/28/23 at 12:37 a.m.

1/13/24 at 10:15 a.m.

2/9/24 at 2:11 p.m.

4/13/24 at 4:35 p.m.

5/17/24 at 1:33

Additionally, the fire drills conducted on 8/30/23, 9/30/23, and 5/17/24 did not indicate a.m. or p.m.

The fire drill record did not indicate the number of residents evacuated during the drill conducted on 6/22/24 at

132c - Fire Drill Records (continued)

11:20 p.m.

REPEAT VIOLATION: 7/27/23

Plan of Correction

Accept [redacted] - 09/24/2024)

On 8/27/2024 [redacted] updated Fire Drill log to ensure SVL staff mark in the correct information. Starting on 9/3/2024 [redacted] check all fire drill logs to make sure the staff have correctly filled them out.

Starting on 9/3/2024 [redacted] will go over upcoming fire drills during the quality management meetings.

Licensee's Proposed Overall Completion Date: 08/28/2024

Implemented [redacted] 03/26/2025)

141b1 - Annual Medical Evaluation

24. Requirements

2600.

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

Description of Violation

A medical evaluation belonging to resident #2 was completed on [redacted]/22; however, another medical evaluation was not completed until 1/6/24.

Plan of Correction

Accept [redacted] - 10/04/2024)

on 8/9/24- [redacted] acknowledged that Resident #2 did not have a medical Evaluation for 2023 in their chart.

On 8/16/24- [redacted] find a Medical Evaluation for Resident #2 in a different location. [redacted] med lead will audit charts to make sure all up to date evaluations are present. This will start 10/1/2024.

On 8/16/2024- [redacted]-Filed the Medical Evaluation in Resident #2 chart.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [redacted] - 03/26/2025)

225a - Assessment 15 Days

25. Requirements

2600.

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

225a - Assessment 15 Days (continued)

Description of Violation

Resident #3 had a diagnosis of diabetes; however, this diagnosis was not addressed in the initial assessment dated [REDACTED]/24.

Plan of Correction

Accept [REDACTED] - 10/04/2024)

On 8/9/24- [REDACTED] acknowledged that the missing Diagnosis was not on Resident #3 on their assessment.

On 8/12/2024- [REDACTED] had the diagnosis was added to the Assessment

On 8/12/2024- [REDACTED] educated [REDACTED] on inputting all diagnoses listed for the residents.

By 9/9/2024- [REDACTED] - will add each diagnoses to the resident assessments as they are being done to accurately have all the correct information on each assessment. Monthly all assessments will be audited to ensure all diagnosis's are listed.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] 03/26/2025)