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

December 10, 2024

[redacted]
DENEANE SMITH
[redacted]

RE: DENEANE'S PERSONAL CARE HOME
142 FAIRVIEW AVENUE
CONFLUENCE, PA, 15424
LICENSE/COC#: 32152

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/27/2024, 08/28/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *DENEANE'S PERSONAL CARE HOME* **License #**: *32152* **License Expiration**: *10/26/2024*

Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA 15424*

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

Administrator

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

Legal Entity

Name: *DENEANE SMITH*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/08/1999* **Issued By**: *Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/28/2024*

Inspection Dates and Department Representative

08/27/2024 - On-Site: [redacted]

08/28/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *5*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

08/27/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/16/2024*

09/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/15/2024*

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

Inspections / Reviews *(continued)*

09/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/15/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/15/2024*

12/10/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/15/2024*

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 [redacted] at 10:17AM, the home's most current licensing summary issued by the Department, dated [redacted] was not posted in a conspicuous and public place in the home.

Repeated Violation - 3/20/2024, 12/5/2023 et al

Plan of Correction ***Accept [redacted] - 09/16/2024)***

• On 08/28/24, the Administrator printed a copy of the most resent license certificate and posted it in the residents dining area.
• Staff will receive education by 10/10/24, instructing them to notify the Administrator if the current license certificate and other required postings are observed to be missing from the resident dining area,
• Beginning 10/01/24, monthly audits will be completed by the Administrator or designee to ensure that the current license certificate and other required postings are in the dining area.
• Documentation of staff education and monthly audits will be kept by the home and available for review by the department.

Licensee's Proposed Overall Completion Date: *09/16/2024*

Implemented [redacted] - 12/10/2024)

15a - Resident Abuse Report

3. 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

A resident-to-resident abuse incident was reported to Staff Member A about two weeks prior to the inspection date. Staff Member A confirmed [redacted] had overheard a "commotion" upstairs during a 10:00PM shift at the home after which Resident [redacted] was agitated with Resident [redacted] and Staff Member A separated the two residents. Staff Member A was informed by residents during [redacted] next work shift that Resident [redacted] had bitten Resident [redacted] on the arm. Resident [redacted] confirmed to Staff Member A that this occurred. A skin tear was observed where the resident stated [redacted] was bitten. However, an Act 13 Mandatory Abuse Reporting form was not completed and submitted to AAA as of [redacted].

Plan of Correction ***Directed [redacted] - 09/23/2024)***

• Resident [redacted] answers "yes" to all questions. Resident [redacted] does not remember the names of long-term staff members that are in the home working daily. Resident [redacted] does not remember events that have happened in the past. The Administrator and staff does not believe that Resident [redacted] was bitten.
• At the time of the exit interview at the inspection on [redacted] the Administrator and staff were educated that even an accusation of resident-to-resident abuse must be reported to AAA. The Administrator and designee will report this incident to AAA on [redacted].
• The Administrator and designee now understand this regulation and will report any accusations or incidents of

15a - Resident Abuse Report (continued)

resident-to-resident abuse to AAA.

• By [redacted], staff will be trained on all types of incident reporting and staff will be instructed to inform the Administrator or designee of any instances that should be reported to AAA or the Department. The Administrator and designee will continue to remind staff of this regulation throughout the year and have conversations with staff and residents to ensure that all incidents, even allegations of abuse are reported to to AAA and the Department.

• Documentation of staff education will be kept by the home and available for review by the department.

(Directed)

In addition to the above plan of correction:

Beginning 10/1/24, the Administrator or designee will discuss any incidents that may have occurred in the home from the day prior with staff. If any allegations of abuse were reported and/or witnessed, the Administrator or designee will audit the report sent to AAA to ensure it was sent timely.

Directed Completion Date: *10/10/2024*

Implemented [redacted] - 12/10/2024)

16c - Written Incident Report

4. 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

A resident-to-resident abuse incident was reported to Staff Member A about two weeks prior to the inspection date. Staff Member A confirmed that [redacted] had overheard a "commotion" upstairs during a 10:00PM shift at the home after which Resident [redacted] was agitated with Resident [redacted] and Staff Member A separated the two residents. Staff Member A was informed by residents during [redacted] next work shift that Resident #4 had bitten Resident [redacted] on the arm. Resident [redacted] confirmed to Staff Member A that this occurred. A skin tear was observed where the resident stated [redacted] was bitten. As of [redacted], the home did not report this incident the Department.

Resident [redacted] fell at the home on [redacted] and did not want to go to the hospital at that time as per hospital summary dated [redacted]. The resident went to the hospital on [redacted], at which time an acute displaced transcervical fracture of the left femur was diagnosed. As of [redacted] the home did not report this incident the Department.

Plan of Correction ***Directed [redacted] - 09/23/2024)***

• Resident [redacted] answers "yes" to all questions. Resident [redacted] does not remember the names of long-term staff members that are in the home working daily. Resident [redacted] does not remember events that have happened in the past. The Administrator and staff do not believe that Resident [redacted] was bitten.

• At the time of the exit interview at the inspection on [redacted] the Administrator and staff were educated that even an accusation of resident-to-resident abuse must be reported to the Department. The Administrator and designee will report this incident to the Department on [redacted]

• The Administrator and designee now understand this regulation and will report any accusations or incidents of resident-to-resident abuse to the Department.

• By 10/10/24, staff will be trained on all types of incident reporting and staff will be instructed to inform the

16c Written Incident Report (continued)

Administrator or designee of any instances that should be reported to AAA or the Department. The Administrator and designee will continue to remind staff of this regulation throughout the year and have conversations with staff and residents to ensure that all incidents, even allegations of abuse are reported to AAA and the Department.
• Documentation of staff education will be kept by the home and available for review by the department.

In addition to the above plan of correction:
Beginning 10/1/24, the Administrator or designee will discuss any incidents that may have occurred in the home from the day prior with staff. If any allegations of abuse or neglect were reported and/or witnessed, the Administrator or designee will audit the report sent to the Department to ensure it was sent timely.

Directed Completion Date: *10/10/2024*

Implemented [redacted] - 12/10/2024)

18 - Compliance With Laws

5. 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

On [redacted] at approximately 10:20AM, the carbon monoxide alarm located in the basement was not labeled with the date of installation as per the Care Facility Carbon Monoxide Alarm Standards Act.

Repeated Violation 3/20/2024, 12/5/23, et al.

Plan of Correction ***Accept ([redacted] - 09/23/2024)***

• On [redacted] the battery in the carbon monoxide alarm located in the basement was replaced with a new battery and dated by the designee.
• The Administrator educated the designee and all staff personally of this regulation on or before 9/2/24. This regulation will also be included in a form staff training 10/9/2024.
• Beginning 9/1/24 monthly audits of all carbon monoxide alarms will be completed by the Administrator or designee to ensure the batteries are labeled with the date of installation and replaced at least once annually or at such a time as the carbon monoxide alarm signals a drained or failing battery, whichever is sooner.
• Completed monthly audits will be kept by the home and available for review by the Department.

Licensee's Proposed Overall Completion Date: *10/09/2024*

Implemented [redacted] - 12/10/2024)

42b - Abuse

6. 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.

Description of Violation

Resident [redacted] reported to an agent of the Department on [redacted] at approximately 3:30PM that [redacted] had bitten

42b - Abuse (continued)

Resident [redacted] at nighttime a couple of weeks prior. Resident [redacted] stated that [redacted] doesn't like the Resident [redacted] because the resident wanders upstairs and opens Resident [redacted] room door. Three other residents of the home and Resident [redacted] later reported on [redacted] to the agent of the Department that Resident [redacted] had bitten Resident [redacted] approximately four times on the arm that night, drawing blood. Staff Member A later confirmed to the home's Administrator after the on-site inspection that [redacted] overheard a "commotion" upstairs during a 10:00PM shift at the home after which Resident [redacted] was agitated with Resident [redacted] and Staff Member A separated the two residents. Staff Member A was informed by residents during [redacted] next work shift that Resident [redacted] had bitten Resident [redacted] on the arm. Resident [redacted] confirmed to Staff Member A that this occurred. A skin tear was observed where the resident stated [redacted] was bitten.

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

• Resident [redacted] answers "yes" to all questions. Resident [redacted] does not remember the names of long term staff members that are in the home working daily. Resident [redacted] does not remember events that have happened in the past. The Administrator and staff does not believe that Resident [redacted] was bitten.

• The Administrator spoke to Staff Member A regarding the incident between Resident #[redacted] and Resident [redacted]. Staff Member A could not remember the date, but [redacted] stated at the 10pm shift change, when [redacted] came in the door she heard some commotion at the top of the steps. [redacted] stood at the bottom of the steps and asked what was going on. Resident [redacted] was yelling about Resident [redacted] walking around. Staff Person A asked Resident [redacted] to come down stairs a minute and said to Resident [redacted] [redacted] coming down stairs, go ahead back to bed, so [redacted] did. Staff Person A never walked upstairs, never "split-up" a fight and when Resident [redacted] came down stairs staff asked [redacted] if [redacted] was okay [redacted] said [redacted] was and [redacted] seemed fine and normal. Staff didn't notice any marks, ect. on [redacted]. All the other residents were in bed during this commotion. The next time Staff Member A went into work, Resident [redacted] and other residents told [redacted] that Resident [redacted] had bit Resident [redacted]. Resident [redacted] showed staff the spot [redacted] supposedly bit [redacted]. Staff immediately looked at the spot and said the mark was a skin tear that Resident [redacted] previously had and it did not resemble a bite at all.

• After investigation, Administrator and staff does not believe that Resident [redacted] was bitten. Resident [redacted] is known to make up stories for attention and at the moment [redacted] has some health issues going on which is making this behavior for [redacted] worse. Other residents in the home are very annoyed with Resident [redacted], they are repeating the story that has been told to them by Resident [redacted] in hopes of [redacted] "having to move from the home".

• By 10/10/24, staff will be trained on all types of incident reporting and staff will be instructed to inform the Administrator or designee of any instances that should be reported to AAA or the Department. The Administrator and designee will continue to remind staff of this regulation throughout the year and have conversations with staff and residents to ensure that all incidents, even allegations of abuse are reported to to AAA and the Department.

• Documentation of staff education will be kept by the home and available for review by the department.

• Staff will regularly monitor Resident [redacted] and investigate all allegations that Resident #4 speaks of along with any allegations told to staff by any resident.

(Directed)

In addition to the above plan of correction:

- *The Administrator or designee will provide staff with education on abuse as well as positive interventions and resident rights. Training to be completed by 10/10/24.*
- *A review of Resident [redacted] assessment and support plan, including the resident's supervision needs, will be completed by the Administrator or designee by 10/10/24 to determine if the home can continue to meet Resident [redacted] needs.*
- *Resident [redacted] will be counseled by the Administrator or designee regarding resident rights and abuse by 10/10/24.*

42b - Abuse (continued)

- *Documentation of resident counseling, staff training and the updated assessment and support plan will be kept by the home and available for review by the Department.*

Directed Completion Date: *10/10/2024*

Implemented (- 12/10/2024)

64c - Annual Training

7. Requirements

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

Description of Violation

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

Plan of Correction ***Accept - 09/23/2024)***

• The Administrator received 7.5 hours of in person training in the training year of 2023.
• The Administrator will ensure to schedule at least 24 hours annually of continuing education and only 12 hours of that time will be completed online.
• Beginning 10/01/24, the Administrator will keep a log of training hours scheduled to ensure all training hours are completed and in the appropriate manner.
• At this time the Administrator has received 6.5 in-person training hours for 2024 and is registered to attend a 6 hour training course on 10/24/2024.
• Please see attachments.

Licensee's Proposed Overall Completion Date: *10/01/2024*

Implemented - 12/10/2024)

82b - Poisonous Material Storage

8. Requirements

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

Description of Violation

On at approximately 10:51AM, two bottles of 2-in-1 toilet cleaner and a box of Pure Bright Germicide Ultra Bleach bottles were stored on the floor area of the home's outside dry food storage shed which contains packages of food and drinks.

Plan of Correction ***Accept - 09/16/2024)***

• The 2-in-1 toilet cleaner and Pure Bright Bleach were moved out of the food storage area on 08/28/24 by the designee.
• Education will be provided to all staff by 10/10/24 informing them that poisonous materials cannot be kept in the

82b Poisonous Material Storage (continued)

food storage areas.

• Beginning 9/1/24 the Administrator or designee will do monthly audits to ensure that poisonous materials are not located in the food storage areas.

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

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 12/10/2024)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

On [redacted] at approximately 10:15AM, reddish brown smears of blood were observed on the hallway walls adjacent to the 2nd floor bathroom and in the 2nd floor resident hallway by the front of the home.

Plan of Correction ***Accept [redacted] - 09/16/2024)***

• On 08/27/24 the hallway walls adjacent to the 2nd floor bathroom and the 2nd floor resident hallway by the front of the home were cleaned and sanitized.

• Staff were all spoken to individually regarding this regulation and sanitary conditions. Formal education will be provided to all staff on or before 10/10/24. Beginning 9/1/24 the Administrator or designee will perform weekly walk throughs to ensure that sanitary conditions are maintained throughout the home.

• Documentation of education and completed audits will be kept by the home for review by the Department.

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 12/10/2024)

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 [redacted] at 10:42AM, a 1' x 2' section of the faux wood linoleum in Room [redacted] was observed to be missing, exposing the sub flooring.

Plan of Correction ***Directed [redacted] - 09/23/2024)***

• The Administrator will ensure that linoleum in Room [redacted] will be replaced on or before 11/1/24. The work will be completed by a private individual and begin no later than 10/15/24. The home is unable to find a contractor or private individual in our remote location to complete this repair any sooner than indicated.

• Staff will be educated of the importance to report any issues of surfaces not being in clean, good repair and free of hazards to the Administrator or designee.

88a Surfaces (continued)

• Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify areas where maintenance is required. Maintenace and repairs will be completed in a timely manner. The home will strive to have all maintenance and repairs completed within 30 days depending on the particular repair needed and the schedule of a contractor or a private individual.
• Documentation of the staff education and weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.

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

- *Staff will be educated of the importance to report any issues of surfaces not being in clean, good repair and free of hazards to the Administrator or designee by 10/10/24.*
- *Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify areas where maintenance is required. Maintenance and repairs will be completed in a timely manner. Areas being identified as a hazard will be repaired within 1 week. The home will strive to have all other maintenance and repairs completed within 15 days depending on the particular repair needed and the schedule of a contractor or a private individual.*

Directed Completion Date: *10/15/2024*

Implemented [redacted] - 12/10/2024)

93a - Handrails

11. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On [redacted] at 10:50AM, the right ascending handrail on the exterior fire escape from the ground leading up to the second landing was observed to be loose and wobbly with minimum weight applied to it.

Repeated Violation 12/5/23, et al.

Plan of Correction ***Accept [redacted] 09/23/2024)***

• On 09/05/24, the hand railing was tightened and secured to the structure preventing it from being loose and wobbling by a private individual.
• Staff will be educated formally by 10/10/24 of the importance to report any issues with ramps, interior stairways or outside steps being well secured to the Administrator or designee.
• Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify areas where maintenance is required and also checking that all handrails are secure.
• Documentation of the staff education and weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.

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

93a - Handrails *(continued)*

Implemented [redacted] - 12/10/2024)

95 - Furniture and Equipment

12. Requirements

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

Description of Violation

On [redacted] at 3:16PM, the second floor bathroom faucet was leaking through the handle and creating a pool of water on the floor between the toilet and the sink, thus causing a slipping hazard.

On [redacted] at 10:18AM, a faceplate was observed to be missing from a light switch in the dining room near front entrance, exposing the wiring for the switch.

On [redacted] at 12:07PM, the Whirlpool refrigerator located in the kitchen was leaking fluid onto the kitchen floor, creating a slipping hazard.

Repeated Violation - 12/5/23, et al.

Plan of Correction ***Directed [redacted] 09/23/2024)***

• On [redacted], a private individual tightened a screw in the faucet preventing it from continuing to leak. A new faucet will be installed on or before [redacted] to ensure that the screw does not loosen allowing the faucet to leak again. Staff were educated to inform the Administrator or designee if they notice the faucet leaking once again. The Administrator or designee will also do weekly walk through checking the faucet to ensure it is not leaking.
• On [redacted] a new faceplate was installed by the designee. Staff were educated to inform the Administrator or designee if they notice any faceplates missing throughout the home. The Administrator or designee will also do monthly audits ensuring all faceplates are present in the home.
• A repair company fixed the refrigerator 09/12/24. Please see attached invoice.
• Staff will be educated of the importance that all furniture and equipment are in good repair, clean and free of hazards. Staff will be educated on or before 10/10/24 to report any issues to the Administrator or designee.

• Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to ensure all furniture and equipment is in good repair, clean and free of hazards. Maintenace of furniture and equipment and repairs needed will be completed in a timely manner. The home will strive to have all maintenance and repairs completed within 30 days depending on the particular repair needed and the schedule of a contractor or a private individual.
• Documentation of the staff education and weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.
**** the repair of the faucet is technically completed, as nit no longer leaks; we will have a new, permanent faucet on or before 11/01/24. I understand the department has an urgency to get some things repaired in a timely manner, but in our rural area and the small number of private individuals or contractors available to complete repair work our time frames are limited.*

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

95 Furniture and Equipment (continued)

- *Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to ensure all furniture and equipment is in good repair, clean and free of hazards Maintenance of furniture and equipment repairs will be completed in a timely manner. Areas being identified as a hazard will be repaired within 1 week. The home will strive to have all other maintenance and repairs completed within 15 days depending on the particular repair needed and the schedule of a contractor or a private individual.*
- *The repair of the faucet is technically completed as of 9/23/24, as it no longer leaks; we will have a new, permanent faucet on or before 11/01/24.*

Directed Completion Date: *10/10/2024*

Implemented [redacted] - 12/10/2024)

96a - First Aid Kit

13. 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

On [redacted], the home's First Aid kit did not contain a thermometer.

Plan of Correction ***Accept ([redacted] - 09/16/2024)***

• On 08/28/24 a new, working thermometer was placed in the first aid kit.
• Education will be provided to all staff by 10/10/24 informing and reminding them to be sure all items are in the first aid kits and that they are in working order.
• Beginning 9/1/24 the Administrator or designee will do monthly audits to ensure that all items are in the first aid kits and working properly.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 12/10/2024)

100a - Exterior - Free of Hazards

14. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On [redacted] at 10:50AM, the upper and lower landings of the exterior wooden fire escape have approximately seven loose planks which are missing nails and not secured. The planks can easily be lifted off both sides of the landing base, causing a safety risk for residents.

Plan of Correction ***Directed [redacted] - 09/23/2024)***

• On 09/05/24, the upper and lower landings and the entire exterior wooden fire escape was repaired adding more screws and securing all wood planks by a private individual.

• Staff will be educated by the Administrator and designee by 10/10/24 of the importance to report any issues with

100a Exterior Free of Hazards (continued)

the exterior of the building and the building grounds and yard ensuring all areas are in good repair and free of hazards.

• Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify areas where maintenance is required and also checking that all areas of the home are in good repair and free of hazards. Maintenace and repairs will be completed in a timely manner. The home will strive to have all maintenance and repairs completed within 30 days depending on the particular repair needed and the schedule of a contractor or a private individual.

• Documentation of the staff education and weekly walkthroughs will be retained by the home for review by the department, and the documentation will include all issues found.

(Directed)

In addition to the above plan of correction:

- *Beginning 9/1/24, the Administrator or designee will conduct a walkthrough of the interior and exterior of the building on a weekly basis to identify areas where maintenance is required and also checking that all areas of the home are in good repair and free of hazards. Maintenance and repairs will be completed in a timely manner. The home will strive to have all maintenance and repairs completed within 15 days depending on the particular repair needed and the schedule of a contractor or a private individual. Areas being identified as a hazard will be repaired within 1 week.*

Directed Completion Date: *10/10/2024*

Implemented [redacted] 12/10/2024)

102h - Toilet Paper

15. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On [redacted] at 10:09AM, there was no toilet paper available in the second floor bathroom.

On [redacted] at 10:34AM, there was no toilet paper available in the first floor shower bathroom located by resident rooms.

Plan of Correction ***Accept [redacted] - 09/16/2024)***

• Toilet paper was immediately placed in both bathrooms on 08/27/24 by the designee.

• On 8/30/24 education was provided to all staff individually and by 10/10/24 it will be rediscussed at a formal staff training that toilet paper is required in all bathrooms.

• Beginning 9/1/24 the Administrator or designee will do weekly walk throughs throughout the home to ensure that there is toilet paper available in all bathrooms at all times.

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

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 12/10/2024)

103e - Left Overs

16. 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

On [redacted] at 10:30AM, the white refrigerator in the kitchen had an unlabeled, undated Ziplock bag containing cooked meat. Per Staff Member C, the meat was leftover pork.

Plan of Correction ***Accept [redacted] - 09/23/2024)***

• The Ziplock bag of meat was immediately discarded by the designee.
• The Administrator informally educated each staff member that all food items must be labeled and dated.
• Administrator or designee will continue to educate and remind staff of this and will go over it again formally during a staff training held on or before 10/10/24. • The Administrator or designee will conduct weekly audits of the refrigerators and freezers to ensure that all food items are labeled and dated on 09/16/24.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department.

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

Implemented [redacted] 12/10/2024)

124 - Notice to Fire Department

18. Requirements

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

Description of Violation

On [redacted], the home's documentation of written notification to the local fire department of the assistance needed to evacuate in an emergency was inaccurate. The document dated [redacted] indicates that there were no immobile residents in the home. However, Resident [redacted] assessment and support plan, dated [redacted] indicates Resident [redacted] requires full staff assistance for transfers and total staff assistance in the event of an emergency. Resident [redacted] medical evaluation, dated [redacted] also indicates the resident requires total staff assistance to evacuate in an emergency.

Plan of Correction ***Accept ([redacted] 09/23/2024)***

• The Administrator documented that Resident [redacted] needed assistance on the fire evacuation plan to the local fire department, however, did make an error in the letter.
• The Administrator updated the letter to the fire department correcting the error and re-sent it to them on 09/11/24.
• The Administrator will be more mindful when writing the letters to the local fire department providing them with correct information so they can better assist our facility in case of an emergency.
• Annually or as needed, the Administrator and designee will both review the letters written to the fire department so ensure accuracy beginning 09/22/2024..
• Please see attached documents.

Licensee's Proposed Overall Completion Date: *09/22/2024*

Implemented [redacted] - 12/10/2024)

142b - Refusal-Medical Treatment

19. Requirements

2600.
142.b. If a resident refuses routine medical or dental examination or treatment, the refusal and the continued attempts to educate and inform the resident about the need for health care shall be documented in the resident's record.

Description of Violation

As per hospital summary dated [redacted], Resident [redacted] fell at the home on [redacted] refused to go to the hospital at that time, and was diagnosed with a femur fracture. Staff reported that the resident often refuses medical care, including physical therapy and recommendation to go to the hospital on [redacted] due to a change in medical condition. Resident [redacted] refusals and continued attempts to educate and inform the resident about the need for health care were not documented in the resident's record.

Plan of Correction ***Accept ([redacted] 09/23/2024)***

- *On [redacted], Resident [redacted]s RASP and his other resident records were updated to include the resident's refusals for medical care and or dental treatments by the Office Assistant.*
- *Staff will be educated by the Administrator and designee on Regulation 2600.142(b) as well as the homes practices to still call for emergency service on or before 10/10/24.*
- *The staff will continue to educate Resident [redacted] of the importance of proper healthcare.*
- *Education will be randomly in general and also if there is an urgent need for healthcare.*
- *If Resident [redacted] is in need of healthcare from a hospital, ect. and Resident #6 is refusing, staff will still call for emergency services and allow Resident [redacted] to refuse healthcare and assistance to EMS.*
- *Staff will document the attempts to educate Robert of the importance of proper healthcare. Resident education will be provided by the Office Assistant, designee and Administrator. Documentation of this resident education will be kept in the resident file. Resident education regarding Regulation 2600.142(b) began on 09/09/24, by the Office Assistant.*
- *Please see attached documents.*

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

Implemented [redacted] - 12/10/2024)

144c1 - Smoking Area Guidelines

20. 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:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On [redacted] at approximately 10:49 AM, 100+ cigarette butts were observed in a plastic, non-fire resistant storage container and on the ground around the corner from the rear office exit, which is not a designated smoking area per the home's smoking policy.

144c1 Smoking Area Guidelines *(continued)*

Plan of Correction ***Accept [redacted] - 09/16/2024)***

• The plastic bin containing cigarette butts were butts put into the bin days after being extinguished. The butts were previously extinguished and were not hot or warm when put into the plastic bin.
• The plastic bin was removed by the designee on 8/28/24.
• Staff and residents were educated on the proper safeguards regarding smoking. This will also formally be discussed and training provided at our staff training on or before 10/10/24.
• Starting 9/1/24, the Administrator or designee will conduct monthly audits of the homes outside areas to ensure that all cigarette butts are placed in the dumpster after being extinguished and not in any type of container near the home.
• Documentation of the staff training and these audits will be kept by the home for review by the Department.

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 12/10/2024)

162c - Menus Posted

21. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] at 10:03AM, the home's menu for the week of [redacted] was posted in both the resident dining area as well as in the kitchen. However, the home did not have a menu posted 1 week in advance.

Repeated Violation 12/5/2023 et al

Plan of Correction ***Accept [redacted] - 09/16/2024)***

• Menu's were updated and posted in the resident dining area by the Administrator and designee on 8/30/24.
• All staff were informed that menus must be current and posted one week in advance and hung in the resident dining area. A formal training will be conducted by 10/10/24.
• Beginning 9/1/24, the Administrator or designee will complete weekly audits to ensure a current weekly menu and a menu for one week in advance are posted in the resident dining area.
• Documentation of the training and completed audits will be kept by the home and available for review by the Department.

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] 12/10/2024)

183d - Prescription Current

22. Requirements

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

183d - Prescription Current *(continued)*

Description of Violation

On [redacted] at 3:23 PM, [redacted] prescribed for Resident [redacted] was in the home's medication cart; however, the medication was discontinued on [redacted].

Plan of Correction ***Accept [redacted] - 09/16/2024)***

• On [redacted] the [redacted] for Resident [redacted] was discarded by the designee.
• Education was provided on an individual basis to all staff and a formal staff training will be held on or before 10/10/24, informing staff that all discontinued medications must be removed from the medication cart immediately when discontinued.
• An initial audit of med cart was conducted on 09/02/24 to ensure all medications in the med cart are current.
• Beginning 9/1/24, the Administrator or designee will complete monthly audits of the med cart to ensure that only current medications are in the med cart.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 12/10/2024)

225a - Assessment 15 Days

24. Requirements

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

Description of Violation

On [redacted] at approximately 9:10AM, agents of the Department observed Resident [redacted] lower calves and feet to be dark purple in color, with small scabs, flaking skin and overgrown toenails. Staff reported that resident has received podiatry and medical care for these conditions and was evaluated for hospice services, which [redacted] declined. Additionally, staff report sitting Resident [redacted] up after meals to ensure [redacted] does not aspirate food. Staff reported that the dark purplish color of [redacted] legs is alleviated when [redacted] legs are elevated and that [redacted] skin flakes due to psoriasis. Staff stated that [redacted] has small scaley patches at the base of the neck, on [redacted] right arm and on [redacted] shoulder that they ensure they do not put cream on, rather around it, to prevent it from bleeding. These needs and supports are not reflected in the resident's most recent assessment dated [redacted]

Plan of Correction ***Directed [redacted] 09/23/2024)***

• Resident [redacted] updated information was added to the assessment on 09/09/2024 by the Office Assistant. Please see attachment.
• On 08/30/2024 office staff were reminded and trained that all significant changes must be updated on the assessment form by the Administrator and designee.
• Administrator and designee performed an initial audit on all current resident's RASP's by 9/21/24. Beginning October 2024, monthly audits of resident records and RASP's will be performed to ensure that all assessments and RASP's are up to date with current information by the Administrator or designee.
• Documentation of the trainings and completed audits will be kept by the home for review by the Department

225a - Assessment 15 Days (continued)

(Directed)

In addition to the above plan of correction:

- *Beginning October 1, 2024, monthly audits of resident records and RASP's will be performed to ensure that all assessments and RASP's are up to date with current information by the Administrator or designee.*

Directed Completion Date: *10/01/2024*

Implemented [redacted] - 12/10/2024)