Pennsylvania
Department of Human Services

Sent via e-mail
May 5, 2025

Administrator
Kaysim Housing Group, Inc.
5919 Wayne Avenue
Philadelphia, Pennsylvania 19144

RE: Kaysim Court Manor
License #: 109660

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on February 21, 2025 and May 1, 2025 of the above facility, we have determined that your submitted plan of correction for the October 2 and 3, 2024 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *KAYSIM-COURT MANOR* **License #**: *10966* **License Expiration**: *12/14/2024*

Address: *5909-19 WAYNE AVENUE, PHILADELPHIA, PA 19144*

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

Administrator

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

Legal Entity

Name: *KAYSIM HOUSING GROUP INC*

Address: *5909-19 WAYNE AVENUE, PHILADELPHIA, PA, 19144*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/07/2000* **Issued By**: *City of Phila L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/03/2024*

Inspection Dates and Department Representative

10/02/2024 - On-Site: [redacted]

10/03/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served**: *67*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *63* **Are 60 Years of Age or Older**: *34*

Diagnosed with Mental Illness: *67* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *9* **Have Physical Disability**: *0*

Inspections / Reviews

10/02/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/31/2025*

05/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *Exception*

3c - Post Current License

1. Requirements

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

Description of Violation

On 10/2/2024, the home's current violation report dated 6/27/2023 was not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed ([redacted] - 02/21/2025)***

The home's administrator will post the most recent violation report dated 6/27/23 within 72 hours of the receipt of the plan of correction.
The administrator will ensure that public postings and subsequent licensing inspection summaries are posted as required. .
The administrator or designee will complete weekly audit documents to confirm that public postings including the licensing inspection summaries are posted in a public and conspicuous place on a weekly basis for 4 weeks and then monthly thereafter. The audit tools will be maintained in the home.

Directed Completion Date: *03/07/2025*

Implemented ([redacted] - 05/01/2025)

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

CARE FACILITY CARBON MONOXIDE ALARMS STANDARDS ACT - ENACTMENT Act of Jun. 23, 2016, Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.
The home did not have a carbon monoxide detector installed within 15 feet of the gas range in the kitchen.

The Clean Indoor Air Act - Personal care homes are considered "public places" under the Clean Indoor Air Act (35 P.S. § 637.1 – 637.11) and thus are subject to those regulations as well. According to the act, personal care homes must post a sign at each entrance that states "Smoking Permitted in Designated Areas Only" or "No Smoking." The international "No Smoking" symbol is also permitted. It is recommended that "Smoking Permitted" signs be posted at outdoor designated smoking areas. If the building is a multi-purpose building (such as a building that has independent living and/or skilled nursing as well as personal care services), signs shall be posted at every entrance to the personal care home part of the building. Smoking is not permitted in independent apartments that are intermingled with personal care home apartments, as the building is being used to provide food or health care-related services and is subject to the smoking ban.
The home does not have signs at the entrance indicated that smoking is only permitted in designated areas. The home also does not have signs at the designated smoking area indicating this is the is designated smoking area.

18 - Compliance With Laws (continued)

Pennsylvania State Law: Act 112, Section 6305: It is Pennsylvania state law that any business that wants to sell tobacco and/or vaping products must first get a Tobacco Sales license from the Pennsylvania Department of Revenue. There are criminal charges associated with selling tobacco or "Other Tobacco Products" (OTP) without obtaining a license for the Pennsylvania Department of Revenue.
There are also criminal penalties associated with selling tobacco products from "out of state". For example, cigarettes with tax stamps from states other than Pennsylvania. In addition to required state tobacco licensure, any tobacco/e-cigarette retailer located in the City of Philadelphia must also obtain a Philadelphia tobacco retailer permit.
The home has resident 1 rolling cigarettes for the residents. The residents are paying an undetermined amount for these cigarettes based on what they can afford.

Plan of Correction ***Directed (- 02/25/2025)***

Within one day of receipt of this plan of correction, a carbon monoxide detector will be installed in proximity of but not less than 15 feet of the gas range in the kitchen.
Within 3 days of the receipt of this plan of correction the administrator or designee shall audit all areas of the home that have any fossil-fuel burning devices or appliances for carbon monoxide detectors.
Carbon monoxide detectors will be monitored on a monthly basis in conjunction within the monthly fire drills beginning in March 2025. Documentation will be kept.

Within 3 days of the receipt of this plan of correction the administrator will post signs at the entrance of the home indicating that smoking is only permitted in designated areas. The administrator will also post signs at the designated smoking area indicating this is the is designated smoking area. The administrator or designee will check on a monthly basis that the signs are posted as required by the Clean Indoor Air Act (35 P.S. § 637.1 – 637.11)

Immediately upon receipt of this plan of correction, the administrator will meet with resident #1 and advise that will cease rolling cigarettes on behalf of the home for sale to other residents. Selling of tobacco and/or vaping products is prohibited by Pennsylvania State Law: Act 112, Section 6305. The administrator will assist residents with locating sources to obtain tobacco products outside of the home.

Directed Completion Date: *03/07/2025*

Implemented (- 05/01/2025)

26b - Quality Management Plan Content

3. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

26b - Quality Management Plan Content *(continued)*

Description of Violation

The home's quality management meetings do not address resident concerns. The home is not holding resident council meetings regularly. The meetings held informs residents of activities and does not address any of their concerns or suggestions.

Plan of Correction ***Directed (█ - 02/25/2025)***

The home's administrator will review and update the home's quality management plan to ensure that the periodic review includes all of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

A complete quality management review that addresses resident and/or family councils, concerns and suggestions will be completed by 3/31/25. Documentation will be maintained.

Directed Completion Date: *03/31/2025*

Implemented (█ - 05/01/2025)

42b - Abuse

4. Requirements

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

Description of Violation

On 10/3/2024, resident 1 was observed rolling cigarettes for the home. Resident 1 works an hour a day, 7 days a week. Resident 1 is receiving a rent reduction of $75.00. Resident 1 should receive $50.75 per week with a monthly rate of $203.00. Resident 1 is only receiving a rent reduction of 75.00 per month off of their rent.

Resident 1 rolls cigarettes for the home and the home states this is a club. The home states that the residents who receive cigarettes pay what they can afford. Some residents pay $1.00 and others pay more. The home states this prevents the residents from panhandling outside for cigarettes and helps the residents who can't afford cigarettes to obtain them from this club. The home also states it helps the residents save money on the price of cigarettes.

Plan of Correction ***Directed (█ - 02/25/2025)***

Immediately upon receipt of this plan of correction, resident #1 will cease to roll cigarettes on behalf of the home to be sold to other residents. This is in violation of Pennsylvania State Law: Act 112, Section 6305, which states: It is Pennsylvania state law that any business that wants to sell tobacco and/or vaping products must first get a Tobacco Sales license from the Pennsylvania Department of Revenue. There are criminal charges associated with selling tobacco or "Other Tobacco Products" (OTP) without obtaining a license for the Pennsylvania Department of Revenue. There are also criminal penalties associated with selling tobacco products from "out of state". For

42b - Abuse (continued)

example, cigarettes with tax stamps from states other than Pennsylvania. In addition to required state tobacco licensure, any tobacco/e-cigarette retailer located in the City of Philadelphia must also obtain a Philadelphia tobacco retailer permit.

All residents including resident #1 may not perform duties on behalf of the home unless they are paid in accordance with Federal wage and hour requirements (at least minimum wage) for any work they choose to do on behalf of the home. Compensation must be made in cash or by check negotiable for cash. It may not be made in barter (such as for cigarettes or other goods) or for in-kind services (such as for a reduction in rent).

Directed Completion Date: *03/05/2025*

Implemented (- 05/01/2025)

42q - Compensation

5. Requirements

2600.
42.q. A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident’s personal space or common areas of the home.

Description of Violation

Resident 1 rolls cigarettes for the home's residents and works an hour a day, seven days a week. The resident receives, a rent reduction of $75.00 per month, which means the resident receives $2.50 per hour.

Plan of Correction ***Directed (- 02/25/2025)***

Effective immediately resident #1 will stop rolling cigarettes for the home and the home's residents as this resident has not been paid in accordance with Federal wage and hour requirements (at least minimum wage) for any work they choose to do on behalf of the home. This includes the performance of any task that would otherwise have to be completed by a staff person. Residents may not volunteer to perform such tasks without compensation. Compensation must be made in cash or by check negotiable for cash. It may not be made in barter (such as for cigarettes or other goods) or for in-kind services (such as for a reduction in rent). In addition, the rolling of and preparation in order to sell tobacco products to other residents violates Pennsylvania State Law: Act 112, Section 6305: It is Pennsylvania state law that any business that wants to sell tobacco and/or vaping products must first get a Tobacco Sales license from the Pennsylvania Department of Revenue. There are criminal charges associated with selling tobacco or “Other Tobacco Products” (OTP) without obtaining a license for the Pennsylvania Department of Revenue. There are also criminal penalties associated with selling tobacco products from “out of state”. For example, cigarettes with tax stamps from states other than Pennsylvania. In addition to required state tobacco licensure, any tobacco/e-cigarette retailer located in the City of Philadelphia must also obtain a Philadelphia tobacco retailer permit.

Directed Completion Date: *03/05/2025*

Implemented (- 05/01/2025)

42s - Privacy

6. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 10/3/2024, the public restroom did not have blinds or curtains for privacy.

Plan of Correction ***Directed (█ - 02/25/2025)***

Within 2 days of the receipt of the plan of correction, curtains or blinds will be installed at the public restroom windows. The administrator will monitor weekly to ensure that privacy is provided by curtains or blinds at all windows. All staff persons will be educated concerning the right to privacy of self and possessions provided to the resident during bathing, dressing, changing and medical procedures. Documentation of education will be kept.

Directed Completion Date: *03/14/2025*

Implemented (█ - 05/01/2025)

51 - Criminal Background Check

7. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

On 10/3/2024, staff person A did not have a criminal background check through the Pennsylvania State Police.

Plan of Correction ***Directed (█ - 02/25/2025)***

Effectively immediately upon receipt of the plan of correction, staff person A will be removed from the work schedule until and unless a criminal background check through the Pennsylvania State Police is obtain in compliance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
The administrator will audit all staff records by 3/14/25 to ensure that both PA State Police and FBI background checks if needed, have been completed. Documentation of criminal history checks will be maintained.

Directed Completion Date: *03/14/2025*

57b - 1 Hour/Day

8. 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 9/30/2024, there were 67 residents in the home, requiring a minimum of 67 hours of direct care service. On these days, only 58.5 hours of direct care staffing was provided.

On 10/11/2024, there were 67 residents in the home, requiring a minimum of 67 hours of direct care service. On these days, only 58.5 hours of direct care staffing was provided.

57b - 1 Hour/Day *(continued)*

Plan of Correction ***Directed (- 02/25/2025)***

The administrator or designated staff person will review current staff schedules by 3/14/25, and develop and implement a schedule that includes the availability of providing at least one hour per day of personal care services for each mobile resident and two hours per day of personal care services for each resident who has mobility needs. At least 75% of the required personal care service hours will be available during waking hours and additional personal care service staffing hours will be scheduled to meet the needs of the residents as specified in the resident's assessments, support plans and as needed to safely evacuate the residents in the event of an emergency. Beginning 3/15/25 the administrator will review the schedule and residents' assessments and support plans at least weekly to ensure adequate staffing is scheduled.

Directed Completion Date: *03/14/2025*

Implemented (- 05/01/2025)

57d - Waking Hours

9. 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 9/30/2024, a total of 50.25 hours of direct care was required. However, only 35.5 of the required hours were provided during waking hours.

On 10/05/2024, a total of 50.25 hours of direct care was required. However, only 45.5 of the required hours were provided during waking hours.

Plan of Correction ***Directed (- 02/25/2025)***

The administrator or designated staff person will review current staff schedules by 3/14/25, and develop and implement a schedule that includes the availability of providing at least one hour per day of personal care services for each mobile resident and two hours per day of personal care services for each resident who has mobility needs. At least 75% of the required personal care service hours will be available during waking hours and additional personal care service staffing hours will be scheduled to meet the needs of the residents as specified in the resident's assessments, support plans and as needed to safely evacuate the residents in the event of an emergency.

Beginning 3/15/25 the administrator will review the schedule and residents' assessments and support plans at least weekly to ensure adequate staffing is scheduled.

Directed Completion Date: *03/14/2025*

57d - Waking Hours *(continued)*

Implemented (█ - 05/01/2025)

60a - Staff/Support Plan

10. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 8/17, 8/24, 8/31, 9/7, 9/14, 9/21 and 9/28, between the hours of 11:30 pm - 7:00 am there were no trained medication technicians to administer medications to the residents of the home.

On 8/18, 8/25, 9/1, 9/8, 9/15, 9/22, and 9/29, between the hours of 11:30 pm - 9:00 am there were no trained medication technicians to administer medications to the residents of the home.

Plan of Correction ***Directed (█ - 02/25/2025)***

The administrator will ensure that there is always a staff person who is trained and certified to administer medications present in the home. The administrator or designated staff person will review current staff schedules by 3/7/25 to ensure that availability of trained medication technicians on each shift and will conduct weekly staff schedule audits beginning 3/14/25 to ensure compliance.

Directed Completion Date: *03/14/2025*

Implemented (█ - 05/01/2025)

62 - Contact List

11. Requirements

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

Description of Violation

Staff person █ the administrator, could not provide a complete staff contact list to include contact information and dates of hire.

Plan of Correction ***Directed (█ - 02/26/2025)***

The administrator will compile and maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers. The contact list will be reviewed on a monthly basis by the administrator to ensure all information is current.

Directed Completion Date: *03/14/2025*

Implemented (█ - 05/01/2025)

63a - First Aid/CPR Training

12. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

63a - First Aid/CPR Training *(continued)*

Description of Violation

During the overnight shifts at the home from 11:30 pm to 9:00 am, 67 residents were present in the home. During this time 0 staff persons were present in the home who are certified in CPR/First Aid.

Plan of Correction ***Directed (- 02/26/2025)***

The administrator or designated staff person will audit the schedule and staff working hours weekly to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation is present in the home at all times. Training in first aid, certified in obstructed airway techniques and CPR will be provided to additional staff to ensure sufficient coverage at all times. Documentation of staffing, training, and certification will be kept by the home.

Directed Completion Date: *03/07/2025*

Implemented (- 05/01/2025)

65a - FS Orientation 1st Day

13. Requirements

2600.

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

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

Description of Violation

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

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

Plan of Correction ***Directed (- 02/26/2025)***

Staff persons A and C will have all of the training required by this regulation by 3/7/25. The administrator will conduct an audit of all staff training records to ensure that all required training has been provided by 3/14/25. An audit tool will be developed and implemented for all staff records to track and ensure all newly-hired staff persons

65a - FS Orientation 1st Day (continued)

receive the training required by this regulation on or before the first work day. The administrator will conduct an audit of all staff training records by 3/14/25.

Directed Completion Date: *03/14/2025*

Implemented (- 05/01/2025)

65b - Rights/Abuse 40 Hours

14. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

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

Plan of Correction ***Directed (- 02/26/2025)***

Staff persons A will have all of the training required by this regulation by 3/7/25. Documentation of training will be kept. The administrator will develop and implement an audit tool and system to ensure that all newly-hired staff persons receive the training required by this regulation within 40 scheduled working hours. The administrator will conduct an audit of all staff training records by 3/14/25.

Directed Completion Date: *03/14/2025*

Implemented (- 05/01/2025)

65d - Initial Direct Care Training

15. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.

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

vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services on [redacted] However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Directed ([redacted] - 02/26/2025)***

Staff person A will not provide unsupervised ADL services until [redacted] completes the Department approved direct care training course and passes the competency test. The administrator will conduct an audit of all staff records by 3/14/25 to ensure that all staff who provide unsupervised ADL services have taken the Department approved direct care training course and passed the competency test. The administrator will review staff records of all newly hired staff to ensure the course has been taken and the competency test passed prior to providing unsupervised ADL's.

Directed Completion Date: *03/14/2025*

65f - Training Topics

16. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2023.

65f - Training Topics (continued)

Plan of Correction ***Directed (- 02/26/2025)***

Staff person D will have completed all required training by 3/7/25 for the 2023 and 2024 training years. Documentation of training will be kept.
The administrator will review all current staff training records by 3/14/25 to ensure all staff persons have completed the required training in accordance with regulation 2600.65f during the 2024 training year.
In addition, the administrator will conduct periodic reviews of staff training, as part of the quality management plan, to ensure that all staff receive the required training courses within each training year

Directed Completion Date: *03/14/2025*

65g - Annual Training Content

17. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

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

Description of Violation

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2023 to 2024.

Plan of Correction ***Directed (- 02/26/2025)***

Direct care staff person D will receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously

65g - Annual Training Content (continued)

served, if applicable by 3/7/25.

The administrator or designated staff person will review all current staff training records and complete an audit document by 3/14/25 to ensure all staff persons have completed the required training in accordance with regulation 2600.65g during the past training year.

The administrator or designated staff person will routinely review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65g.

Directed Completion Date: *03/14/2025*

65i - Training Record

18. Requirements

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

Description of Violation

The home's record of direct care staff training for staff person D does not include any of the annual training.

Plan of Correction ***Directed (█ - 02/26/2025)***

The administrator will complete a training record for staff person D to reflect all annual training provided. The administrator will develop and implement an audit tool for all staff records to be used to document completion of all training. All staff records will be reviewed by 3/21/25. Documentation will be kept.

Directed Completion Date: *03/21/2025*

Implemented (█ - 05/01/2025)

85d - Trash Receptacles

19. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 10/3/2024, there was a full, uncovered, unattended trash can in the public restroom.

On 10/3/2024, there was a full, uncovered unattended trash can in the hallway outside the public restroom.

Plan of Correction ***Directed (█ - 02/26/2025)***

The identified cans will be covered. The administrator/designee will conduct a physical site review to ensure that all trash cans in the home are covered as required by 3/7/25. Monthly checks of all trash receptacles will be conducted by the administrator/designee and documented.
All staff will be educated that trash in kitchens and bathrooms shall be kept in covered trash receptacles. Documentation of the education will be kept.

Directed Completion Date: *03/07/2025*

85d - Trash Receptacles *(continued)*

Implemented (█ - 05/01/2025)

88a - Surfaces

20. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 10/3/2024, there were loose floor tiles near the emergency exit door on the third floor.

Plan of Correction ***Directed (█ - 02/26/2025)***

The loose floor tiles near the emergency exit door on the third floor will be repaired or replaced by 3/14/25. Staff will be educated in the need to report maintenance issues to the administrator upon detection for repair. The administrator will conduct bi-weekly physical site reviews to ensure that the home is properly maintained. Documentation of the physical site reviews will be kept.

Directed Completion Date: *03/14/2025*

89b - Hot Water Temperature

21. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 10/3/2024, the hot water temperature at the shared bathroom in the 100 wing of the home measured 139.2 degrees Fahrenheit and an hour later it was 136 degrees Fahrenheit.

Plan of Correction ***Directed (█ - 02/26/2025)***

Immediately upon receipt of the plan of correction, the hot water temperature will be adjusted so that water accessible to residents does not exceed 120 degrees Fahrenheit. The administrator will check hot water temperatures throughout the facility 2 times per week for 4 weeks to ensure compliance and then monthly thereafter. Documentation of the water temperature testing will be kept.

Directed Completion Date: *03/14/2025*

Implemented (█ - 05/01/2025)

92 - Windows

22. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The screen in the hall window off of the courtyard is torn.

Plan of Correction ***Directed (█ - 02/26/2025)***

The screen in the hall window off of the courtyard will be repaired or replaced by 3/14/25. Staff will be educated that windows, including windows in doors, must be in good repair and securely screened when doors or windows are open and to report maintenance issues to the administrator or designee immediately. Documentation of the

92 - Windows (continued)

education will be kept. The administrator will conduct physical site reviews on a bi-weekly basis to ensure the home is properly maintained.

Directed Completion Date: *03/14/2025*

95 - Furniture and Equipment

23. Requirements

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

Description of Violation

On 10/3/2024, the second-floor bathroom next to room 204 had a broken radiator cover that was being kept next to the sink and not covering the radiator.

Plan of Correction ***Directed (█ - 02/26/2025)***

The radiator cover will be repaired by 3/7/25. The administrator will conduct physical site reviews on a bi-weekly basis to ensure the home, furnishings and equipment are maintained. Documentation of physical site reviews will be kept.
Staff will be educated to report maintenance issues to the administrator or designee immediately. Documentation of the education will be kept.

Directed Completion Date: *03/07/2025*

96a - First Aid Kit

24. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the office does not include tweezers, thermometer and breathing shield.

Plan of Correction ***Directed (█ - 02/26/2025)***

The first aid kit in the office will immediately be restocked with tweezers, thermometer and a breathing shield.
The administrator shall produce a checklist of the required contents to be at or in every first aid kit. The first aid kit(s) will be reviewed by the administrator or a designated staff person on a monthly basis to ensure all required contents are present in the first aid kit.

Directed Completion Date: *03/07/2025*

Implemented (█ - 05/01/2025)

100a - Exterior - Free of Hazards

25. Requirements

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

Description of Violation

On 10/3/2024, the Fire escape stairs from the third floor down to the second floor were missing steps and also rusted on the other steps.

100a - Exterior - Free of Hazards *(continued)*

Plan of Correction ***Directed (█ - 02/26/2025)***

The fire escape stairs from the third floor to the second floor will be repaired by 3/7/25.
Staff will be educated in the need to report maintenance issues to the administrator upon detection for repair. The administrator will conduct bi-weekly physical site reviews to ensure that the home is properly maintained. Documentation of the physical site reviews will be kept.

Directed Completion Date: *03/07/2025*

Implemented (█ - 05/01/2025)

101j2 - Bedroom Chairs

26. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident’s needs.

Description of Violation

Bedroom 102 is occupied by 2 residents; however, there are no chairs in this room.

Plan of Correction ***Directed (█ - 02/26/2025)***

Two chairs will be place in room #102 within 2 days of the receipt of the plan of correction.
An initial audit will be completed by 3/14/25 to ensure that there is a chair for each resident in their bedroom.
Beginning 4/1/25, monthly audits of resident bedrooms will be completed by the administrator or designee to ensure that a chair remains for each resident.
Staff will be educated in the requirement for each resident to have a chair in their room. Documentation of the staff education and the audits will be kept.

Directed Completion Date: *03/14/2025*

Implemented (█ - 05/05/2025)

101j7 - Lighting/Operable Lamp

27. Requirements

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

Description of Violation

Room 102 is occupied by 2 residents; they do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Directed (█ - 02/26/2025)***

A source of lighting that can be turned on/off by each resident at bedside in room 102 will be provided immediately.
An initial audit will be completed by 3/14/25 to ensure that there is a source of lighting at bedside for each resident.
Beginning 4/1/25, monthly audits of resident bedrooms will be completed by the administrator or designee to ensure that a source of lighting that can turned on at bedside remains for each resident.
Staff will be educated in the requirement for each resident to have a bedside lamp or source of lighting that can be turned on/off at bedside. Documentation of the staff education and the audits will be kept.

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

Directed Completion Date: *03/14/2025*

Implemented (█ - 05/01/2025)

102i - Soap Dispenser

28. 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

On 10/3/2024, the second-floor bathroom next to room 204 did not have soap in the dispenser.

Plan of Correction ***Directed (█ - 02/26/2025)***

A staff person assigned to housekeeping duties or a designee will check all bathrooms on a daily basis to ensure that there is soap available. Check sheets will be prepared and used to document that there is soap available beginning 3/7/25.

The documentation check sheets will maintained for 2 months.

Directed Completion Date: *03/07/2025*

107c - Food/Water 3 Day Supply

29. 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 10/3/2024, the home served 65 residents, requiring 195 gallons of emergency drinking water. However, the home had 0 gallons of water. The home does not have a contract with a local bottled water supplier that includes 195 gallons of emergency drinking water.

On 10/3/2024, the home did not have an emergency food supply on site to cover 3 days for an emergency.

Plan of Correction ***Directed (█ - 02/26/2025)***

Effective 3/7/25 the administrator will keep a three day supply of water on-hand in the home for each resident or will obtain documentation of an emergency supply of water which will be delivered in the event of an emergency. If water can not be immediately supplied, the home will maintain the required amount of water on-hand until the emergency supply can be delivered.

The administrator or designated staff person will monitor the food supply in the home weekly to ensure there is at least a three day supply of nonperishable food and water available for each resident. Additional nonperishable food will be obtained as needed on an ongoing basis.

Documentation of the food and water supply will be kept.

Directed Completion Date: *03/07/2025*

Implemented (█ - 05/05/2025)

107d - Procedure Emergency Management Agency Submission

30. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to Philadelphia Emergency Management Agency.

Plan of Correction ***Directed (█ - 02/26/2025)***

The administrator shall update and submit the home's emergency procedures to the Philadelphia Emergency Management Agency by 3/7/25. The administrator will develop a policy regarding the annual review and submittal of the procedures.
Confirmation that the plan has been reviewed and submitted shall be kept and made available for the Department's review upon request.

Directed Completion Date: *03/07/2025*

Implemented (█ - 05/01/2025)

124 - Notice to Fire Department

31. Requirements

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

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Directed (█ - 02/26/2025)***

By 3/7/25 the administrator or designee shall send written notification the the local fire department. Documentation of the notice shall be maintained in the home and made available for review by the Department upon request.

Directed Completion Date: *03/07/2025*

Implemented (█ - 05/01/2025)

132b - Safety Inspection/Fire Drill

32. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have documentation of a fire safety inspection and a fire drill by a fire safety expert.

Plan of Correction ***Directed (█ - 02/26/2025)***

By 3/7/25, the administrator shall reeducate all staff regarding the requirement that a fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of the education shall be kept.

132b - Safety Inspection/Fire Drill (continued)

Directed: By 3/14/25, the administrator shall schedule the annual fire inspection and drill with a fire-safety expert for 2025, to ensure the maximum safe evacuation time is specified in writing by a fire safety expert is completed within the annual (365 day) timeframe. Documentation shall be kept.

Directed Completion Date: *03/14/2025*

132d - Evacuation

33. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills: 7/15/2024 at 10:30 am lasting 2 minutes 35 seconds.

Plan of Correction ***Directed (- 02/26/2025)***

By 3/14/25, the administrator shall reeducate all staff regarding the requirement that residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert or 2 minutes, 30 seconds.

The home will provide residents with education on evacuation policies and procedures. Documentation of this education shall be kept.

By 3/14/25 and monthly thereafter, the administrator or designee shall monitor the home's fire drill records to ensure all residents are able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert or 2 minutes 30 seconds. Documentation shall be kept.

Directed Completion Date: *03/14/2025*

141b1 - Annual Medical Evaluation

34. Requirements

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

Description of Violation

On 10/2/2024, the home did not have a completed annual medical evaluation for Resident 2.

On 10/2/2024, the home did not have a completed annual medical evaluation for Resident 3.

On 10/2/2024, the home did not have a completed annual medical evaluation for Resident 4.

141b1 - Annual Medical Evaluation (continued)

On 10/2/2024, the home did not have a completed annual medical evaluation for Resident 5.

On 10/2/2024, the home did not have a completed annual medical evaluation for Resident 6.

On 10/2/2024, the home did not have a completed annual medical evaluation for Resident 7.

Plan of Correction ***Directed (█ - 02/26/2025)***

The administrator or designee will obtain current annual medical evaluations for residents #2, 3, 4, 5, 6 and 7 by 3/14/25.
The administrator will conduct an audit of all resident records by 3/21/25 to ensure that all residents have a current medical evaluation. A medical evaluation will be completed for any resident who does not have a current one.
By 3/21/25 the administrator will create and use a tracking system to monitor when annual medical evaluations are due and when they are completed.

Directed Completion Date: *03/21/2025*

181d -Storing Medication

35. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 8 self-administers medications and stores medications in their room. On 10/3/24, at 10:49 am, there were several unlocked, unattended medications to include sea moss 19,445 mg and shilajit 19,445 mg in resident 8 bedroom.

Plan of Correction ***Directed (█ - 02/26/2025)***

Resident #8 will immediately be re-evaluated for the ability to self administer medications.
All residents who are capable to self administer their medications will be re-educated in the requirement to keep all medications locked and secure in a safe location. Residents who are capable to self administer medications will be provided with a lock box if needed. Staff will routinely monitor that all medications are kept locked and secure.
Medication trained staff will be educated by 3/14/25, on the importance of educating residents on the need for all medications to be locked and secure. Documentation of the education will be kept.

Directed Completion Date: *03/14/2025*

183e - Storing Medications

36. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications *(continued)*

Description of Violation

The following medications Vitamin D3 125 mg belonging to resident 2 expired 3/2024 and remained in the medication cart.

On 10/3/2024, Latanoprost Eye drops belonging to resident 5 was opened with no open date on the container. According to the manufacturer's instructions this medication expires 6 weeks after opening.

On 10/3/2024, Latanoprost Eye drops belonging to resident 9 was unopened and was not being stored in the refrigerator before opening.

The following medications Zofran 4mg belonging to resident 10 expired 4/5/2024 and remained in the medication cart.

The following medications Betamethasone DP .05% belonging to resident 11 expired 11/30/2023 and remained in the medication cart.

Plan of Correction ***Directed (█ - 02/25/2025)***

The administrator or staff person that is qualified to administer medications will conduct a medication cart audit by 3/14/25. All medications that are identified during the audit as being outdated, expired or no longer prescribed shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations.. Subsequent medication cart audits will be conducted on a weekly basis. A record of the medication audit results will be maintained.

The Latanoprost Eye drops belonging to residents 5 and 9 shall immediately be destroyed and replaced to ensure safety per the manufacturer's instructions.
The administrator or designee qualified to administer medication shall audit all medication stored in the home by 3/14/25 and then weekly thereafter, to ensure medication, including eye drops is stored in accordance with the manufacturer's instructions. Documentation shall be kept.

Directed Completion Date: *03/14/2025*

185a - Implement Storage Procedures

37. 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

On 10/3/2024, during the medication audit for the home, Department representative discovered that the home is not tracking counts on controlled substances. The home had no narcotic count sheets for each of the medications and nor are counts conducted at shift change to prevent theft of controlled medications.

185a - Implement Storage Procedures (continued)

Resident 5 is prescribed Acetaminophen 325 mg as needed. On 10/3/2024, this medication was not available in the home.

Plan of Correction ***Directed (- 02/25/2025)***

Within 48 hours of receipt of the plan of correction the administrator will review and document all controlled medications stored in the home with a count sheet or tracking form that accurately reflects the current count of controlled medications in the home.
Staff will be educated in the daily review and documentation of all controlled medications by 3/14/25. The administrator or a staff person who is qualified to administer medications will audit the tracking process to ensure that the accurate count of the controlled medications is maintained on a monthly basis.
Documentation of the staff education and controlled medication count audits will be kept.

The administrator or staff person who is qualified to administer medications will conduct an audit of all medications to ensure that all prescribed medications including those prescribed on an as needed basis is available for administration in the home. The initial audit will be completed by 3/10/25 and subsequent audits will be conducted monthly beginning 4/1/25.

Directed Completion Date: *03/14/2025*

190a - Completion Medication Course

38. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On 10/1/2024, and 10/2/2024 at 7:00 pm, administered Divalproex 500 mg to resident 8.
On 10/1/2024 and 10/2/24 at 8:00 pm, administered Perphenazine 16 mg Tab to resident 8.

Plan of Correction ***Directed (- 02/25/2025)***

Within 1 calendar day of receipt of the plan of correction, staff person D shall cease administering medication until has completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test.

190a - Completion Medication Course (continued)

By 3/25/25 and monthly thereafter, the administrator or designee shall audit records of all staff performing medication administration to ensure they have successfully completed a Department approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years. Documentation shall be kept.

Directed Completion Date: *03/25/2025*

190c - Record of Training

39. Requirements

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

Description of Violation

The home's medication administration training record for staff person D does not include a copy of the current medication trainer's certificate for training.

Plan of Correction ***Directed (- 02/25/2025)***

Beginning immediately staff person D will not administer medications until a copy of the medication trainer's certificate for training is obtained. Documentation of the trainer's certification will be maintained.
The administrator will audit the training records of all staff who administer medications by 3/25/24 to ensure that training records are complete.

Directed Completion Date: *03/25/2025*

224a - Preadmission Screen Form

40. 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 6 was admitted to the home on ; however, the resident’s preadmission screening form was not completed.

Plan of Correction ***Directed (- 02/25/2025)***

The administrator will document the reason for the non-compliant preadmission screening in the record of resident #6. The administrator will audit all resident preadmission screenings to ensure they are complete, accurate and timely. The administrator will develop a new admission checklist by 3/7/25 to ensure that preadmission screenings are completed within the required timeframe.

224a - Preadmission Screen Form (continued)

224a - Preadmission Screen Form (continued)

Directed Completion Date: *03/07/2025*