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

February 5, 2025

[redacted], COO
PETER BECKER COMMUNITY
800 MAPLE AVENUE
ATTN:DIRECTOR OF PERSONAL CARE
HARLEYSVILLE, PA, 19438

RE: PETER BECKER COMMUNITY
800 MAPLE AVENUE, 1ST FLOOR
HARLEYSVILLE, PA, 19438
LICENSE/COC#: 12773

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/17/2024, 09/18/2024 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: *PETER BECKER COMMUNITY* **License #**: *12773* **License Expiration**: *06/09/2025*

Address: *800 MAPLE AVENUE, 1ST FLOOR, HARLEYSVILLE, PA 19438*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *PETER BECKER COMMUNITY*

Address: *800 MAPLE AVENUE, ATTN:DIRECTOR OF PERSONAL CARE, HARLEYSVILLE, PA, 19438*

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *07/30/1974* **Issued By**: *Dept of Labor and Industry*

Type: *I-1* **Date**: *03/20/2011* **Issued By**: *Township of Franconia*

Type: *I-2* **Date**: *08/15/2012* **Issued By**: *Township of Franconia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/18/2024*

Inspection Dates and Department Representative

09/17/2024 - On-Site: [redacted]

09/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *68* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lakespur Lane* **Capacity**: *11* **Residents Served**: *9*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*

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

Have Mobility Need: *19* **Have Physical Disability**: *0*

Inspections / Reviews

09/17/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/11/2024*

Inspections / Reviews *(continued)*

10/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/18/2024*

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

10/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/18/2024*

Reviewer: [redacted]*r* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/01/2024*

02/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/18/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 9/18/2024, at 9:34 AM, resident medical records left visible on a computer screen in the unlocked, unattended, Westview/Ridgeview medication room. There was no staff member in the room or immediate area.

Plan of Correction ***Accept (- 10/31/2024)***

Residents' Medical Record will not be left visible on the computer screen in the unlocked, unattended medication room.

Staff will be re-in-serviced to exit out of their screen so protected information is not visible by October 31st, 2024 by a Registered Nurse.

Director of Personal Care/Designee will spot check weekly for 4 weeks, and then monthly for 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented (- 01/15/2025)

41e - Signed Statement

2. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 1, 2, and 3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept (- 10/31/2024)***

Residents 1, 2 and 3 received and signed statements acknowledging receipt of the resident rights and complaint procedures -- attached. Resident 1 signed the statement on 10/10/24; resident 2 signed the statement on 10/10/2024 and resident number 3 signed the statement on 10/10/24.

Initial audit of all current resident records will be done by 11/15/24 and then it will be audited for all new admissions monthly x 6 months by Director of Personal Care/Designee.

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented (- 01/15/2025)

42s - Privacy

3. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

42s - Privacy *(continued)*

Description of Violation

On 9/17/2024 at 9:28 am, a camera on the ceiling in the Westview area was pointing down a hallway with a view of a resident's room. Due to the camera's angle a resident could been seen exiting and entering ████ room. Staff indicated the camera was recording. There was no sign near the camera indicating that it was recording.

Plan of Correction ***Directed (██ - 10/31/2024)***

Signs were installed by all cameras in personal care to indicate that the camera was recording on 9/20/24. Facilities department has provided in-services to staff who will monitor cameras for compliance monthly on 11/10/24.

Directed POC: In addition to the above plan of correction, the monthly monitoring for appropriate signage shall begin within 7 calendar days of the completion of the staff in-service training. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (██ - 01/15/2025)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed (██ - 10/31/2024)***

Attached please find educational information for Staff Person A. Staff person A was hired in ███ and has resigned. Human Resources Department will audit personal care staff files for compliance with the educational requirements. The HR Department is updating their hiring process to include sign off approval of qualifications of each candidate.

Directed POC: Within 10 business days of the receipt of this POC, the administrator or designee shall audit all current direct care staff to ensure documentation of their qualifications is present in their file. Should any document be missing or non-compliant with educational requirements as defined in the Regulatory Compliance Guide, that staff person shall be removed from the schedule until the appropriate documentation/verifications have been received. Going forward the administrator or designee shall audit new employee files prior to their first scheduled shift to ensure correct qualifications and documentation are present in the employees file. Documentation of completed trainings, and completed audits shall be kept and made available to the Department upon request.

Directed Completion Date: *11/15/2024*

Implemented (██ - 01/15/2025)

54a - Direct Care Staff *(continued)*

62 - Contact List

5. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person █ the administrator, maintains a list of staff persons that does not include substitute staff.

Plan of Correction ***Directed (█ - 10/31/2024)***

Our electronic scheduling system has a list of all staff who are available to work. This list can be printed at any time. Scheduler will be re-in-services to maintain a list of all staff who are available to work, including agency staff.

Directed POC: The administrator or designee shall provide in-service training to the scheduler within 10 business days of the receipt of this plan of correction. The training shall include maintaining a complete list of all staff who work in the Personal Care/SDCU and the requirement to provide a full and accurate list to agents of the Department upon request. Documentation of trainings shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/15/2024*

Implemented (█ - 01/15/2025)

63a - First Aid/CPR Training

6. 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 9/3/2024, from 11:30 PM to 7:30 AM, 55 residents were present in the home. During this time no staff persons were present in the home who was certified in first aid, obstructed airway techniques and CPR.

On 9/11/2024, from 3:30 PM to 7:30 AM the next day, 55 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On 9/14/2024, from 3:30 PM to 7:30 AM the next day, 55 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept (█ - 10/31/2024)***

Attached staff on the night shift have received CPR training.
A spread sheet was created 10/25/24 with the names of personal care staff, date of CPR and First Aide Training and expiration dates for each staff member by the HR Assistant and Scheduler. Personal Care Director/Designee will monitor monthly x 6 months to ensure compliance with training. Staff members who do not have the above certificates will be offered a class by the end of November 2024.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

65a - FS Orientation 1st Day

7. Requirements

2600.

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

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

Description of Violation

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

Plan of Correction ***Directed ([redacted] - 10/31/2024)***

Attached please find the orientation for staff C, D and E. Fire Safety/Disaster Plan -- includes a tour pointing out fire safe walls/areas of where to evacuate, staff duties during fire drills or emergency procedures, transportation, no smoking policy, location of smoke detectors and fire alarms as well as the use of fire extinguishers.
Newly hired staff will receive all 1st day requirements training during orientation by Sr. Director of Facilities/Designee, effective immediately. Above education was provided to PBC staff on October 15th, 2024.
Staff person D has resigned [redacted] position.

Directed POC: Within 10 business days of the receipt of this POC, the administrator or designee shall audit all current staff to ensure initial training or re-training has been conducted and documented for each staff person. Should any employee be found to be out of compliance, an in-service training for that employee shall be conducted prior to their next scheduled shift. Going forward the administrator or designee shall audit new employee files monthly to ensure completion of training and to ensure documentation is present in the employees file. Documentation of completed trainings, completed audits and any needed in-service/re-education shall be kept and made available to the Department upon request.

Directed Completion Date: *11/15/2024*

Implemented ([redacted] - 01/15/2025)

65b - Rights/Abuse 40 Hours

8. Requirements

2600.

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

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

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

Description of Violation

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

Plan of Correction ***Accept ([redacted] - 10/31/2024)***

Attached please find staff person E's education on all areas above, except for emergency medical plan.
in-services on Emergency Medical Plan will be provided to staff by November 15, 2024.
New staff receive Emergency Preparedness, resident rights, mandatory reporting of abuse and neglect training on the first day of employment, before they go to their assigned areas -- HR/Designee will monitor for compliance after each new employee orientation day x 3 months. Director of Personal Care/Designee will monitor for compliance of Emergency Plan education for new staff x 3 months.

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented ([redacted] - 01/15/2025)

65d - Initial Direct Care Training

9. Requirements

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

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.

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

xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person G, hired on [redacted], began providing unsupervised ADL services on [redacted] However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice, complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Directed ([redacted] - 10/31/2024)***

Staff person G will be provided training to include above listed topics by Nov. 15, 2024.

Personal Care Director/Designee will monitor for compliance of training for new staff on all topics above before they are able to have provide direct care and will audit monthly for compliance.

Directed POC: Within 10 business days of the receipt of this POC, the administrator or designee shall audit all current direct care staff to ensure initial training has been conducted and documented for each staff person. Should any employee be found to be out of compliance, an in-service training for that employee shall be conducted prior to their next scheduled shift. Going forward the administrator or designee shall audit new employee files monthly to ensure completion of training and to ensure documentation is present in the employees file. Documentation of completed trainings, completed audits and any needed in-service/re-education shall be kept and made available to the Department upon request.

Directed Completion Date: *11/22/2024*

Implemented ([redacted] - 01/15/2025)

65f - Training Topics

10. 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 medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, safe management techniques during training year 7/1/2023-6/30/2024.

Direct care staff person D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, safe management techniques during training year 7/1/2023-6/30/2024.

65f - Training Topics (continued)

Direct care staff person H did not receive training in medication self-administration training during training year 7/1/2023-6/30/2024.

Plan of Correction ***Directed (█ - 10/31/2024)***

Staff A and H will receive the above training by October 30th, 2024. Staff D has resigned █ position. Personal Care Director/Designee will monitor staff records for above education x 4 months.

Directed POC: Within 10 business days of the receipt of this POC, the administrator or designee shall audit all current direct care staff to ensure annual training has been conducted and documented for each staff person. Should any employee be found to be out of compliance with annual trainings for the current training year, an in-service training shall be scheduled for them as soon as possible. Going forward the administrator or designee shall audit employee files monthly to ensure completion of training in accordance with the training plan and to ensure documentation is present in the employees file. Documentation of completed trainings, completed audits and any needed in-service/re-education shall be kept and made available to the Department upon request.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

65i - Training Record

11. Requirements

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

Description of Violation

The home's record of direct care staff training for annual in-person PC fire safety does not include the source of the training.

Plan of Correction ***Accept (█ - 10/31/2024)***

Going forward, the training documentation will include source of the training for staff. This will be monitored by the Personal Care Director/Designee beginning Nov. 1, 2024 monthly, times six months.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

82c - Locking Poisonous Materials

12. Requirements

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

Description of Violation

On 9/17 at 10:07 AM a bottle of foaming hand sanitizer, with a manufacture's label indicating "if swallowed call poison control", was unlocked, unattended, and accessible to residents in the Secure Dementia Care Unit (SDCU) dining area in the upper cabinets on the right side.

82c - Locking Poisonous Materials (continued)

On 9/17 at 10:11 AM Medline anti-perspirant, Kissable oatmeal daily moisturizing lotion and Soft Whisper shampoo and conditioner, all with a manufacture's label indicating "if swallowed call poison control", were unlocked, unattended, and accessible to residents in the bathroom of room 9.

Not all the residents of the home, including residents in the SDCU, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Directed (█ - 10/31/2024)***

Foaming hand sanitizer, anti-perspirant, daily moisturizer lotion, shampoo and conditioner were immediately removed from the dining area and residents' rooms, respectively. The re-in-services of the staff will be completed by 10/30/24. Audits for compliance will be performed bi-weekly x 3 months by Personal Care Director/Designee.

Going forward, residents in the SDCU will be assessed for capability of recognizing and using poisons safely.

Directed POC: In addition to the above plan of correction, the bi-weekly monitoring shall be defined as two times a week for 3 months, then weekly monitoring shall be conducted for at least two additional months or longer until compliance is maintained. Additionally, the Administrator or designee shall ensure that residents in the SDCU are assessed appropriately for the specific kinds of poisonous toiletry items as defined in the Regulatory compliance guide. Documentation of the assessments for residents and abilities to use toiletry items safely shall be kept in the residents file and reviewed at least annually. Additionally, if a resident is determined to be able to use toiletry items safely, those items must still be secured safely to prevent access by any other resident in the home who has not been assessed as capable of recognizing or safely using those items. Documentation of completed trainings and completed audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

85a - Sanitary Conditions

13. Requirements

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

Description of Violation

On 9/17 at 10:02 AM, there was a large brown, dried sticky soda-like residue in the SDCU dining area, on the bottom of the upper cabinets on the right side.

Plan of Correction ***Directed (█ - 10/31/2024)***

Large, brown, dried sticky soda-like residue was cleaned and removed in the SDCU dining area from the bottom of the upper cabinets on the right side.

Housekeeping and Memory Care Staff will monitor for spillage and clean any affected areas. Director of Personal Care/Designee will monitor weekly times 3 months for compliance.

Directed POC: In addition to the above plan of correction, the weekly monitoring shall begin within 10 business days of the receipt of this plan of correction. Documentation of any completed trainings and completed audits shall be kept and made available to the Department upon request for verification.

85a - Sanitary Conditions *(continued)*

Directed Completion Date: *11/15/2024*

Implemented (█ - 01/15/2025)

91 - Telephone Numbers

14. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in Rooms: WV-130, WV- 138, and LL-5.

Plan of Correction ***Accept (█ - 10/31/2024)***

A list of Emergency Telephone numbers has been placed by each telephone with an outside line.

Director of Personal Care/Designee will audit quarterly to ensure compliance, beginning in November of 2024..

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

100a - Exterior - Free of Hazards

15. 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 9/17/24 at 10:07 AM, an open orange bucket with broken terracotta pots was in the garden station of the memory care courtyard and easily accessible to residents.

Plan of Correction ***Directed (█ - 10/31/2024)***

Open orange bucket with broken terracotta pots in the garden was removed immediately.

Staff will be re-in-serviced by 10/30/24 to remove any sharp or harmful objects from the garden. Director of Personal Care/Designee will monitor monthly for compliance.

Directed Plan of Correction: Directed POC: In addition to the above plan of correction, and within 10 business days, the Administrator or Designee shall monitor the exterior of the home weekly for 2 months then monthly thereafter for exterior hazards/obstructions/debris. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

105g - Lint Removal and Duct Cleaning

16. Requirements

105g - Lint Removal and Duct Cleaning *(continued)*

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 9/17/2024 at 9:32 AM, there was an approximate 1/4 inch accumulation of lint in the lint trap of the Ridgeview resident first floor dryer. There were no clothes in the dryer at the time.

Repeat Violation: 6/22/2024

Plan of Correction ***Directed (- 10/31/2024)***

The dryer lint was removed immediately.

Staff will be re-in-serviced on removing lint from each dryer after usage by October 30th, 2024. Signs have been placed by the dryers to remind and re-enforce removal of lint from the lint trap after each usage.
Housekeeping/designee will monitor for compliance weekly times 3 months..

Directed POC: In addition to the above plan of correction, the weekly monitoring of dryers shall begin within 7 calendar days of the completion of the staff in-service training. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (- 01/15/2025)

107b - Emergency Procedures

17. Requirements

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

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

Description of Violation

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

Plan of Correction ***Directed (- 10/31/2024)***

Our IT company has a system that backs up and updates all electronic medical records daily, including the name of each resident's designated person. In an emergency, the staff would take the laptop containing all this information and if for some reason we couldn't access our electronic medical record on our system, we would have access to it on our back up system. The back-up system is cloud based and can be accessed remotely.

The emergency plan will be updated to include the use of the electronic system to access contact information.

Directed Plan of Correction: In addition to the above plan of correction, the emergency plan/policy shall be updated within 10 business days of the receipt of this POC. Documentation of the updated plan shall be provided to the Department upon request.

107b - Emergency Procedures *(continued)*

Directed Completion Date: *11/15/2024*

Implemented (█ - 01/15/2025)

109a - Pets

18. Requirements

2600.
109.a. The home rules shall specify whether the home permits pets on the premises.

Description of Violation

The home rules indicate that only service pets are permitted in the home with a physicians order or documentation of the residents need for a service animal. However, the home does permit residents to have pets that are not service animals. The home has not updated their pet policy.

Plan of Correction ***Accept (█ - 10/31/2024)***

The pet policy was updated in September 2024, to reflect that the residents are allowed to have pets that are not service animals.
Residents have been aware of the pet policy for some time, but a formal education will be provided at the resident council meeting in November. New residents will be provided information on pet policy at admission.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

131e - Accessible Extinguishers

19. Requirements

2600.
131.e. Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

Description of Violation

On 9/17/24 at 9:53 AM the fire extinguisher in the Grand Oak kitchen was stored behind a large rack of cups and plates. The rack was pushed up against the fire extinguisher and is therefore inaccessible to staff.

Plan of Correction ***Directed (█ - 10/31/2024)***

The rolling rack was removed and it is now kept away from the fire extinguishers.
Staff will be re-in-serviced to not place items in front of the fire extinguishers. Sr. Director of Facilities/Designee will monitor weekly for compliance.

Use and storage of the fire extinguishers are discussed in the New Hire Orientation and annually.

Directed Plan of Correction: the above proposed in-service training and weekly monitoring shall begin within 10 business days of the receipt of this Plan of correction unless already completed. Documentation of trainings and audits/monitoring shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

131f - Fire Extinguisher Inspection

20. 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

On 9/17 at 9:55 am the fire extinguisher in the Primrose hall next to room 21 had not been inspected by a fire safety expert since 2019.

Plan of Correction ***Directed (- 10/31/2024)***

The fire extinguisher has been replaced with a current inspected extinguisher.
Sr. Director of Facilities/Designee will monitor random fire extinguishers monthly for inspection.

Directed POC: In addition to the above plan of correction the Sr. Director of Facilities or designee shall begin to monitor all fire extinguishers in the home monthly beginning in November 2024.

Directed Completion Date: *11/29/2024*

Implemented (- 01/15/2025)

132a - Monthly Fire Drill

21. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of 8/2024.

Plan of Correction ***Accept (- 10/31/2024)***

Fire drill was conducted during sleeping hours but the alarms were not activated.
Sr. Director of Facilities will re-in-service staff to ensure alarms are sounded during all fire drills. Sr. Director of Facilities/Designee will monitor monthly for compliance.
Going forward, alarms will be activated at every fire drill.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (- 01/15/2025)

132h - Designated Meeting Place

22. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The home has 2 separate Personal Care areas, and conducted fire drills do not include both areas for every drill. During the following fires drills not all the residents were evacuated to a designated meeting place outside of the home or withing the fire safe areas: 3/20/2024 at 11:00 AM, 4/18/2024 at 9:55 PM, 5/26/24 at 12:44 AM, and 7/26/24 at 4:44 PM.

Plan of Correction ***Accept (- 10/31/2024)***

Fire drills will be conducted simultaneously in both personal care areas each month.

132h - Designated Meeting Place (continued)

Sr. Director of Facilities will re-in-service staff to perform fire drills in both areas of personal care.
Sr. Director/Designee will monitor for compliance monthly.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented (- 01/15/2025)

141b1 - Annual Medical Evaluation

23. Requirements

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

Description of Violation

Resident 2's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

Plan of Correction ***Directed (- 10/31/2024)***

Medical evaluations for residents will be completed annually.
Wellness Nurse/Designee will monitor weekly to ensure compliance. Director of Personal Care/Designee will audit monthly to ensure compliance.

Directed POC- In addition to the above plan of correction, the weekly and monthly monitoring of resident DME's for compliance shall begin within 10 business day of the receipt of this POC. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (- 01/15/2025)

183e - Storing Medications

24. 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 9/18/2024 resident 4's Trelegy inhaler, was open and undated. According to the manufacturer's instructions this must be discarded 6 weeks after opening.

Resident 5's blister pack of Lorazepam tablet 0.5mg had the cardboard punctured on pill 19, which was taped over.

Resident 6's blister pack of Lorazepam tablet 0.5mg had punctured foil on pills 4 and 8. The pills were still in the packaging.

Plan of Correction ***Directed (- 10/31/2024)***

Resident 4's Trelegy inhaler was discarded and re-ordered.
Resident 5 and 6's punctured blister pack medications were discarded as per the policy.

183e - Storing Medications (continued)

Staff will be re-educated by a Registered Nurse by October 30, 2024 on proper storage of medication.
Director of Personal Care/Designee will monitor monthly for compliance.

Directed POC: In addition the the above plan and within 7 calendar days of the receipt of this POC, the Director of Personal Care or other Designee shall being a weekly audit of all medication storage areas to ensure compliance. Weekly audits shall be documented in detail and include specifics on what was monitored, any non-compliance items found, corrections made, the date of the audit and the name/signature of person completing the audit. Weekly audits shall continue for 3 months or longer if non-compliance continues to be identified. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

185a - Implement Storage Procedures

25. 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 7 is prescribed Aluminum-Magnesium-Simethicone suspension 200-200-20 MG/5ML as needed every 4 hours. On 9/18/24 this medication was not available in the home.

Resident 8 is prescribed glucose oral tablet ever 4 hours as needed, and Ipratropium-albuterol solution 0.5-2.5 3MG/3ML every 4 hours as needed. On 9/18/2024, this medication was not available in the home.

On 9/18/2024 resident 8's glucometer was not calibrated for the correct date and read 10/17.

Resident 8's blood glucose level was taken on the following days, however no readings were documented on the glucose record:
121 on 9/14/24 at 8 AM
69 on 9/17/2024 at 17:00
274 on 9/18/2024 at 7 AM

Plan of Correction ***Directed (█ - 10/31/2024)***

The medication mentioned above for resident s 7 and 8, not available at the time of the survey has been ordered, except for Ipratropium-albuterol solution prescribed to resident 8 which was discontinued by the physician.
The glucometer for resident 8 was calibrated and for the correct date.
Late entry notes were entered into the glucose record for resident 8.
Staff will be re-in-serviced by Registered Nurse by October 30, 2024 on safe storage, access, security, distribution and use of medications and medical equipment. Wellness Nurse/Designee will audit for compliance monthly x three months.

Directed POC: In addition the the above plan and within 7 calendar days of the receipt of this POC, the Director of Personal Care or other Designee shall being a weekly audit of all medication storage areas, a sample of 10% of resident MARS and medications, and glucometers to ensure compliance. Weekly audits shall be documented in

detail and include specifics on what was monitored, any non-compliance items found, corrections made, the date of the audit and the name/signature of person completing the audit. Weekly audits shall continue for 3 months or longer if non-compliance continues to be identified. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

185a - Implement Storage Procedures *(continued)*

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

187b - Date/Time of Medication Admin.

26. 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 6 is prescribed Lorazepam tablet 0.5mg once a day in the evening. This medication was administered on 9/17/2024 by staff person I according to the medication administration record; however, it is not documented as being administered on the resident's narcotic log, the narcotic log is documented as being received twice on 9/16/2024 at 1800.

Plan of Correction ***Directed (█ - 10/31/2024)***

Narcotic log was adjusted to reflect the correct date of administration of meds by staff.
Staff were re-in-serviced by a Registered Nurse on proper documentation on the narcotics log. Wellness Nurse/Designee will monitor for compliance weekly.

Directed POC: In addition the the above plan and within 7 calendar days of the receipt of this POC, the Director of Personal Care or other Designee shall being a weekly audit of all medication storage areas, a sample of 10% of resident MARS and medications, and glucometers to ensure compliance. Weekly audits shall be documented in detail and include specifics on what was monitored, any non-compliance items found, corrections made, the date of the audit and the name/signature of person completing the audit. Weekly audits shall continue for 3 months or longer if non-compliance continues to be identified. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

187d - Follow Prescriber's Orders

27. Requirements

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

Description of Violation

Resident 8 was prescribed NovoLOG injection solution 100 unit/ML, inject 8 units with meals, hold if under 100. However, resident 8 was administered 8 units on 9/12/24 at 8:00 am when █ glucose reading was 99, and was administered 8 units on 9/17/24 when █ glucose reading was 69.

Plan of Correction ***Directed (█ - 10/31/2024)***

Chart was reviewed and the resident did not exhibit any signs and symptoms of low blood sugar. Staff entered a late entry note to reflect charting error of documenting the insulin was administered.
Medication Technicians will receive re-education on appropriate medication administration and documentation.
Wellness Nurse/Designee will monitor monthly for compliance.

Directed POC: In addition the the above plan and within 7 calendar days of the receipt of this POC, the Director of Personal Care or other Designee shall being a weekly audit of all medication storage areas, a sample of 10% of resident MARS and medications, and glucometers to ensure compliance. Weekly audits shall be documented in

detail and include specifics on what was monitored, any non-compliance items found, corrections made, the date of the audit and the name/signature of person completing the audit. Weekly audits shall continue for 3 months or longer if non-compliance continues to be identified. Documentation of trainings and audits shall be kept and made available to the Department upon request for verification.

187d - Follow Prescriber's Orders *(continued)*

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

190c - Record of Training

28. Requirements

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

Description of Violation

The home's medication administration training record for staff person A and staff person E does not include documentation of successful completion of the training.

Plan of Correction ***Directed (█ - 10/31/2024)***

Personal Care Director/Designee will monitor staff medication administration training monthly and ensure education is provided as needed.

Attached please find medication administration training for staff E.
Staff A has resigned.

Directed POC: Within 10 business days of the receipt of this POC, the administrator or designee shall audit all current Med Tech staff files to ensure current medication administration training has been conducted and documented for each staff person. Should any employee be found to be out of compliance, the employee shall be removed from the schedule as a med tech until remediation training can be conducted. Going forward the administrator or designee shall audit Med Tech files monthly to ensure training is current and to ensure documentation is present in the employees file. Monthly audits shall continue for 3 months then quarterly thereafter. Documentation of completed trainings, completed audits and any needed in-service/re-education shall be kept and made available to the Department upon request.

Directed Completion Date: *11/29/2024*

Implemented (█ - 01/15/2025)

236 - Staff Training

31. Requirements

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

Description of Violation

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had only 4 hours of training in dementia care during the 7/1/2023 to 6/30/2024 training year.

Plan of Correction ***Directed (█ - 10/31/2024)***

Staff Person D successfully completed 6 hours of dementia care training. Please see attached.
HR Department/Designee will monitor annual completion for the additional six hours of dementia training for

236 - Staff Training (continued)

memory care staff.

Directed POC: Within 10 business days of the receipt of this POC, the administrator or designee shall audit all current direct care staff to ensure required annual dementia training hours have been completed and documented for each staff person. Should any employee be found to be out of compliance with annual trainings for the current training year, an in-service training shall be scheduled for them as soon as possible. Going forward the administrator or designee shall audit employee files monthly to ensure completion of training in accordance with the annual training plan and to ensure documentation is present in the employees file. Documentation of completed trainings, completed audits and any needed in-service/re-education shall be kept and made available to the Department upon request.

Directed Completion Date: *11/29/2024*

Implemented (- 01/15/2025)