



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 3, 2024

[REDACTED], Owner
Karen Adams
[REDACTED]

RE: The Adams House
License/COC #: 413711

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 29, 2024, and September 18, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 413710) dated March 13, 2023 – March 13, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 3, 2024 to June 3, 2025.

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

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

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
141(b)(1)	III	21	\$3	\$63	15 calendar days from mailing date of this letter
225(c)(1)	III	21	\$3	\$63	15 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED], Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 [REDACTED], Health and Welfare Building
 [REDACTED]
 PH: [REDACTED]

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

Sincerely,



Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [Redacted], Office of General Counsel
[Redacted] Bureau Director
[Redacted], Director of Operations
[Redacted], Regional Director

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

Facility Information

Name: *THE ADAMS HOUSE* License #: *41371* License Expiration: *03/13/2025*
Address: *314 FALLOWFIELD AVENUE, CHARLEROI, PA 15022*
County: *WASHINGTON* Region: *WESTERN*

Administrator

██████████ Phone: ██████████ Email: ██████████

Legal Entity

Name: *KAREN ADAMS*
Address: *314 FALLOWFIELD AVENUE, CHARLEROI, PA, 15022*
Phone: ██████████ Email: ██████████

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/02/1998* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *21* Waking Staff: *16*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *05/29/2024*

Inspection Dates and Department Representative

05/29/2024 - On-Site: ██████████

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *21* Residents Served: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *21* Are 60 Years of Age or Older: *15*
Diagnosed with Mental Illness: *18* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *0* Have Physical Disability: *1*

Inspections / Reviews

05/29/2024 Full

Lead ██████████ Follow-Up Type: *POC Submission* Follow-Up Date: *07/04/2024*

07/08/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 08/06/2024
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 07/12/2024

07/12/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 08/06/2024
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 08/06/2024

11/08/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 08/06/2024
Reviewer: [REDACTED] Follow Up Type: Enforcement

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

At 9:06 am, the home's laptop was unlocked, unattended and accessible. The laptop was open and displayed a list of resident #1's medications, to include the following:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

REPEAT VIOLATION: 12/1/2022, et. al.

Plan of Correction

Accept [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Direct Care Aide on duty to select the privacy glasses on the EMAR application that is used on the laptop, this action provides access to the EMAR when needed but closes it down to those around when the Aide walks away so that no one around may be able to read the confidential information.

To enhance the currently compliant operations, on 07/09/2024 all Direct Care Aides and Administration will have a meeting to discuss Regulation 2600.17 and how the home is supposed to use the EMAR privacy glasses on the EMAR application on the laptop with confidentiality of the resident in mind, with a completion date of 07/09/2024. Documentation will be provided.

Effective 07/10/2024 the Administrator shall monitor the entire home, including EMAR laptops, daily for 1 month then weekly thereafter to maintain compliance with keeping resident records confidential, and, except in emergencies, to not not allow access 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. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. Since this inspection summary, to try to improve much more, the home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

17 - Record Confidentiality (continued)

Implemented [redacted] 11/08/2024)

18 - Compliance With Laws

2. 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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device. Also, the act requires the date of battery installation must be present on all battery-operated carbon monoxide detectors, and that the batteries must be changed at least annually. However, the battery-operated carbon monoxide detector, located in the basement, does not include the date of battery installation.

Plan of Correction

Accept [redacted] 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

- 1. on 05/31/2024 the Administrator checked that [redacted] had recently changed the batteries in the carbon monoxide alarm and wrote the date on the batteries. The log has been removed.

To enhance the currently compliant operations, on 07/9/2024 the Maintenance staff will participate in the staff meeting and will have the carbon monoxide battery changing added to their job duties to check monthly. The maintenance staff will change the batteries at least annually and document on this sheet. Maintenance have been educated on this law at the meeting with a completion date of 07/09/2024.

Effective 07/10/2024 the Administrator has checked all CO detectors in the home and will perform quarterly checks ongoing to maintain compliance with complying with applicable Federal, State and local laws, ordinances and regulations. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Not Implemented [redacted] - 11/08/2024)

20b2 - Access to Money

3. Requirements

2600.

20b2 - Access to Money (continued)

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

2. Resident funds shall be disbursed during normal business hours within 24 hours of the resident's request.

Description of Violation

The home manages finances for numerous residents, to include residents #3 and #4; however, according to numerous staff person and resident interviews, the residents only have access to their money every other Wednesday and cannot get access to their money within 24 hours of requesting it during normal business hours.

Plan of Correction

Accept [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Administrator that the residents have access to their money within 24 hours of requesting it during normal business hours. The residents were given out personal needs allowance on Wednesday, May 29 by the Director. The Administrator manages finances for two residents now due to many more residents getting private payee services. The Administrator does not manage finances for Resident #4. That resident has a payee. The Administrator does manage finances for Resident #3 and is their payee now. The personal needs allowance is given out every Wednesday not every other Wednesday.

To enhance the currently compliant operations, on 07/08/2024 the Director will audit the resident contracts. The Administrator will publish a written 30 Day Advance Notice to change the contracts. The notice to all residents will be July 15, 2024. The administrator will also start signing in to the job so [REDACTED] will make sure to be available during business hours. Because the regulation requires resident funds be dispersed within 24 hours of request, the Director will be present the days the Administrator is not. This will be monitored by a schedule of attendance for both and a sign in calendar for both, with a completion date of 07/15/2024.

Effective 07/15/2024 the Director will perform weekly reviews ongoing to maintain ongoing compliance with disbursing resident funds during normal business hours within 24 hours of a resident's request as well as compliance with record keeping for the resident's the home manages funds for including the financial record and the quarterlies. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Implemented [REDACTED] - 11/08/2024)

25b - Contract Signatures**4. Requirements**

2600.

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

25b - Contract Signatures (continued)

Description of Violation

Resident #2's resident-home contract, dated [REDACTED], is not signed by the administrator or a designee of the home.

Plan of Correction

Accept ([REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, the contract was not signed by the administrator but was signed by the resident upon entry to the home on [REDACTED]. Immediate action was taken on [REDACTED] by the Administrator when he returned after inspection and was informed [REDACTED] did not sign the contract. He immediately signed Resident #2's resident-home contract and verified completeness. Please see attached.

To enhance the currently compliant operations:

1. on 07/02/2024 the Administrator audited resident #2's file for missing signatures and audited the file for completion, with a completion date of 07/02/2024.
2. on 07/08/2024 the Director will audit all resident file contracts for completeness, with a completion date of 07/12/2024.
3. On July 9, 2024 at our meeting the Director who is responsible for creating and auditing contracts was re-educated on Regulation 2600.25b to ensure contracts are checked for completeness. The Administrator completes going over the contract with the resident. He neglected to sign his administrator signatures but did get the resident to sign their signatures within 24 hours of admission. He was also re-educated on July 9, 2024 of Reg. 2600.25b in relation to finishing signatures thoroughly before moving on to other responsibilities and ensuring completeness to the contract.

Implementation of preventive actions will be overseen by the Director with an initial audit occurring on 7/8/24 and monthly audits thereafter.

Effective 07/08/2024 the Director will perform an initial audit and monthly audits through to maintain ongoing compliance with having contract signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Not Implemented ([REDACTED] - 11/08/2024)

56 - Admin 20 Hours/Week

5. Requirements

2600.

56 - Admin 20 Hours/Week (continued)

56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

According to numerous staff person and resident interviews, staff person A, [REDACTED], is not present in the home an average of 20 hours or more per week. Interviews indicate staff person A is only usually present in the home for a few hours on Wednesdays.

Plan of Correction

Accept ([REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/31/2024 by the Administrator. The administrator came back to work after illness on 5/31/2024 and checked in with the home during regular hours.

To enhance the currently compliant operations, effective date of 07/02/2024 the Administrator will be present in the home for an average of 20 hours or more a week. To assure that the Administrator signs in with [REDACTED] days and times, [REDACTED] will have on a calendar like all other staff do to sign in on. This calendar will be for the Administrator and Director and will be posted on July 15, 2024 and ongoing. The posted schedule will be public for residents to have access to money, any issues needing addressed, as well as so staff can communicate with administration. This will include the Director and Administrator's scheduled days and times so that one will be present to assist with management compliance and assistance.

Effective 07/08/2024 the Director will perform weekly inspections of the schedule and sign in calendar ongoing to maintain ongoing compliance with ensuring the administrator is present in the home an average of 20 hours or more per week, in each calendar month. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

All staff have discussed this at the July 9, 2024 meeting.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Implemented ([REDACTED] - 11/08/2024)

57b - 1 Hour/Day

6. Requirements

2600.

57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 5/17/24, there were 21 residents in the home, requiring a total minimum of 21 hours of direct care staffing. On

57b 1 Hour/Day (continued)

this day, only 19 hours of direct care staffing were provided.

Plan of Correction

Accept [redacted] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

- 1. on 05/31/2024 the Administrator researched the Regulation 2600.57.b and audited our mobility needs and did calculations as to how we have fallen short with the 1 hour per resident rule for the month of May and beforehand.
- 2. on 07/05/2024 the Administrator will create an ongoing system for incoming residents in evaluating their care needs and mobility status by reviewing the preadmission report so that the home may understand how many hours are needed and conduct new job duties list if needed related to this research.

To enhance the currently compliant operations, on 07/01/2024 the Administrator created a new July schedule that includes Housekeeping helping with the job duties of cleaning and cooking during the day so that the minimum of 21 hours of direct care staffing can be met, with a completion date of 07/01/2024.

The Administrator shall review the direct care staffing schedule daily to ensure compliance with 2600.57b effective beginning 7/11/2024.

Effective 07/08/2024 the Administrator will perform monthly reviews through ongoing to maintain ongoing compliance with ensuring direct care staff persons are available to provide at least 1 hour per day of personal care services to each mobile resident. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

All staff have been educated on this at the July 9 meeting.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Implemented [redacted] - 11/08/2024)

57d - Waking Hours

7. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 5/4/24, there were 19 residents in the home, requiring a total minimum of 14.25 hours of direct care staffing during waking hours. On this day, only 11.5 hours of direct care staffing were provided during waking hours.

57d - Waking Hours (continued)

On 5/12/24, there were 20 residents in the home, requiring a total minimum of 15 hours of direct care staffing during waking hours. On this day, only 12 hours of direct care staffing were provided during waking hours.

On 5/17/24, there were 21 residents in the home, requiring a total minimum of 15.75 hours of direct care staffing during waking hours. On this day, only 11.5 hours of direct care staffing were provided during waking hours.

Plan of Correction**Directed (█ - 07/12/2024)**

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/31/2024 by the Administrator to research the Regulation 2600.57.d and audit our mobility needs and did the calculations as to how the home has fallen short with the 75% personal care service hours during waking hours rule for the month of May and beforehand.
2. on 07/05/2024 the Administrator will create an ongoing system for incoming residents in evaluating their care needs and mobility status with the preadmission report to understand how many hours are needed during the 75% waking hours and conduct new job duties lists if applicable related to this research.

To enhance the currently compliant operations, on 07/01/2024 the Administrator created a new July schedule that includes Housekeeping helping with the job duties of cleaning and cooking during the day so that the 75% of service hours of direct care staffing can be met during waking hours, with a completion date of 07/01/2024.

The Administrator shall review the direct care staffing schedule daily to ensure compliance with 2600.57d. (DIRECTED: The daily reviews of the direct care staffing schedule shall begin within 24 hours of receipt of this plan of correction. █ 7/12/24).

All staff were educated on Reg 2600.57d on July 9, 2024.

Effective 07/08/2024 the Administrator will perform weekly reviews through 07/08/2024 to maintain ongoing compliance with ensuring at least 75% of the personal care service hours specified in subsections (b) and (c) are available during waking hours. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

57d - Waking Hours (continued)

Directed Completion Date: 07/25/2024

Not Implemented (████) 11/08/2024)

87 - Lighting

8. Requirements

2600.

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

Description of Violation

The light fixture in the home's 2nd floor hallway is inoperable and does not allow adequate lighting to safely move through the home and safely evacuate. No other operable lighting was present in the 2nd floor hallway.

Plan of Correction

Directed (████) - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/31/2024 by the Administrator to checked the 2nd floor hallway lighting.
2. on 06/10/2024 the Administrator consulted an electrician because a bulb change would not fix the light.
3. on 07/04/2024 the Administrator will purchase a new entire lighting unit to be replaced and Maintenance replaced this lighting unit on 07/11/2024.

To enhance the currently compliant operations, on 07/16/2024 the Maintenance Staff will check the lighting throughout the facility according to their job duties checklist and have a meeting on 07/09/2024 related to the job duties checklist and Regulation 2600.87 on lighting and how to report a need for special order units and bulbs, with a completion date of 07/09/2024.

All staff including the Administrator and Maintenance, were educated on this regulation and this concern and our reporting procedure described below on July 9, 2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. (████) 7/12/24). The maintenance job duties checklist and job duties agreement was updated and signed on July 10, 2024.

Effective, 7/15/2024, procedures will be Maintenance will have a written form that he can request supplies, tools, monies for projects, or outsource projects to professionals by in (████) daily folder (████) will fill out the form and will put it in the Administrators mailbox that he will check every scheduled shift. The Administrator will have 14 days to complete this request so that items around the home can get fixed quickly and effectively. This, we hope, cut out the ineffective communication of the prior improper chain of command.

87 - Lighting (continued)

Effective 07/16/2024 the Maintenance Staff will perform daily inspections through to maintain ongoing compliance with ensuring hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes are lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Implemented () - 11/08/2024

88a - Surfaces

9. 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

An approximate 1' x 1' area of the flooring is missing from the 2nd floor bathroom, which poses a potential tripping hazard.

An approximate 3" x 4" hole is present in a ceiling tile above the sink in the 2nd floor bathroom. Also, numerous dark brown water stains are present on this ceiling tile.

Large dark brown water stains are present on the ceiling tile above the paper towel dispenser in the 2nd floor bathroom.

Plan of Correction

Directed () - 07/12/2024

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/31/2024 the Administrator measured the damaged ceiling in the 2nd floor bathroom and ordered the tiles needed to replace the hole and water stains. Maintenance replaced the tiles and fixed the hole on 7/9/2024.

88a - Surfaces (continued)

2. on 05/31/2024 the Administrator surveyed the 1x1 foot damaged flooring and decided on what to do to fix it. Maintenance staff will fix the flooring on 07/10/2024.

To enhance the currently compliant operations:

1. on 07/16/2024 the Maintenance Staff will inspect damaged flooring and tiles according to the job duties checklist. Damage and ceiling tiles are items already on the daily checklist and will be gone over again when the home has the staff meeting on 07/09/2024. The tiles will be cut and replaced and the flooring will be repaired, with a completion date of no later than 07/11/2024.
2. on 07/09/2024 the Administrator will have discussion of the job duties checklist and the maintenance will be encouraged to bring projects needing special ordering or additional monetary expenditures to the attention of the administrator, with a completion date of 07/09/2024.

Implementation of preventive actions will be overseen by the Administrator, with an overall completion date of 07/16/2024.

All staff including the Administrator and Maintenance, were educated on this regulation and this concern and our reporting procedure described below on July 9, 2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 7/12/24). The maintenance job duties checklist and job duties agreement was updated and signed on July 10, 2024.

Effective, 7/15/2024, procedures will be Maintenance will have a written form that he can request supplies, tools, monies for projects, or outsource projects to professionals by in his daily folder. He will fill out the form and will put it in the Administrators mailbox that he will check every scheduled shift. The Administrator will have 14 days to complete this request so that items around the home can get fixed quickly and effectively. This, we hope, cut out the ineffective communication of the prior improper chain of command.

Effective 07/16/2024 the Maintenance staff will perform daily inspections through to maintain ongoing compliance with ensuring floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

88a Surfaces (continued)

Not Implemented (█ - 11/08/2024)

95 Furniture and Equipment

10. Requirements

2600.

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

Description of Violation

The lids to the toilet tanks were not present on the following toilets. According to numerous staff person and resident interviews, the flanges are broken on both toilets and residents and staff persons have to place their hands in the toilet tanks to pull up the flange to flush the following toilets:

- *The toilet in the bathroom across from the administrator's office*
- *The toilet in the bathroom next to the 1st floor medication room*

The emergency light fixture in the 2nd floor hallway is inoperable and is detached from the wall and hanging by electrical cords and wrapped with electrical and caution tape.

Plan of Correction

Directed (█ - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/31/2024 by the Administrator to inspect the inoperable light and the toilets for parts and decide what to do. On 07/03/2024, the Administrator ordered the parts. The toilets and inoperable light were all fixed by Maintenance on 7/11/2024. Attached is 2 pictures of the toilets and all are fixed with lids back on. Please see attached.

To enhance the currently compliant operations, on 07/11/2024 the Maintenance fixed the toilets and inoperable light when parts were available around 7/8/2024 to ship in and █ replaced the lids and removed all broken instructional signage for the toilets and the taping for the inoperable light removed with a completion date of 07/11/2024.

All staff were educated on Reg 2600.95 and Administrator and Maintenance also discussed the procedures for reporting described below on July 9, 2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 7/12/24). The maintenance job duties checklist and job duties agreement was updated and signed on July 10, 2024.

Effective, 7/15/2024, procedures will be Maintenance will have a written form that he can request supplies, tools, monies for projects, or outsource projects to professionals by in his daily folder. █ will fill out the form and will put it in the Administrators mailbox that █ will check every scheduled shift. The Administrator will have 14 days to complete this request so that items around the home can get fixed quickly and effectively. This, we hope, cut out the ineffective communication of the prior improper chain of command.

Effective 07/16/2024 the Maintenance staff will perform daily inspections through to maintain ongoing compliance

95 - Furniture and Equipment (continued)

with ensuring floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement. (DIRECTED: The daily maintenance inspections shall also ensure that all furniture and equipment is in good repair, clean and free of hazards. [REDACTED] 7/12/24).

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Not Implemented ([REDACTED] - 11/08/2024)

100a - Exterior - Free of Hazards

11. 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

Two of the wooden deck boards on the 2nd floor external wooden deck are loose, causing the boards to move and shift when walking over them.

Plan of Correction

Directed ([REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/31/2024 by the Administrator to inspect the 2nd floor external decks wooden boards that are shifting. [REDACTED] accounted for the decay and damage to survey how much needed repaired.

To enhance the currently compliant operations, on 07/04/2024 the Administrator will pick up the supplies and begin repair of the deck, with a completion date of 07/04/2024.

Effective 07/09/2024 the Maintenance will perform daily inspections through to maintain ongoing compliance with ensuring the exterior of the building and the building grounds or yard are in good repair and free of hazards. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

All staff were educated on Reg 2600.100a and Administrator and Maintenance also discussed the procedures for reporting described below on July 9, 2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/12/24). The maintenance job duties checklist and job duties agreement was updated including outside areas and signed on July 10, 2024.

Effective, 7/15/2024, procedures will be Maintenance will have a written form that [REDACTED] can request supplies, tools,

100a - Exterior - Free of Hazards (continued)

monies for projects, or outsource projects to professionals by in his daily folder. [REDACTED] will fill out the form and will put it in the Administrators mailbox that [REDACTED] will check every scheduled shift. The Administrator will have 14 days to complete this request so that items around the home can get fixed quickly and effectively. This, we hope, cut out the ineffective communication of the prior improper chain of command.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Not Implemented ([REDACTED]) - 11/08/2024)

102i - Soap Dispenser

12. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There were 3 unlabeled and used bars of soap in the common bathroom next to the medication room.

102i - Soap Dispenser (continued)

Plan of Correction**Directed () - 07/12/2024)**

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Direct Care Aide to removed the unlabeled and used bars of soap from the bathroom next to the medication room.

To enhance the currently compliant operations:

- 1. on 07/03/2024 the Housekeeping will been recently hired and will have this duty added to their job duties checklist, with a completion date of 07/03/2024.*
- 2. on 07/09/2024 the Direct Care Aides will re-educated on the use of the bathroom caddies. Extra caddies will be kept in the basement and all residents will receive a caddy labeled if they don't have one. All residents are to have a bathroom caddy they are to be using with their name on it and their own supplies for the shared bathrooms. This policy was agreed upon by staff and residents prior and needs to be reinstated by Administration at our staff meeting. The housekeeping will be expected to participate in policing this rule but will be responsible for their cleaning duties. This would be a shared duty due to the volume of use all the bathrooms receive. The direct care aides are responsible for the caddies and the housekeeping is responsible for the cleaning but both will work together to police it. Direct care have been educated to remove soaps, caddies, and washcloths after resident showers from all bathrooms and housekeeping to do the same during bathroom cleanings for all bathrooms. We will revisit this at the QM plan with staff to see if the caddies are working well and consider other options if needed such as wall mounted body wash dispensers and/or rectangular plastic bar soap holders that would be individually labeled and kept separate for each resident. The staff meeting and re-education will be on Tues, July 9 at 1:30pm, with a completion date of 07/09/2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 7/12/24).*

Effective 07/10/2024 the Direct Care Aides will perform daily checks through to maintain ongoing compliance with providing a dispenser with soap within reach of each bathroom sink, and to not permit bar soap unless there is a separate bar clearly labeled for each resident who shares a bathroom. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

102i - Soap Dispenser (*continued*)*Implemented* [REDACTED] - 11/08/2024)

103f - Refrigerator/Freezer Temps

13. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 9:52 am, the Frigidaire refrigerator, located in the basement, was 45 degrees Fahrenheit.

At 9:54 am, the Whirlpool freezer, located in the basement, was 20 degrees Fahrenheit.

At 3:50 pm, the kitchen refrigerator was 45 degrees Fahrenheit.

REPEAT VIOLATION: 12/1/2022, et. al.

Plan of Correction*Directed* [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

- 1. on 05/29/2024 by the Direct Care to monitored the temperatures for the rest of the day. A Direct Care Aide found the thermometer for the kitchen refrigerator and it was keeping temperature. The other refrigerator has had trouble holding temperature and is no longer being used. The freezer is holding temperature. Please see attached readings and temp logs.*
- 2. on 07/09/2024 the administrator will assure the dietary person continues accurate record keeping of the refrigerator and freezer temperatures so that these units can be replaced if needed.*
- 3. on 07/02/2024 the Administrator had determined that the freezer still not holding temperature will be not used and the other 2 units will be thoroughly cleaned by Maintenance on 07/04/2024 to optimize cooling.*

To enhance the currently compliant operations, on 07/09/2024 the Administrator will emphasize the importance of tracking the thermometers stay in place and that the fridges and freezers are holding proper temperatures. The home will discuss procedures for this with all staff including dietary at the meeting July 9 at 1:30pm. Documentation will follow, with a completion date of 07/09/2024.

Effective 07/10/2024 the Dietary person will perform daily inspections through to maintain ongoing compliance with ensuring food requiring refrigeration is stored at or below 40°F, and frozen food is kept at or below 0°F, and thermometers are present in refrigerators and freezers. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

All staff were educated on Reg 103f on July 9, 2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/12/24).

103f - Refrigerator/Freezer Temps (continued)

Documentation of the daily temperature checks of all refrigerators and freezers shall be kept.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Not Implemented (█ - 11/08/2024)

107b - Emergency Procedures

14. Requirements

2600.

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

- 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 alternate means of meeting resident needs in the event of a utility outage.

Plan of Correction

Accept (█ - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/30/2024 by the Director to audit the existing binders to see what needed updated and review the notes from the exit interview to effectively develop a cohesive binder for emergency preparedness and not a separate policy binder with emergency preparedness information in it.

To enhance the currently compliant operations, beginning 07/05/2024 the Director will update all of the information and it will be combined and updated to the new emergency preparedness binder with current plans and agreements for all utility outages including but not limited to electric, gas, heat, water, sewage, EMAR, etc, with a final overhauled project completion date of 07/19/2024.

Effective 07/22/2024 the Director will perform quarterly audits through to maintain ongoing compliance with having written emergency procedures that include alternate means of meeting needs of residents in the event if utility outages. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

All staff were educated on July 9, 2024, on this regulation and important issue and the location of the new binder

107b Emergency Procedures (continued)

when it is complete July 19.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Not Implemented () - 11/08/2024)

107c - Food/Water 3 Day Supply**15. Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 5/29/24, the home served 21 residents, requiring 63 gallons of emergency drinking water to be available; however, the home only had 58 gallons of drinking water present in the home. The home does not have a current contract with a local bottled water supplier to provide water to the home in the event of an emergency.

Plan of Correction

Accept () - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/31/2024 by the Administrator to replace the 5 gallons of missing water and assure that the water is properly stored.

To enhance the currently compliant operations, on 07/03/2024 the Administrator will assure that anytime water is used from the supply for any reason that it is replaced. This involves a new checklist close to the water supply where tally would be kept by anyone removing water or adding water gallons. Please see attached. The Administrator would audit this quarterly, with a completion date of 07/03/2024. This new log will be announced at the staff meeting on 07/09/2024.

Effective 07/08/2024 the Administrator will perform monthly checks through to maintain ongoing compliance with maintaining at least a 3 day supply of nonperishable food and drinking water for residents. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

The administrator shall check the water supply at least monthly to ensure compliance with 2600.107c.

All staff participated in education on Reg 107c and the in/out check.

The home had a quality management plan meeting in January 2024. The home will have an additional post

107c - Food/Water 3 Day Supply (continued)

inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Not Implemented ([REDACTED] 11/08/2024)

107d - Procedure Emergency Management Agency Submission

16. Requirements

2600.

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

Description of Violation

There is no documentation present indicating the home's written emergency procedures have been reviewed, updated and submitted to the local emergency management agency within the past year.

Plan of Correction

Directed [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/29/2024 by the Director to took note that the emergency procedures needed to be updated and combined into one, from which it was in separate notations in the emergency preparedness binder and the policy binder. The Director was not aware that emergency procedures needed to be submitted to the local emergency management agency annually.
2. on 07/05/2024 the Director will formulate a plan to combine all information into one project for which all procedures will be updated and submitted to the local emergency management agency by 7/19/2024. (DIRECTED: Documentation of notification to the local emergency management agency shall be kept. [REDACTED] 7/12/24).

To enhance the currently compliant operations, beginning 07/05/2024 the Director will audit both binders and combine them. [REDACTED] will update all applicable utilities and procedures for 2024 and submit this to the local emergency management agency, with a completion date of 07/19/2024.

Effective 07/22/2024 the Director will perform quarterly audits through to maintain ongoing compliance with reviewing, updating and submitting annually, to the local emergency management agency, written emergency procedures. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

All staff had education on Regulation 107d including the Director.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a

107d Procedure Emergency Management Agency Submission (continued)

date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Not Implemented [redacted] - 11/08/2024)

109b - Rabies Vaccination

17. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

The home does not have a current certificate of rabies vaccination for the the home's visiting dog, Sirenty.

Plan of Correction

Accept [redacted] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/29/2024 the Director requested removal of the visiting dog from the facility until further notice and prohibited visiting by the dog until vaccinated.
2. on 05/29/2024 the Director researched vaccine clinics to provide proper vaccination for the visiting dog so that it may return to visiting residents.
3. on 06/04/2024 the Director took the staff member and the visiting dog to a clinic where the dog was vaccinated. Proof of vaccination attached.

To enhance the currently compliant operations, on 05/29/2024 the Director will assure that any visiting pet or animal will be vaccinated and in good health and fit to visit, by doing so this will go into the policy binder, with a completion date of 07/05/2024.

Effective 06/04/2024 the Director will perform monthly reviews of any visiting animal to maintain ongoing compliance with ensuring cats and dogs present at the home have current rabies vaccinations, and to keep current certificate of rabies vaccinations from licensed veterinarians. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The Director created a visiting animal policy and will provide 30 Day Notice to Staff and Residents on July 15, 2024, the policy will be attached for review.

109b Rabies Vaccination (continued)

The policy and regulation 2600.109b was reviewed at the July 9 meeting with all staff.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Implemented [REDACTED] 11/08/2024)

125a - Combustible Storage

18. Requirements

2600.

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

Description of Violation

At 10:10 am, there was a camouflage blanket laying on the ground directly behind the home's electric dryer.

Plan of Correction

Directed [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Maintenance staff to remove the blanket directly behind the dryer.

To enhance the currently compliant operations, on 07/09/2024 All Staff will have a meeting Tues. July 9 to educate all staff of regulation 2600.125s on combustible and flammable materials near any heat source and hot water tank, not just the dryer, and the dryer lint cleaning routine as well as the checks behind the dryer and washer. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/12/24). The checks were already to be done and the shelving was put in place to prevent items from falling behind the dryer before. This policy will be retrained on for all staff and documentation will be kept, with a completion date of 07/09/2024.

Housekeeping and Direct Care had their job duties checklist updated to include the behind the dryer cleaning added on their laundry responsibility effective 7/9/2024.

The Administrator will be purchasing a grabbing tool July 15, 2024 to help the direct care retrieve items from behind the units.

Effective 07/10/2024 the Direct Care Aides and Housekeeping both will perform daily checks ongoing during laundry duties to maintain ongoing compliance with locating combustible and flammable materials away from heat sources or hot water heaters. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrative Assistant for further review and continuous improvement.

130g - Smoke Detector Repair (continued)

[Redacted]

[Redacted]

Violation withdrawn B.S. 11/27/2024

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

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

The home's fire extinguishers have not been inspected by a fire safety expert since April, 2023.

Plan of Correction

Directed [Redacted] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

- 1. on 05/30/2024 by the Director to audit the building's fire extinguishers and check records in the fire binder.
- 2. on 7/4/2024 the Administrator will pay the balance online of the account that lead to the delay in the company automatically coming out. On 07/05/2024 when the company opens after the 4th of July, the Administrator will schedule a fire extinguisher inspection of all 5 units.

To enhance the currently compliant operations, on 07/03/2024 the Director will audit the building's fire binder and check the inspection stickers, with a completion date of 07/03/2024.

Effective 07/03/2024 the Director will perform quarterly inspections through 07/03/2024 (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. Quarterly audits shall continue indefinitely to ensure compliance with 2600.131f. [Redacted] 7/12/24). to maintain ongoing compliance with ensuring fire extinguishers are inspected and approved annually by a fire safety expert, and to ensure the date of the inspection is on each extinguisher. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

131f - Fire Extinguisher Inspection (continued)

All fire extinguishers are scheduled to be inspected with new tags on Tues, July 26, 2024 by CertiSite. Documentation will be kept.

All staff have been educated including the Director on Reg 131 f on July 9, 2024.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/26/2024

Not Implemented ([redacted] - 11/08/2024)

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 April, 2024.

Plan of Correction

Directed [redacted] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/29/2024 the Director reviewed the fire binder and on 05/30/2024 the Fire Drill Supervisor reviewed the fire training binder and conducted a fire drill immediately that day.
2. on 07/02/2024 by the Administrator to reviewed the fire department's letter and knows the fire box was fixed but didn't obtain a receipt. He attempted to obtain proof via phone that the fire box was fixed and will obtain receipt of repair when the company opens again on 07/05/2024.
3. on 07/09/2024 the Administrator will educate the relatively new hired fire drill supervisor to conduct a fire drills under the new training at the meeting.

To enhance the currently compliant operations, on 07/10/2024 the Director will review the fire drill audit form that was created last year. The Director will perform a fire drill audit after the re-training of the Fire Drill Supervisor, with a completion date of 07/10/2024.

132a - Monthly Fire Drill (continued)

Effective 07/13/2024 the Fire Drill Supervisor will perform monthly checks to maintain ongoing compliance with holding an unannounced fire drill at least once a month. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

All staff including the Fire Drill Supervisor were educated on Reg 132a on July 9. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/12/24). The Fire Drill Supervisor was educated that [REDACTED] should document [REDACTED] failed fire drills and that a re-do needs done within 48 hours of the failed drill and any equipment failure needs to be fixed within 48 hours and reported to the Fire Dept.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Implemented ([REDACTED] - 11/08/2024)

132e - Fire Drill Sleeping Hours

22. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The most recent fire drill held during sleeping hours was conducted on 5/23/23 at 12:36am.

Plan of Correction

Directed ([REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. on 05/30/2024 by the Fire Drill Supervisor to reviewed the fire training binder and conducted a fire drill immediately but failed to conduct a sleeping hour drill.
2. on 07/02/2024 by the Administrator to reviewed the fire department's letter and knows the fire box was fixed but didn't obtain a receipt. He attempted to obtain proof via phone that the fire box was fixed and will obtain receipt of repair when the company opens again on 07/05/2024.
3. on 07/09/2024 the Administrator will educate the relatively new hired fire drill supervisor to conduct a sleeping hours July fire drill immediately under the new training at the meeting.

132e Fire Drill Sleeping Hours (continued)

To enhance the currently compliant operations:

1. on 07/08/2024 the Director will review the fire drill audit form that was created last year. The Director will perform a fire drill audit 7/10/24 and update the form for it did not have a box related to checking for sleeping hour drills. So although fire drills were being done they were not being done during sleeping hours since the fire drill supervisor began her position in February, with a completion date of 07/10/2024.
2. on 07/08/2024 a sleeping hour drill was conducted. There was an 8:20pm drill which was prior to this inspection and prior 8pm and later was approved as an appropriate sleeping hour time. The log shows we had a fire drill 9/4/2023 at 8:20pm but we still had remained out of compliance as the fire drill supervisor states that sleeping hour drills were attempted but not documented as they failed. The residents were difficult to evacuate and it took too long but this was not reported. Additionally, retraining of this job is needed and job duties needs to be re educated with the importance of failed drills and procedure as well as sleeping hours corrected to be after 12am. There was a list of rules created with this job when it began in the beginning of the year. Prior it was the administrator's job. The retraining will take place July 8 with a sleeping hours drill at 11pm, with a completion date of 07/08/2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. Documentation of the sleeping hour fire drill conducted on 7/8/24 shall be kept in accordance with 2600.132c. [REDACTED] 7/12/24, [REDACTED] 7/12/24).

Implementation of preventive actions will be overseen by the Director, with an overall completion date of 07/10/2024.

Effective 07/13/2024 the Fire Drill Supervisor will perform monthly checks to maintain ongoing compliance with holding a fire drill during sleeping hours once every 6 months. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Director for further review and continuous improvement.

All staff including the Director and the Fire Drill Supervisor were educated on Reg 132e and the fire drill sleeping drills. Document attached.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Implemented ([REDACTED] - 11/08/2024)

183b - Meds and Syringes Locked

23. Requirements

2600.

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

Description of Violation

At 9:06 am, the home's medication cart was unlocked, unattended and accessible, which contained numerous medications for numerous residents, to include the following:

- Resident #1's
- Resident #3's
- Resident #4's

Plan of Correction**Accept () - 07/12/2024)**

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Administrative Assistant to lock the medication cart and secure the medications were untampered.

To enhance the currently compliant operations, on 07/09/2024 the Direct Care Aide Staff will have a meeting with Administration on Tues. July 9 at 1:30pm. All documentation will be kept, with a completion date of 07/09/2024.

Effective 07/10/2024 the Administrative Assistant will perform daily inspections ongoing to maintain ongoing compliance with ensuring prescription medications, OTC medications, CAM and syringes will be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

Attached is what the Daily Check list for the Administrative Assistant is, documentation will be kept.

All staff including those administering medications were educated on Reg 183b as well and documentation is attached.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

183b Meds and Syringes Locked (continued)

Licensee's Proposed Overall Completion Date: 07/25/2024

Not Implemented [REDACTED] - 11/08/2024)

183d - Prescription Current

24. Requirements

2600.

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

Description of Violation

On [REDACTED], resident #4 was prescribed [REDACTED] into affected ears everyday for 5 days; however, this medication was still present in the home at the time of inspection.

REPEAT VIOLATION: 12/1/2022, et. al.

Plan of Correction

Accept [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Administrative Assistant to remove and dispose of the drops from the medication cart and check that the ear drops are off the MAR.

To enhance the currently compliant operations, beginning 07/10/2024 the Administrative Assistant will audit the medication cart for any old, discontinued medications and assure they are removed from the medication EMAR. All Direct Care Staff will be re educated on keeping the cart clean and organized and the importance and regularly checking what is in the cart alongside the Administrative Assistant's audits. This meeting will be on July 9 at 1:30pm. Documentation can be provided of the education and meeting sign in, with a completion date of 07/17/2024.

Effective 07/10/2024 the Administrative Assistant will perform daily checks to maintain ongoing compliance with ensuring only current prescription, OTC, sample and CAM for individuals living in the home will be kept in the home. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

Attached is what the Daily Check list for the Administrative Assistant is, documentation will be kept.

Additionally, to keep everyone educated and involved in keeping a clean and organized medication cart, monthly, a Direct Care Aide will be selected by the Administrator to pull a sample of 5 different residents to audit for regulation 183d. Please attached audit sheet. This audit will begin effective 7/24/2024 and ongoing. Documentation will be kept.

All staff including those administering medications were educated on Reg 183d as well and documentation is attached.

The home had a quality management plan meeting in January 2024. The home will have an additional post

183d - Prescription Current (continued)

inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Licensee's Proposed Overall Completion Date: 07/25/2024

Implemented (█) - 11/08/2024)

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 #1's glucometer is not set to the current date and time.

Plan of Correction

Directed (█) - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Director to label the glucometers of Resident #1 and Resident#4's glucometers.

To enhance the currently compliant operations, on 07/02/2024 the Administrative Assistant set the current date and time of Resident #1 and Resident #4's glucometers and will check the glucometers of all other residents, with a completion date of 07/02/2024. Please see attached.

185a - Implement Storage Procedures (continued)

Effective 07/10/2024 the Administrative Assistant will perform daily checks through to maintain ongoing compliance with ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

DIRECTED: Beginning on 7/15/24: The administrator/designee shall check all resident glucometers monthly to ensure each resident's glucometer is labeled with their first and last names and to ensure all resident glucometers are set to the current date and time. [REDACTED] 7/12/24

Attached is what the Daily Check list for the Administrative Assistant is, documentation will be kept.

All staff including those qualified for administering medications were educated on Reg 185a as well and documentation is attached.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Not Implemented ([REDACTED] - 11/08/2024)

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 #1 is prescribed [REDACTED] -Take 1 tablet by mouth at bedtime; however, this medication was not documented as administered on resident #1's resident's [REDACTED] medication administration record (MAR) on [REDACTED].

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

Resident #1 is prescribed [REDACTED] (12.5mg) by mouth 2 times a day; however, this medication was documented as administered on resident #1's [REDACTED]

The following medications were not documented as administered on resident #3's [REDACTED]:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

The following medications were not documented as administered on resident #4's [REDACTED]:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Plan of Correction

Directed [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/30/2024 by the Administrator to investigate why there was a lapse in documentation. The Direct Care Staff that documented that day report that they did chart. The Administrator had found that the MAR application had been in the process of updating and had a final update from one application to another on June 5, 2024 and it may have caused problems as they stated in the email update. Please see attached.

To enhance the currently compliant operations, on 07/09/2024 the Administrative Assistant will continue to monitor for any lapses in coverage of the EMAR application and report it to the administrator and the EMAR company. Any lapses of utility or coverage would be cause for a paper MAR to be created. The administrative assistant has assured we have paper MARs for this scenario and all direct care aides that work with the EMAR will be educated on this Regulation 2600.187.b on 07/09/2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 7/12/24).

The administrative assistant will audit the EMAR weekly for 1 month beginning on July 10 to catch any trends in error of documentation or EMAR application problems and will audit monthly thereafter. The Administrative Assistant will remind direct care staff to report glitches and problems at the meeting the home will have for re-education on Tues. July 9 at 1:30pm. Documentation will be provided after this meeting, with a completion date of 07/9/2024.

Effective 07/10/2024 the Administrative Assistant will perform weekly reviews for 1 month. The sample will be 5 different residents per shift per week and then monthly reviews of all 21 residents to maintain ongoing compliance with ensuring the information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

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

All staff including those administering medications were educated on Reg 187b as well and documentation is attached.

Attached is the audit sheet the Administrative Assistant will be using and continue to use this week to audit beginning 7/10-7/17.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Implemented ([REDACTED] 11/08/2024)

187d - Follow Prescriber's Orders

27. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed [REDACTED] -Take 1 tablet twice a day; however, this medication was only administered once on [REDACTED]

Resident #3 is prescribed [REDACTED] once a day; however, this medication was not administered to resident #3 daily from [REDACTED]

187d - Follow Prescriber's Orders (continued)

Plan of Correction**Directed** [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/30/2024 by the Direct Care Aide to schedule a consult with Resident #1 and resident#3's house nurse. The Administrative Assistant also communicated with all Direct Care Aides regarding proper charting and what to do if refusals or missed medications occur. This determination could be for a medication change or a discontinuation of a medication depending on dr's order. The staff will be having a meeting regarding violations including Regulation 2600.187.d on Tuesday, July 9 at 1:30pm and documentation will be created for this meeting and re-education of procedures.

To enhance the currently compliant operations, beginning 07/10/2024 the Administrative Assistant will follow up with the residents doctors to make a plan for a physical for them both in August following the meeting, all direct care staff will be re-educated on proper charting for refusals, such as notifying the dr. As well as proper charting notes, such as documenting refusals not in a way to repeatedly chart refused for reasons irrelevant such as "unable to take" but to properly address the issue of why the resident has missed or refused their medicines. This would included notifying the Dr and evaluating residents that repeatedly refuse or miss a medication due to drowsiness or complaints of side effects, etc, with a completion date of 08/6/2024 unless the doctor reschedules [REDACTED] visit. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 7/12/24).

Effective 07/17/2024 the Administrative Assistant will perform weekly reviews to maintain ongoing compliance with ensuring the home must follow the directions of the prescriber. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement. (DIRECTED: During the weekly audits, the administrative assistant shall review the medications and MAR's for 5 different residents during each audit to ensure compliance with 2600.187d. [REDACTED] 7/12/24)

All staff including those administering medications were educated on Reg 187d as well and documentation is attached.

Attached is the audit sheet the Administrative Assistant will be using and continue to use this week to audit beginning 7/10-7/17. Documentation will be kept.

The reason resident #1's [REDACTED] was not administered was because [REDACTED] had a nosebleed that wouldn't stop and was hospitalized. The discharge has been attached. The importance of proper charting that would indicate hospitalization was emphasized at the July 9 meeting.

The root cause of the failure to administer Resident #3 [REDACTED] was refusal due to it giving [REDACTED] diarrhea. Attached is the bottle showing we have it in the cart. The refusal was improperly charted for that shift as it is a daily medicine and the Dr has been notified it gives [REDACTED] too much diarrhea so the medication will no longer be a daily medication but will be changed to a PRN as soon as the Dr changes the frequency. The staff that improperly charted and all medication administering staff were instructed and educated at the July 9 meeting that we cannot chart "physically unable to take" for this reason and that the Dr should be notified so we can help the problem instead of chart it that way. Please see attached meeting notes and picture.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

187d - Follow Prescriber's Orders (continued)

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 08/06/2024

Implemented (█) - 11/08/2024)

224a - Preadmission Screen Form**28. Requirements**

2600.

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

Description of Violation

Resident #2's preadmission screening form is undated so it is unable to be determined if it was completed within 30 days prior to admission. Additionally, resident #2's preadmission screening form does not include a determination that the needs of the resident can be met by the services provided by the home, does not indicate if the resident is safe around poisons and is not signed by the person who completed the preadmission screening form. These sections on resident #2's preadmission screening form are blank. Resident #2 was admitted to the home on █.

Plan of Correction

Directed (█) - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/30/2024 by the Administrator to date Resident #2's preadmission screening form and mark a determination that needs can be met, and indicate the resident is safe around poisons, and was signed by the Administrator. Please see attached.

To enhance the currently compliant operations, beginning 07/08/2024 the Director will audit all files for preadmission forms and assure they are all completed with signatures and dates and accurate check boxes and information pertaining to the admission of all the residents, with a completion date of 07/12/2024.

The monthly audits, see attached, will include an audit form that asks for completion, poisonous material check, capability of meeting needs, and signature check of person completing. It will be a review of all resident records admitted that month to ensure compliance as well. (DIRECTED: The monthly audits shall begin on 7/15/24. LM 7/12/24)

Effective 07/15/2024 the Director will perform monthly audits through to maintain ongoing compliance with ensuring a determination is made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

All staff including the Director were educated on Reg 224a as well and documentation is attached.

224a - Preadmission Screen Form (continued)

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Implemented [REDACTED] - 11/08/2024)

225a - Assessment 15 Days**29. Requirements**

2600.

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

Description of Violation

Resident #2 was admitted to the home on [REDACTED]; however, no assessment was completed for resident #2.

Plan of Correction

Directed [REDACTED] - 07/12/2024)

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/30/2024 by the Director to create an assessment and support plan for Resident #2. Please see attached.

To enhance the currently compliant operations, on 07/10/2024 the Director will audit all files for current RASPs and any missing RASPs will be created and/or updated as applicable, with a completion date of 07/24/2024 for all completion of RASPs in need.

Effective 07/10/2024 the Director will perform monthly audits through to maintain ongoing compliance with ensuring each resident has a written initial assessment that is documented on the Department's assessment form within 15 days of admission. (DIRECTED: The monthly audits shall include a review of all resident records for those residents admitted in the past month to ensure compliance with 2600.225a. [REDACTED] 7/12/24). The administrator or designee, or a human service agency may complete the initial assessment. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

225a - Assessment 15 Days (continued)

All audits will include determination whether a 15 day assessment and support plan were made and if a long term resident whether an annual assessment and support plan is complete and current and if the RASP is accurate to the resident's condition. The 2 audit sheets are attached to the other violation for Reg 225c and this one for Reg 225a. The reviews will included resident records admitted that month to ensure compliance.

All staff including the Director were educated on Reg 225a as well and documentation is attached.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 07/25/2024

Implemented [REDACTED] - 11/08/2024)

225c - Additional Assessment

30. Requirements

2600.

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

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

Description of Violation

Resident #3's most recent assessment was completed on [REDACTED] however, resident #3's previous assessment was completed on [REDACTED]

REPEAT VIOLATION: 6/21/2023

225c Additional Assessment (continued)**Plan of Correction****Directed [REDACTED] - 07/12/2024)**

In response to the violation on 05/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 05/29/2024 by the Director to investigate this gap during the exit interview, where the inspectors agreed to disregard this violation as it was the result of a previous inspection for this same resident. The Director was told at the exit interview that this violation would be redacted from the list due to the context that it was founded based upon a previous inspection of this same residents RASP and the RASP in question was generated from a previous violation as part of plan of correction.

To enhance the currently compliant operations, on 07/10/2024 the Director will go into all the files and audit the RASPs currently for any missing ones and fix any missing Assessment and Support Plans, with a completion date of 07/24/2024.

Effective 07/10/2024 the Director will perform monthly audits through 07/10/2024 to maintain ongoing compliance with ensuring each resident has additional assessments, including annually, and if the condition of the resident significantly changes prior to the annual assessment, and at the request of the Department upon cause to believe that an update is required. Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement.

The administrator shall develop and implement a tracking system on Google Calendar which includes the names of all residents and their current assessment/support plan dates. The tracking system shall be reviewed and updated monthly by the Director when she audits. (DIRECTED: The tracking system shall be developed and implemented by 7/20/24. The monthly reviews of the tracking system shall begin on 8/1/24. [REDACTED] 7/12/24)

All staff including the Director, who now understands the difference in violation, were educated on July 9 about 2600.225c.

The home had a quality management plan meeting in January 2024. The home will have an additional post inspection quality management plan meeting to review of all items of the POC and all PCH regulations, with a date of completion of July 25, 2024 and documentation of the QM meeting will be kept.

Proposed Overall Completion Date: 07/25/2024

Please see attached.

Directed Completion Date: 08/01/2024

Not Implemented ([REDACTED]) - 11/08/2024)

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

Facility Information

Name: *THE ADAMS HOUSE* License #: *41371* License Expiration: *03/13/2025*
Address: *314 FALLOWFIELD AVENUE, CHARLEROI, PA 15022*
County: *WASHINGTON* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *KAREN ADAMS*
Address: *314 FALLOWFIELD AVENUE, CHARLEROI, PA, 15022*
Phone: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: *21* Waking Staff: *16*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Monitoring* Exit Conference Date: *09/18/2024*

Inspection Dates and Department Representative

09/18/2024 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *21* Residents Served: *21*

Secured Dementia Care Unit

In Home: <i>No</i>	Area:	Capacity:	Residents Served:
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Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: <i>20</i>	Are 60 Years of Age or Older: <i>12</i>
Diagnosed with Mental Illness: <i>20</i>	Diagnosed with Intellectual Disability: <i>1</i>
Have Mobility Need: <i>0</i>	Have Physical Disability: <i>0</i>

Inspections / Reviews

09/18/2024 - Partial

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *10/04/2024*

Inspections / Reviews (*continued*)

10/08/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/07/2024
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 10/14/2024

10/15/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/07/2024
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 11/07/2024

11/08/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 11/07/2024
Reviewer: [REDACTED] Follow Up Type: Enforcement

25b - Contract Signatures

1. Requirements

2600.

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

Description of Violation

Resident #1's resident-home contract, dated [REDACTED], is not signed by the resident or the home's administrator/designee.

Plan of Correction

Accept [REDACTED] - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to investigate where the contract signature page for Resident #1 was and it was out of the file in the office on a filing cabinet. It was immediately placed back in with the resident-home contract.

To enhance the currently compliant operations:

on 10/10/2024 the Administration and Director will be educated on Regulation 2600 25b and will create a process in their routine to complete signatures in an organized uninterrupted manner with the resident involved in the resident-home contract review where they do not proceed in the contract review without signatures of both parties and all of this concludes with the resident-home contract being filed away properly.

On 10/4/2024 the Director audited all current resident-home contracts for signatures of both resident and administrator.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with having the contract signed by the administrator and the resident. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings. Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The process in the routine entails using signature marking stickers in completing signatures always in the privacy of the office in an uninterrupted manner with the resident involved in the review. The administration will not proceed in the contract review without signatures of both parties and all of this concludes with the resident-home contract being filed away by the administrator properly.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

Please see attached meeting date notice.

I want to apologize for the errors in writing the regulations because normally I use the sanswrite assistant program and this time I didn't and made mistakes. I am sorry for the inconvenience and I believe I successfully corrected the regulations I noted.

Licensee's Proposed Overall Completion Date: 10/24/2024

Not Implemented [REDACTED] - 11/08/2024)

57d - Waking Hours

2. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On numerous dates, to include on 9/15/24, 9/16/24 and 9/17/24, there were 21 residents in the home, requiring a total minimum of 15.75 hours of direct care staffing during waking hours. However, on these days, only 14.5 hours of direct care staffing were provided during waking hours.

Plan of Correction

Accept (█) - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/19/2024 by the Administrator to meet with waking hour staff to come up with possible new scheduling options to secure the adequate waking direct care staffing.

To enhance the currently compliant operations:

on 9/27/2024 the Administrator discussed a plan with Department of Human Service Licensing to add an additional direct care staff during the day shift this staffing will add additional hours to the census for when the home is full.

On 10/10/2024, the Administration and Director will be educated on Regulation 2600 57d and will continually review the schedule daily to ensure staffing.

Effective 10/1/2024 the Administrator has been performing daily checks to maintain ongoing compliance with 2600 57d. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

Proposed Overall Completion Date: 10/24/2024

Licensee's Proposed Overall Completion Date: 10/24/2024

Not Implemented (█) - 11/08/2024)

65a - FS Orientation 1st Day

3. 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.

65a FS Orientation 1st Day (continued)

7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person A, whose first day of work was 9/17/24, did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction

Directed ([redacted] - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/19/2024 by the Administrator to meet with the direct care staff person A to conduct the orientation and properly fill it out and file it in the staff person's file. (DIRECTED: Documentation of staff person A's training shall be kept in staff person A's record in accordance with 2600.65i. LM 10/15/24).

To enhance the currently compliant operations:

On 10/10/2024, the Administration and Director will be educated on Regulation 2600 65a.

Effective 10/4/2024 the Director audited all staff person files for the orientation record to maintain ongoing compliance with 2600 57d. (DIRECTED: By 10/20/24: The administrator shall review all current staff person's records to ensure each current staff person has received orientation on all topics specified in 2600.65a and 2600.65b, and to ensure documentation of all orientation training is kept in each staff person's record in accordance with 2600.65i. LM 10/15/24).

Effective 10/15/2024 the Director will perform weekly checks due to the high turnover rate to maintain ongoing compliance with regulation 65a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

Proposed Overall Completion Date: 10/24/2024

Directed Completion Date: 10/24/2024

Implemented ([redacted] - 11/08/2024)

85a - Sanitary Conditions

4. Requirements

85a Sanitary Conditions (continued)

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At 9:35am, there were no paper towels, operable hand dryer or other sanitary means of hand drying present in 1st floor common restroom across from the administrator's office.

REPEAT VIOLATION: 12/1/2022, et. al.

Plan of Correction

Accept (████ - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to assure the home had paper towels in the 1st floor common restroom.

To enhance the currently compliant operations:

On 10/10/2024, the Administration, Director, and Maintenance will be educated on Regulation 2600 85a.

Effective 10/8/2024 Maintenance will check all bathrooms for paper towels on a daily basis to maintain ongoing compliance with 2600 57d.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 57d. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

By 11/1/2024, the Administrator will purchase hand dryers for all restrooms and will assist maintenance to install them with a completion date of 11/7/2024.

Please see attached.

Correction:

Effective 10/8/2024 Maintenance will check all bathrooms for paper towels on a daily basis to maintain ongoing compliance with 2600 85a.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 85a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been educated on maintaining sanitary conditions. This re-education was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

Please see attached education meeting. Because the file is so large, I only uploaded it to one violation but the education is a packet and it applies to all violations covered.

85a - Sanitary Conditions (continued)

Proposed Overall Completion Date: 11/07/2024

Licensee's Proposed Overall Completion Date: 11/07/2024

Not Implemented (█) - 11/08/2024)

88a - Surfaces

5. 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

There was an approximate 12" long x 1" wide gash in the hallway wall between bedrooms #9 and #10, exposing the plaster behind.

Plan of Correction

Accept (█) 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to assess the gash in the hallway.

To enhance the currently compliant operations:

On 10/10/2024, the Administration, Director, and Maintenance will be educated on Regulation 2600 88a.

Effective 10/8/2024 Maintenance will putty, mesh, dry, and paint to repair the gash into a proper looking wall in the hallway to maintain compliance with 2600 57d with a completion date of 10/17/2024.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 88a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

By 10/22/2024, the Administrator will purchase more supplies to assist maintenance to assess any additional wall repairs as needed with a completion date of 11/1/2024.

Correction:

Effective 10/8/2024 Maintenance will putty, mesh, dry, and paint to repair the gash into a proper looking wall in the hallway to maintain compliance with 2600 88a with a completion date of 10/17/2024.

All current staff persons shall be educated on regulatory compliance, as well as re-educated on the home's reporting procedures for items that need repaired or replaced. This education was conducted by the Administrator on 10/10/2024. and that documentation of the education will be kept in accordance with 2600.65i.

88a Surfaces (continued)

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

Licensee's Proposed Overall Completion Date: 11/01/2024

Not Implemented (████) - 11/08/2024)

95 - Furniture and Equipment**6. Requirements**

2600.

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

Description of Violation

The following furniture in the 1st floor common living room was in disrepair:

- The black vinyl on each of the 2 vinyl sofas was worn away, exposing the under layer of stuffing. Also numerous cracks and tears were present on both sofas
- Numerous cracks and tears, ranging from 4" 8" were present on the tan leather chair

The sink vanity in the 2nd floor common bathroom is in disrepair. The veneer of the vanity is missing, worn and bubbled in numerous areas.

The pink bath mat in the 2nd floor common bathroom was covered in dark stains.

There was extensive dark staining covering approximately 1/3 of the seat of the rolling chair between bedrooms# 9 and #10.

An approximate 6" tear was present on the seat of the vinyl chair between bedroom #9 and the 2nd floor stairwell entrance, exposing the interior foam.

There was no lid on the toilet tank in the 2nd floor common restroom.

Throughout the inspection, the toilet next to the 1st floor medication room would not flush properly.

REPEAT VIOLATION: 12/1/2022, et. al.

Plan of Correction

Accept (████) 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to assess the couches, the sink vanity, the bath mat, the stained seat, the torn chair, the missing toilet lid, and the toilet that was not flushing.

To enhance the currently compliant operations:

Effective 9/19/2024, the Director found the toilet tank lid and put it back on the toilet.

Effective 9/30/2024, the Administrator ordered proper handles for the toilets because they were the wrong ones

95 - Furniture and Equipment (continued)

prior and these new ones that will cause the toilet to properly flush will expect to arrive on 10/7/2024. Maintenance will install the new toilet handles and assure the toilets all flush with an effective completion date of 10/17/2024. On 10/10/2024, the Administration, Director, and Maintenance will be educated on Regulation 2600 95. Effective 10/2/2024, the Administrator purchased a new vanity sink from Lowes and Maintenance will install it beginning on 10/8/2024 with a completion date of 10/17/2024.

Effective 10/3/2024 the Administrator replaced the first cracked vinyl couch with another couch he acquired from another business and he purchased a couch cover for this slightly used couch due to some wear on a cushion and to prevent further wear and tear. The wear on the couch is not cracked or torn but the couch cover will be installed when it arrives 10/6/2024 to prevent further wear.

Effective 10/3/2024, the Administrator bought a second new couch from Big Lots to replace the other cracked vinyl couch and that couch is being delivered on 10/7/2024.

Effective 10/4/2024, the Housekeeper removed the bath mat and the Director purchased a new non-slip rug for the area and it is now placed in the bathroom.

Effective 10/7/2024, the Administrator will remove the stained rolling chair and the torn vinyl chair.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 95. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons shall be educated on regulatory compliance, as well as re-educated on the home's reporting procedures for items that need repaired or replaced. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non-compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week. I also included the monthly and quarterly checks from previous violations but this list is included and not limited to the director's scope of assuring all PA 2600 regulations are in compliance.

Please see attached Director Review. Because it is large and is a packet, I only attached it to one violation but it applies to many violations.

Licensee's Proposed Overall Completion Date: 10/24/2024

Not Implemented [REDACTED] - 11/08/2024)

103f - Refrigerator/Freezer Temps**7. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f Refrigerator/Freezer Temps (*continued*)**Description of Violation**

At 9:30am, there was no thermometer present in the black Frigidaire stand up freezer, located in the home's basement, which contained numerous bags of meats.

REPEAT VIOLATION: 12/1/2022, et. al.

Plan of Correction

Directed [REDACTED] - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to investigate the missing thermometer. The freezer thermometer was accidentally placed into the refrigerator portion with an additional thermometer.

To enhance the currently compliant operations:

On 10/10/2024, the Administration, Dietary, Director, and Maintenance will be educated on Regulation 2600 103f. Effective 10/8/2024 Maintenance will continue to check temperatures daily and notify the Administrator of any missing thermometers to maintain compliance with 2600 103f. (DIRECTED: The daily checks by maintenance shall include a daily check of all refrigerators and freezers to ensure operable thermometers are present in each refrigerator/freezer and to ensure proper food handling temperatures in accordance with 2600.103f. Documentation of daily temperatures in each refrigerator and freezer shall be kept for 2 months. LM 10/15/24).

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 103f. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

Please see attached.

Clarification:

The missing thermometer was found and placed in the correct freezer portion on 9/18/2024 by the Administrator. The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week. All refrigerators and freezers will be included and also ensuring an operable thermometer is present in each and that proper temperatures are being maintained.

103f - Refrigerator/Freezer Temps (continued)

Proposed Overall Completion Date: 10/24/2024

Directed Completion Date: 10/24/2024

Not Implemented (████) 11/08/2024)

103h - Thawing Food

8. Requirements

2600.

103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

At 9:30am, there were (2) 3 lb. pound tubes of ground beef defrosting in a plastic tub in the basement food storage room. The bottom of the tub was covered in a red substance, which appeared to be blood. The instructions on the packages of ground beef indicate to "keep refrigerated or frozen. Thaw in refrigerator or microwave".

Plan of Correction

Accept (████) - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator disposed of the 2 tubes of improperly thawing ground beef. To enhance the currently compliant operations:

On 10/10/2024, the Administration, Director, and Dietary will be educated on Regulation 2600 103h.

Effective immediately, Dietary will thaw food items according to the instructions and on the package and will notify the Administrator of any improperly thawing food items or food safety concerns to maintain compliance with 2600 103h.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 103h. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

103h - Thawing Food (continued)

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non-compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

Licensee's Proposed Overall Completion Date: 10/24/2024

Implemented [REDACTED] - 11/08/2024)

141b1 - Annual Medical Evaluation**9. Requirements**

2600.

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

Description of Violation

Resident #4's most recent medical evaluation was completed on [REDACTED]

Resident #5's most recent medical evaluation was completed on [REDACTED]

REPEAT VIOLATION: 6/21/2023

Plan of Correction

Directed [REDACTED] - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/19/2024 by the Director to investigate the missing updated DMEs, one of which has a guardian. The director thought when the DHS had the visit that the documents were properly in their place. The Med Evals for Resident #4 and Resident #5 were found in a folder improperly filed in a work briefcase. Resident #4's DME was completed [REDACTED] and Resident#5's DME was updated on [REDACTED] with their guardian's signature. Please see attached. We understand it doesn't rectify that the documents were not properly filed and available but all Medical Evaluations were filed properly immediately.

DIRECTED: By 10/18/24: The administrator shall ensure the current medical evaluations for residents #4 and #5 are placed in each resident's record. [REDACTED] 10/15/24

To enhance the currently compliant operations:

On 10/10/2024, the Director and Administration will be educated on Regulation 2600 141b1 and the Director will properly file documents immediately upon completion with the understanding that filing the documents properly ensures the Director gets credit for [REDACTED] work and that DHS has access to the Annual Physicals Forms from the house Dr. The Director understands that these documents ensure that every resident has access to a proper annual physical and we need to ensure this document is properly filed for access and use.

Effective 10/4/2024 the Director audited all resident files for properly filed Annual Medical Evaluations to maintain compliance with 2600 103f and any overdue or due DMEs will be updated immediately with the house doctor with a completion date by 10/15/2024.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 141b1. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings. (DIRECTED: By 10/22/24: The

141b1 Annual Medical Evaluation (continued)

administrator shall develop and implement a tracking system which includes the names of all current residents with the current dates of each resident's medical evaluation. The tracking system shall be reviewed and updated during each weekly director reviews to ensure timely and complete medical evaluations in accordance with 2600.141b. Documentation of the tracking system shall be kept. [REDACTED] 10/15/24).

Please note the DME instruction pages were not attached to save file space but the facility always includes the instruction pages in the document.

See attached please.

Correction:

The Director needs to clarify her mistake in her writing. The Director sends all documents regarding a resident guardianship to the guardian for review. This included the DME. The Director does not ask for a signature from the guardian on the DME but initials. The Director meant to say initials as the Guardian is asked to provide signature for the MA51 and initials for the DME. The physician completed the newest medical evaluation on 7/31/2024. The guardian reviewed the document via DocuSign.

Effective 10/4/2024 the Director audited all resident files for properly filed Annual Medical Evaluations to maintain compliance with 2600 141b1 and any overdue or due DMEs will be updated immediately with the house doctor with a completion date by 10/15/2024.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

Proposed Overall Completion Date: 10/24/2024

141b1 - Annual Medical Evaluation (continued)

Directed Completion Date: 10/24/2024

Not Implemented (████ - 11/08/2024)

183b - Meds and Syringes Locked

10. Requirements

2600.

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

Description of Violation

At 9:00am, the keys to the medication cart were unlocked, unattended and accessible on top of the medication cart in the home's kitchen. Numerous residents were present in the kitchen at the time of discovery.

Plan of Correction

Accept (████ - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrative Assistant to lock the medication cart.

To enhance the currently compliant operations:

On 10/10/2024, the Administration, Director, and Direct Care Staff will be educated on Regulation 2600 183b.

Effective immediately, Direct Care Staff will check hourly and notify the Administrator of an unlocked medication cart maintain compliance with 2600 183b.

Effective 9/19/2024, the Director will do daily written checks of administrative duties including assuring the medication cart is locked.

Effective 10/15/2024, the Director will perform weekly visual checks to maintain ongoing compliance with regulation 183b. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non-compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

Licensee's Proposed Overall Completion Date: 10/24/2024

Not Implemented (████ - 11/08/2024)

183c - Refrigerated Meds Locked

11. Requirements

2600.

183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

183c - Refrigerated Meds Locked (*continued*)**Description of Violation**

At 9:41am, resident #2's Latanoprost 0.005% eye drops were unlocked, unattended and accessible in a metal box in the kitchen refrigerator.

Plan of Correction

Accept () - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrative Assistant to investigate the unlocked metal box with eye drops. The Director bought a lock and key set with extra keys for the lockbox on 9/18/2024 and the eye drops were locked up.

To enhance the currently compliant operations:

On 10/10/2024, the Administration, Director, and Direct Care Staff will be educated on Regulation 2600 183c.

Effective 10/8/2024 Direct Care Staff will continue to check daily and notify the Administrator of any missing locks, keys, or issues with the lockbox locking to maintain compliance with 2600 183c.

Effective 9/19/2024, the Director will do daily written checks of administrative duties including assuring the refrigerated medications have a key, lock, and lockbox.

Effective 10/15/2024 the Director will perform weekly visual checks to maintain ongoing compliance with regulation 183c. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non-compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

Licensee's Proposed Overall Completion Date: 10/24/2024

Implemented () - 11/08/2024)

185a - Implement Storage Procedures

12. 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 #3's glucometer is not set to the current time.

Plan of Correction

Accept () 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to investigate the glucometer and it looks that this prior

185a Implement Storage Procedures (continued)

established resident's glucometer was missed when the glucometers were audited before.

To enhance the currently compliant operations:

On 10/10/2024, the Administration, Director, and Direct Care Staff will be educated on Regulation 2600 185a.

On 10/4/2024, the Director set the time by resetting the device and changing the watch batteries and the Director set the current time for Resident #3's glucometer.

On 10/8/2024 Direct Care Staff will continue to check glucometers daily and notify the Administrator of any issues with the dates and times of glucometers to maintain compliance with 2600 185a.

Effective 9/19/2024, the Director will do daily written checks of administrative duties including assuring the glucometers are labeled and set with current time and dates.

Effective 10/15/2024 the Director will perform weekly visual checks to maintain ongoing compliance with regulation 185a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings.

Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

Licensee's Proposed Overall Completion Date: 10/24/2024

Not Implemented [redacted] - 11/08/2024)

225c - Additional Assessment

13. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #4's most recent assessment was completed on [redacted].

Resident #5's most recent assessment was completed on [redacted].

Resident #6's most recent assessment was completed on [redacted].

REPEAT VIOLATION: 6/21/2023

225c Additional Assessment (continued)

Plan of Correction

Directed [REDACTED] - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/19/2024 by the Director to investigate the missing updated RASPs, one of which has a guardian. The Director thought the RASPs were properly placed in the locked RASP binder available to the Direct Care Staff and DHS. The Annual Assessments for Resident #4 and Resident #5 and Resident #6 were found in a folder improperly filed in a work briefcase. Resident #5s RASP was updated on [REDACTED] with guardian signature. Resident #6s RASP was completed on [REDACTED]. Resident#4s RASP was updated on [REDACTED]. Please see attached. We realize that does not rectify the RASPs being improperly filed and unavailable but all RASPs were filed correctly immediately.

To enhance the currently compliant operations:

On 10/10/2024, the Director and Administration will be educated on Regulation 2600 225c and the Director will properly file documents immediately upon completion with the understanding that the point of producing the documents is for the documents to be available for Staff to read and use and DHS to have access to.

Effective 10/4/2024 the Director audited all resident files for properly filed Annual Resident Assessment and Support Plans to maintain compliance with 2600 225c and any overdue or due RASPs will be updated immediately with a completion date by 10/15/2024.

Effective 10/15/2024 the Director will perform weekly audits to maintain ongoing compliance with regulation 225c. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings. (DIRECTED: By 10/22/24: The administrator shall develop and implement a tracking system which includes the names of all current residents with the current dates of each resident's assessment and support plan. The tracking system shall be reviewed and updated during each weekly director reviews to ensure timely and complete assessments in accordance with 2600.225c.

Documentation of the tracking system shall be kept. [REDACTED] 10/15/24).

Please note Director did not scan the instruction pages for the RASP but the facility includes them in all RASPs. Please see attached.

The RASPs were found improperly filed but were updated. The dates were that Resident #5s RASP was [REDACTED] with guardian signature. Resident #6s RASP was on [REDACTED]. Resident#4s RASP was on [REDACTED] (DIRECTED: By 10/18/24: The administrator shall ensure the current assessments for residents #4, #5 and #6 are placed in each resident's record. [REDACTED] 10/15/24)

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each week and will entail the non compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

225c - Additional Assessment (continued)

Proposed Overall Completion Date: 10/24/2024

Directed Completion Date: 10/24/2024

Not Implemented [REDACTED] - 11/08/2024)

228h - Grounds Discharge/Transfer

14. Requirements

2600.

228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

7. Documented, repeated violation of the home rules.

Description of Violation

On or around [REDACTED], residents #7 and #8 were discharged from the home for violating home rules; however, there is no documentation present in either resident record indicating residents #7 or #8 violated any home rules.

Plan of Correction

Accept [REDACTED] - 10/15/2024)

In response to the violation on 09/18/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/18/2024 by the Administrator to supply the 30 Days Notice and investigated the missing documentation. The documentation for Resident #7 and Resident #8 was not found due to inadequate documenting of the events on paper and it being verbal.

To enhance the currently compliant operations:

On 10/10/2024, the Director and Administration will be educated on Regulation 2600 228h and the Administrator will properly document and file violation of any home rules in the resident's file to keep record of his effective communication of resident rights and our 30 day notice policy as well as the home rules and effective positive behavior between residents and staff to foster a nice home environment.

Effective 9/19/2024 the Administrator created a home rules violation document that will be used to track repeated violation of home rules by residents so that the proper discharge can be done and residents will remain in communication and aware of their resident rights to maintain compliance with 2600 228h.

Effective 10/15/2024 the Director will perform weekly checks to maintain ongoing compliance with regulation 228h. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes at the quality assurance meetings. We will continually review these instances and strive to improve our documentation and discuss this in our quality management meetings.

Please see attached.

The education was produced by the Director and presented by the Administrator on Oct. 10, 2024.

The next Quality Management Meeting will be at The Adam's House on October 24, 2024 at 1pm and documentation of this review shall be kept.

All current staff persons have been be educated on this regulation. This education happened on Oct 10, 2024 and was conducted by the Administrator and that documentation of the education will be kept in accordance with 2600.65i.

The weekly director checks will include points for each regulation the director will be responsible for checking each

228h Grounds Discharge/Transfer (continued)

week and will entail the non compliance details pertaining to the most recent violation in which the home needs to maintain compliance for. The weekly checks will include the ongoing audits as well as a primary document that is a guide for each week.

Proposed Overall Completion Date: 10/24/2024

Licensee's Proposed Overall Completion Date: 10/24/2024

Implemented ([REDACTED] - 11/08/2024)