pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **H AND M PERSONAL CARE HOME INC**
LEGAL ENTITY

To operate **H & M PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **590 BOGGS SCHOOL ROAD, MOON TOWNSHIP, PA 15108**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **18** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **December 23, 2024** until **June 23, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **448481**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 23, 2024

[REDACTED], Owner/Administrator
H and M Personal Care Home Inc.
[REDACTED]
[REDACTED]

RE: H & M Personal Care Home
590 Boggs School Road
Moon Township, Pennsylvania 15221
License/COC #: 448481

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 25, 2024, and October 7, 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), failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 448480) dated July 7, 2024 – July 7, 2025, 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 23, 2024 to June 23, 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.

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
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[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,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *H & M PERSONAL CARE HOME* **License #**: *44848* **License Expiration**: *07/07/2025*

Address: *590 BOGGS SCHOOL ROAD, MOON TOWNSHIP, PA 15108*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *H AND M PERSONAL CARE HOME INC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *07/31/1983* **Issued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/25/2024*

Inspection Dates and Department Representative

06/25/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *11*
Diagnosed with Mental Illness: *16* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

06/25/2024 - Full

Lead Inspector **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/18/2024*

08/21/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/08/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission* **Follow-Up Date:** *08/28/2024*

09/05/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/08/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *09/15/2024*

11/18/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/08/2024*
Reviewer: [redacted]
Follow-Up Type: *Exception*

3c - Post Current License

1. Requirements

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

Description of Violation

At 10:15 a.m., the home did not have the current license posted in a conspicuous and public place in the home. The only license posted was dated December 20, 2022 until June 20, 2023.

The only licensing inspection summary (LIS) publicly posted in the home was dated 10/11/19. The home did not have the LISs from 5/19/23 and 3/29/23 posted in a public and conspicuous place.

Plan of Correction ***Directed (- 09/05/2024)***

On 6/25/2024 an inspection was conducted at H&M Personal Care Home during that inspection it was point out that a current license was not hung up in a common place. Since the inspection the Administrator contacted the state and a new license was provided and is now hung in a public place with the dates being July 7th 2024 to July 7th 2025.Going Forward the home has the correct website and directions to print the current license online. The new Certificate was posted on 6/26/2024
The old license has since been discarded and the new one is now in its place.
In order to prevent this from having again, the administrator will check the dates of the license yearly and if out of date the administrator shall call the state supervisor or personal to ensure that we always have an updated license.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall complete a weekly audit to ensure 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. 9/5/24

Directed Completion Date: *09/06/2024*

Licensee's Proposed Date for POC Implementation ***Implemented (- 11/18/2024)***

17 - Record Confidentiality

2. 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 10:20 a.m. there was an incident report dated 1/8/23 in the yellow accordion file folder titled "State Inspection Required Documentation" that was in the accessible black mail bin next to the bulletin board between the dining area and TV room. The incident report included the names of residents #1 and #2.

Plan of Correction ***Directed (- 09/05/2024)***

During the inspection it was brought to my attention on 6/25/2024 that incident reports for former residents. Since the inspection the incident reports were put into the former residents charts and locked in storage. To ensure that

17 - Record Confidentiality (continued)

we are in compliance with state regulations any information for current and former residents will not be put in places that are accessible to other residents and/or visitors. all files related to residents will now and in the future will be put in charts and locked away in the designated locked file cabinet that we use for all charts.The Home Administrator made this correction on 6/26/2024. Education was held by the administrator and included all staff members and the homes policies and procedures education will be trained by the home administrator and the education was done on 6/26/2024. The monitoring steps will take place anytime a resident leaves the Personal care home and all records will be properly secured at all times starting on 6/25/2024

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall complete a weekly audit of the home to ensure resident records are kept 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. 9/5/24

Directed Completion Date: *09/06/2024*

Licensee's Proposed Date for POC Implementation **Implemented - 11/18/2024)**

18 - Compliance With Laws

3. 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 Influenza Awareness Act requires that each facility shall ensure that the required influenza information as is available on the Department of Health's website is posted in a public place in the facility. However, at 10:20 a.m., there was no influenza poster posted in the home.

Plan of Correction ***Accept - 09/05/2024)***

On 6/25/2024 an inspection was conducted where an influenza posted was not posted, although we did have one posted when the refrigerator delivery guy came and we did not take the poster off an repost it on the new fridge, since the inspection was conducted a new influenza poster was placed in a common place on the refrigerator where everyone can see on 6.26.2024 by the home administration To ensure that this poster remains posted a weekly observations will be conducted starting on 6/26/2024 by the home administrator to make sure this poster remains posted so everyone can see. See attached

Licensee's Proposed Overall Completion Date: *08/25/2024*

Licensee's Proposed Date for POC Implementation **Implemented 11/18/2024)**

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

The home's record indicates that the administrator is in the home for 12 hours a week performing direct care duties. There is no record that the administrator is in the home 20 hours a week on average per month performing administrator duties.

Plan of Correction ***Directed (- 09/05/2024)***

on 6/25/2024 an inspection was conducted and a staff schedule was provided to the inspectors, this schedule to not depict the days and times in which the Home Administrator Chrissy was on there for at least 20 hours a week as per the state regulations, since the inspection a new schedule was made into affect which shows that the administrator is indeed in the personal care home for a minimum of 20 hours, this schedule does not depict the hours that I do pop in and do a couple hours of work a day due to the fact that is not working a shift, this new schedule does show that I am working shift work 20 hours a week with the indication that I do come in and check on things for more time then on the schedule, to ensure that this does not happen again the Home Administrator will update schedules weekly to inform staff and visitors when the Administrator will be in the PCH. The administrator has made a separate schedule for all administrator duties that equals 20 hours hours a week separate from caregiving hours.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within 5 days of receipt of the accepted plan of correction: The administrator shall develop and implement a schedule which includes the administrator being present in the home an average of 20 hours or more per week, in each calendar month performing administrator duties, not direct care duties. Documentation of the schedule shall be kept. 9/5/24

Within 5 days of receipt of the accepted plan of correction: The administrator shall audit the administrators schedule and actual hours worked to ensure the administrator was present in the home an average of 20 hours or more per week, in each calendar month performing administrator duties, not direct care duties. 9/5/24

Directed Completion Date: *09/10/2024* *Not Implemented (- 11/18/24)*

Licensee's Proposed Date for POC Implementation

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

At 11:00 a.m., there was an accumulation of dirt and cobwebs around the inside and outside of the window in resident room #8.

At 11:05 a.m., there were cobwebs and dirt on the screen for the window in resident room #6.

At 11:25 a.m., there was an accumulation of dust on the vents of the exhaust fan in the bathroom closest to resident room #1. The amount of dust was impeding the operation of exhaust fan.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Directed █ - 09/05/2024)***

On 6/25/2024 an inspection was conducted of H&M Personal care home in which the in sections found some dust, cobwebs, and dirty screens. Since the inspections these conditions have improved and cleaned up, to ensure this does not happen again a weekly deep cleaning will be done weekly starting on 6/27/2024, these will be maintained indefinitely every week. Training was provided to all staff to ensure that they are all trained thoroughly on the importance of cleaning and maintaining sanitary conditions for the residents

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall ensure the staff education related to Regulation 2600.85(a) and the home's policy and procedures to maintain compliance with the regulation is kept in accordance with Regulation 2600.65(i). 9/5/24 █

Within five days of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure sanitary conditions are maintained. 9/5/24 █

Directed Completion Date: *09/10/2024*
Licensee's Proposed Date for POC Implementation ***Implemented █ - 11/18/2024)***

85e - Trash Outside Home

7. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11:17 a.m., there was an uncovered trash can on the porch just outside the exit door from the kitchen. The can was nearly filled with trash to include a paper towel core, yellow grocery bag, a drink can, food wrappers and napkins.

Plan of Correction ***Directed █ - 09/05/2024)***

On 6/25/2024 an inspection was conducted on H&M Personal Care home where we were made aware of the trash cans on the porch that did not have a lid, since the inspection on 6/26/2024 this trash can has since been disposed of and a new one with a lid has been provided for the residents to dispose of their trash on6/26/2024, to ensure this does not happen again on a daily routine the Home Administrator and all staff members will check outside and make sure the lid is still secure on the trash can and that all trash is disposed of. Training was provided to staff by the home administrator on the importance of the trash outside and why it has to have a lid on it. The trash cans top cracked off and going forward trash cans will be checked daily by staff and the administrator to make sure they are in good condition. Staff have been advised and trained to immediately remove any trash cans broken or without tops immediately from being used.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall ensure the staff education related to Regulation 2600.85(e) and the home's policy and procedures to maintain compliance with the

85e - Trash Outside Home (continued)

regulation is kept in accordance with Regulation 2600.65(i). 9/5/24 JK

Directed Completion Date: *09/10/2024*
Licensee's Proposed Date for POC Implementation
Not Implemented (█ - 11/18/24)

88a - Surfaces

8. 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

The bathroom on the main level across from bedroom #5 included the following:
• The paint around the interior door handle was worn off exposing the wood. The area measure approximately two inches around the door handle.
• The paint at the bottom of the interior of the bathroom door was worn off exposing the wood the length of the door and approximately 4" upward.

The paint on the railing of the hallway by bedroom #5 was worn off exposing the wood. The exposed area measured approximately 6 feet.

The home's kitchen floor has multiple cracks and chips across the floor. There are several areas where the floor is also worn through. The floor of the outer wall area is lifting up from the subflooring.

The panic hardware on the emergency exit door leading from the kitchen to the outside is completely detached from the hinge side of the door.

Plan of Correction ***Directed █ - 09/05/2024)***

During the inspection 6/25/2024 an inspection was conducted on H&M Personal Care home where some chipped paint was brought to our attention on bathroom doors and hand rails, on 6/27/2024 those areas have since been rectified and no longer showing exposed wood, to ensure this does not happen again the doors and the handrails will be painted quarterly as the residents are hard on these materials and glide there hands on the paint causing them to been worn. The kitchen floor is due to be redone on September 1st 2024 as we needed to find a floor installer with the soonest availability, picture of floor will be submitted when it is finished. The attachments include the new paint on the hand rails and the bathroom floors. Monitoring steps will be the home administrator doing monthly checks of all surfaces including floor and windows to make sure they are in good repair to ensure the safety of all residents

Proposed Overall Completion Date: 08/25/2024
DIRECTED

Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2600.88(a) and the home's policy and procedures to maintain compliance with the regulation. Documentation of education will be kept in accordance with Regulation 2600.65(i).

Within five calendar days of receipt of the accepted plan of correction: The administrator shall initiate the monitoring steps indicated in the plan of correction. 9/5/24█

Directed Completion Date: *09/10/2024*
Licensee's Proposed Date for POC Implementation
Not Implemented (█ - 11/18/24)

89c - Testing Non-Public Water

9. Requirements

2600.
89.c. A home that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is below maximum contaminant levels. A public water system is a system that provides water to the public for human consumption, which has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

Description of Violation

The home's water source is well water. The home had a coliform test completed on 1/15/24. However, the next coliform test was not completed until 6/4/24.

Plan of Correction ***Accept [redacted] - 09/05/2024)***

On 6/25/2024 an inspection was conducted on 6/25/2024 in which the inspectors made us aware of a missed coliform test on the well water we use for the residents, although there is nothing that can be done on the missed test, moving forward our coliform tests will be done every three months which would make our next water testing is to be done in September of 2024, to ensure this does not happen again the Home Administrator shall check and double check all required time frames in which this is needed to be done, these checks will be done monthly starting from 6/4/2024 and the next one being done no later than a week after September 4, 2024, monthly water checks are done every 3 months for water testing but the home administrator shall do monthly checks starting on 6/26/2024 to ensure enough water is provided to the residents in case of an emergency. Going Forward we have hired a new company that will come in every 3 months to sample the water, we have it set up that they just come in and test the water, they will notify home administrator and [redacted] a week before they are coming. this is to ensure that the water testing is done in a timely manner.

Licensee's Proposed Overall Completion Date: *08/25/2024* *Not Implemented ([redacted] - 11/18/24)*

Licensee's Proposed Date for POC Implementation

92 - Windows

10. 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

At 11:00 a.m., the was no screen in the window of resident room #8 on the lower level. The screen was off and lying in the window well outside of the window.

Plan of Correction ***Directed [redacted] - 09/05/2024)***

Upon inspection on 6/25/2024 the screen that was in room #8 on the lower level screen was in the window well, since the inspection the screen was cleaned and placed back in the window on 6/27/2024, to ensure this does not happen again the administrator and the staff will check the windows and screens bi weekly to make sure they are cleaned and securely in the window.The Home Administrator trained all staff members on the I'mportance of the good repair of windows and screens

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within five calendar days of receipt of the accepted plan of correction: The bi-weekly checks by the administrator will begin. 9/5/24 [redacted]

Directed Completion Date: *09/10/2024*

Licensee's Proposed Date for POC Implementation *Not Implemented ([redacted] - 11/18/24)*

101j2 - Bedroom Chairs

11. 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

Three residents reside in resident room #6. However, at 11:05 a.m., there were only 2 chairs in the room.

Two residents reside in resident room #4. However, at approximately 3:00 p.m., there were no chairs in the room.

Repeat Violation 3/29/23

Plan of Correction ***Directed - 09/05/2024)***

Upon inspection on 6/25/2024 it was brought to our attention that 2 chairs were missing in room #4, on 6/26/2024 2 chairs were securely placed under the beds of the residents bed on 6/26/2024 by the home administrator and this is no Longer an issue, to ensure this does not happen again weekly checks of all rooms will be made to ensure that all rooms have chairs for the residents

Proposed Overall Completion Date: 08/25/2024

DIRECTED

Within one day of receipt of the accepted plan of correction: The administrator shall ensure there is a chair for each resident in bedroom #6. 9/5/24

Within one day of receipt of the accepted plan of correction: The administrator shall educate of all staff persons regarding Regulation 2600.101(j)(2) and the home's policy and procedures to maintain compliance with the regulation. documentation of education shall be kept in accordance with Regulation 2600.65(i). 9/5/24

Within one day of receipt of the accepted plan of correction: The administrator shall complete weekly audits of the resident bedrooms to ensure each resident has a chair for each resident that meets the resident's needs in their bedroom. 9/5/24

Directed Completion Date: *09/10/2024* *Not Implemented (- 11/18/24)*

Licensee's Proposed Date for POC Implementation

103f - Refrigerator/Freezer Temps

12. 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 11:20 a.m., there was no thermometer in the freezer section of the refrigerator/freezer in the home's kitchen.

Plan of Correction ***Directed - 09/05/2024)***

Upon inspection on 6/25/2024 there was no thermometer in the refrigerator in the kitchen, on 6/26/2024 a thermometer was purchased and placed inside the refrigerator in the kitchen by the administrator, to ensure this does not happen again weekly checks will be made by the administrator and staff to make sure all refrigerators have thermometers in the them are at the correct temperature every Sunday

103f - Refrigerator/Freezer Temps (continued)

Proposed Overall Completion Date: 08/25/2024

DIRECTED

Within four calendar days of receipt of the accepted plan of correction: The administrator or a designated staff person shall initiate the Sunday checks. 9/5/24 JK

Directed Completion Date: *09/08/2024*

Licensee's Proposed Date for POC Implementation

Implemented (█ - 11/18/2024)

105g - Lint Removal and Duct Cleaning

13. Requirements

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

Description of Violation

At 10:47 a.m., there was an accumulation of lint around the lint trap and inside the flap of the exterior dryer exhaust vent.

Plan of Correction ***Directed (█ - 09/05/2024)***

Upon inspection on 6/25/2024 the external lint trap was brought to our attention that it was caked in lint, since the inspection on 6/26/2024 the external lint trap was cleaned by the home administrator to avoid any hazards, to ensure this doesn't happen again the external lint trap will be cleaned out weekly beginning on 6/26/2024 by either the home administrator or the staff. (Why do I need to provide medication training for lint)

Proposed Overall Completion Date: 08/25/2024

DIRECTED

within 5 calendar days of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2600.105(g) and the home's policy and procedures to maintain compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 9/5/24 █

Directed Completion Date: *09/10/2024*

Licensee's Proposed Date for POC Implementation

Implemented (█ 11/18/2024)

107b - Emergency Procedures

14. Requirements

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

3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.

Description of Violation

The home's emergency preparedness plan did not include (3) Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents nor (4) means of transportation in the even that relocation is required.

107b - Emergency Procedures *(continued)*

Plan of Correction ***Directed 09/05/2024)***

Since the inspection on 6/25/2024 the emergency preparedness plan has been updated with all phone numbers of emergency providers, housing and means of transportation by the home administrator. On 6.26.2024 a meeting was conducted on the emergency procedure to all direct care workers describing what needs to be done in case of an emergency and the new medical procedures are local in an easily accessible place inside the home. Yearly trainings will be done on our emergency medical procedures for all staff to ensure they completely understand the procedure that need to be taken in case of an emergency, an extended detailed emergency Plan has been added to the current emergency plan, it has all phone numbers, places, and a detailed plan of emergency transportation for residents which we will provide a copy to the entailed department.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall maintain the documentation of education in accordance with Regulation 2600.65(i). 9/5/24

Within one calendar day of receipt of the accepted plan of correction: The administrator shall review and update, as necessary, the homes emergency procedures. 9/5/24

Directed Completion Date: *09/06/2024*

Licensee's Proposed Date for POC Implementation ***Implemented 11/18/2024)***

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

The home serves 17 residents which requires that 51 gallons of emergency water be on site. However, at 10:55 a.m., the home only had 45 gallons of emergency water available in the home. The home does not have a contract with a local bottled water supplier.

Plan of Correction ***Accept - 09/05/2024)***

Since the inspection on 6/25/2024, on 6/26/2024 the remaining water supply was replaced and we now have exactly 51 gallons of water for emergency purposes for the residents. All direct care staff was made aware of the importance of having the proper amount of water that is needed for each residents, weekly checks starting on 6/26/2024 will be conducted to make sure no emergency water was used and if so the water will be replaced. A weekly audit of the of the water will be conducted by the administrator to ensure we have enough emergency water for storage. We also added a couple extra gallons for staff or if needed, a checklist sign off sheet was created to ensure checks are done.

Licensee's Proposed Overall Completion Date: *08/25/2024*

Licensee's Proposed Date for POC Implementation ***Implemented - 11/18/2024)***

121a - Unobstructed Egress

16. Requirements

121a - Unobstructed Egress *(continued)*

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 10:50 a.m., there was an adjustable spring bed frame lying on its side outside on the sidewalk between the lower level exit door near the laundry/pantry area and the lower level exit near the bottom of the stairs. The frame blocks the egress route from the rear exit along the sidewalk to front of the home.

Plan of Correction ***Directed (09/05/2024)***

An inspection was conducted on 6/25/2024 where the inspector brought to our attention that the bed frame we have outside on the lower level was obstructing egress and the residents path in case of an emergency, on 6/26/2024 the home administrator removed the bed frame so that the resident have easy access to the emergency rally points. to ensure this does not happen again the Home administrator and staff will check daily starting on 6/26/2024 to make sure nothing else is obstructing the egresses and preventing the residents from exiting the building safely.

Proposed Overall Completion Date: 08/25/2024

DIRECTED

Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2600.121(a) and the home's policy and procedures to maintain compliance with the regulation. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 9/5/24

Directed Completion Date: *09/10/2024*

Licensee's Proposed Date for POC Implementation ***Implemented - 11/18/2024)***

127a - Portable Space Heaters

17. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

The electric fireplace in the living room plugs into a surge protector outlet behind the unit. The unit is operable, and per staff person A, the fireplace heats up.

Plan of Correction ***Directed - 09/05/2024)***

Upon inspection on 6/25/2024 we were made aware that the tv stand in the living room is counted as a space heater since it has a fake flame fireplace installed in it. since the inspection and on 6/30/2024 The home administrator have unplugged the space heater and secured the on/off switch so it no Longer is used as a space heater, we are working on getting a new tv stand and expect it to arrive by September, in which will dispose of the existing tv stand and replace it with one without the space heater. There will be no monitoring of this space heater as we have replaced it with a tv stand that does not have a space heater included. Space heater safety training was conducted to ensure all the staff is educated in the importance of not having a space heater.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff

127a - Portable Space Heaters (continued)

persons on Regulation 2600.127(a) and the home's policy and procedures to maintain compliance with the regulation. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 9/5/24

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure there are no portable space heaters in the home. 9/5/24

Directed Completion Date: *09/10/2024*

Licensee's Proposed Date for POC Implementation ***Implemented - 11/18/2024)***

132b - Safety Inspection/Fire Drill

18. 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 does not have documentation that a fire drill was conducted by a fire safely expert in the past 12 months.

Plan of Correction ***Directed 09/05/2024)***

I apologize but a fire safety fire drill was conducted on 5/23/2024 it states on the paper that the police chief did indeed conduct a fire safety fire drill it clearly states that during inspection it was determined by that the maximum safe evacuation time for the home was in the time frame that the alarm sounds until all residents have been evacuated outside the building, how would conduct a proper inspection of our fire drill policies without conducting a drill that it clearly states on the paper that signed. this has been the only paper that has needed to fill out for 30 years for it clearly states conducted a fire drill, moving forward to avoid this from happening again, the home administrator will have fill out a training log and sign it the same way we do all of our personal care home credits trainings. We have a fire inspection annually and had an annual fire inspection, however during our inspection we were made aware that another form was needed in addition to the fire inspection form. Going forward we will make sure we have the additional form filled out, we had 2600.132 (d) filled out and we have the form 2600.132 (b) that we are currently waiting to get signed by our fire chief in the area. For future inspections from the fire chief we will have all required documents signed by our fire chief has been contacted and will be up to sign it in a timely matter, once we have the additional sheet signed we will submit this to the department when done.

Proposed Overall Completion Date: 08/25/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall produce the documentation of a fire drill conducted by the home's fire safety expert the Department or schedule a fire drill to be conducted by the home's fire safety expert within five days of receipt of the accepted plan o correction. Documentation of the fire drill shall be kept. 9/5/24

Within five days of receipt of the accepted plan of correction: The administrator shall educate all of the staff persons responsible for maintaining compliance with the regulation and the home's policies and procedures. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 9/5/24

Within one day of receipt of the accepted plan of correction: The administrator shall monitor the compliance of

132b - Safety Inspection/Fire Drill (continued)

regulation 2600.132(b) through the quality management review process. 9/5/24

Directed Completion Date: *09/10/2024*
Licensee's Proposed Date for POC Implementation *Not Implemented (- 11/18/24)*

133.3 - Exit Signs Letter Size

19. Requirements

2600.
133.3. Exit Signs - The following requirements apply for a home serving nine or more residents: Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

Description of Violation

The home serves 17 residents. The emergency exit door leading from the kitchen to the outside has an exit sign that has letters which are only 1" X 1" maximum height.

Plan of Correction ***Directed - 09/05/2024)***

Upon inspection on 6/25/2024 the inspectors brought to our attention that the exit signs on the kitchen back door, on 6/26/2024 a new exit sign has been placed by the home administrator that are the dimensions required by the state. to ensure this does not happen again every quarter the exit signs will be maintained to ensure they are securely on the doors and in plain sight for all visitors and residents

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct the quarterly audits indicated in the home's plan of correction. 9/5/24 .

Directed Completion Date: *09/10/2024*
Licensee's Proposed Date for POC Implementation *Not Implemented (- 11/18/24)*

141a - Medical Evaluation

20. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #3 was admitted to the home on However, the resident's initial medical evaluation was completed on 11/29/23.

Plan of Correction ***Directed - 09/05/2024)***

On the inspection date of 6/25/2024 it was brought to my attention that the medical evaluation form needed to be within the 30 days of date of admittance. Resident #3 however did not have that done. had a medical evaluation done before admitted on and instead of it being a yearly evaluation from date of medical evaluation. The Personal Care home administration corrected this mistake on 6/26/2024. Moving forward the residents evaluations will be done upon the arrival of any new resident so there will not be a lapse in time of admittance date and actual evaluation day.
This has been corrected and moving forward to prevent this from happening again the forms will be completed in the allotted time.

141a - Medical Evaluation (continued)

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall educate all of the staff persons responsible for maintaining compliance with the regulation and the home's policies and procedures. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 9/5/24

Within fifteen days of receipt of the accepted plan of correction: The administrator shall complete an initial audit all current resident medical evaluations for accuracy, completeness, and timeliness. 9/5/24

Directed Completion Date: *09/15/2024*
Licensee's Proposed Date for POC Implementation ***Implemented (- 11/18/2024)***

143a - Emergency Medical Plan

21. Requirements

2600.
143.a. The home shall have a written emergency medical plan that includes the following:
1. The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.
2. Emergency transportation to be used.
3. An emergency-staffing plan.

Description of Violation

The home's emergency medical plan did not include the following:
(1) The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.
(2) Emergency transportation to be used.
(3) An emergency-staffing plan.

Plan of Correction ***Directed (09/05/2024)***

After the inspection on 6/25/2024 I was made aware that our emergency m medical plan did not meet the requirements of the state. this is the first year in over 40 years that our emergency medical plan was incorrect. since the inspection calls were made and we now have an effective medical plan that meets all state regulations including the hospital in which they will go in case of an emergency all of which are chosen by the residents and the hospital of choice from all residents they chose hospital in Pittsburgh due to that being where the house doctor that comes in once a month works out of.The VA residents shall go to the VA hospital in Pittsburgh. Emergency transport has been secured by medivac to transport all residents to their respected hospitals of choice and emergency staffing plan has been implemented and the home administrator, the owner and co owner shall be present within 10 mins if an emergency occurs. Direct Care workers that are on duty at the time of an emergency will first call our 911 service to let them know of the emergency at hand and if there were any injuries, then the home administrator, acting home administrator if the Home administratrator is away, owner and co worker shall be informed so they can come to the scene of an emergency and then medieval will pick up residents and take them to a safe and secure site until the emergency is resolved. These policies have already been instructed by the home administrator on 6/26/2024 and will be done yearly, to ensure there is always clarification of these emergency medical plans. The new emergency medical plan was created by the home administrator on 6/26/2024

143a - Emergency Medical Plan (continued)

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one day day of receipt of the accepted plan of correction: The administrator shall maintain the staff training in accordance with Regulation 2600.65(i). 9/5/24

Directed Completion Date: *09/06/2024*
Licensee's Proposed Date for POC Implementation ***Implemented - 11/18/2024)***

183d - Prescription Current

22. Requirements

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

Description of Violation

At 2:05 p.m., there was a Lantus Solostar pen with label that had resident #4's name on it. However, resident #4 no longer resides at the home.

Plan of Correction ***Directed - 09/05/2024)***

During the inspection on 6/25/2024 it was brought to our attention that there was an insulin pen in the drawer with a prior residents name on it. This was purely by mistake as we had thought we had disposed of any and all prior residents medication, this mistake was purely by accident and on 6/25/2024 we properly disposed of the insulin pen and moving forward daily checks starting on 6/25/2024 all medications will be double checked if a resident is discharged, since the inspection all medications were doubled checked by the home administrator and no other medications were that of prior residents. Going forward anytime a resident discharges from the facility a full sweep of the cart and insulin refrigerator will be conducted by the home administrator to make sure all medications are removed. Staff members are also trained on procedures when a resident is discharged and will also do a sweep of the cart and the refrigerator.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one day day of receipt of the accepted plan of correction: The administrator shall maintain the staff training in accordance with Regulation 2600.65(i). 9/5/24

Within five days of receipt of the accepted plan of correction: The administrator shall conduct an initial audit of all current resident medications to ensure compliance with Regulation 2600.183(d) 5/9/24

Within five days of receipt of the accepted plan of correction: The administrator shall conduct a monthly audit of all resident medications to ensure compliance with Regulation 2600.183(d). 5/9/24

Directed Completion Date: *09/10/2024*
Licensee's Proposed Date for POC Implementation ***Implemented - 11/18/2024)***

183e - Storing Medications

23. Requirements

183e - Storing Medications *(continued)*

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

Description of Violation

*Resident #5 is ordered Novolog FlexPen syringe – Inject 4 units subQ three times daily before meals for diabetes. ** Hold if BG<70 or if meal will be missed Call PCP if BG > or = 400. The manufacturer directions on the resident's box of NovoLog FlexPen prefilled syringes indicates "Store refrigerated at 2°C to 8°C (36°F - 46°F) until first use. After first use store at room temperature … and discard after 28 days." At 1:50 p.m., there was an opened Novolog FlexPen identified as resident #5's that was being kept refrigerated.*

Repeat Violation 3/29/23

Plan of Correction ***Directed - 09/05/2024)***

Due to the inspection that was held on 6/5/2024 we were made aware that all opened insulin pens should be at room temperature and locked in the med cart as we were storing all insulin pens in a temp regulated refrigerator. Since the inspection and on 6/5/2024 the administrator has moved all open insulin pens to the med cart, with labels on the insulin pens and put in labeled baggies to ensure safe administration,to ensure this does not happen again The home administrator called a meeting with all staff and made them aware that all opened pens are to be secured in the med cart and in the designated labeled baggies. moving forward the Home administrator will check weekly starting on 6/25/2024 that this regulation is implemented

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one day day of receipt of the accepted plan of correction: The administrator shall maintain the staff training in accordance with Regulation 2600.65(i). 9/5/24

Within five days of receipt of the accepted plan of correction: The administrator shall complete an initial audit of all current resident medications to ensure compliance with Regulation 2600.183(e). Documentation of audits shall be kept. 9/5/24

Within five days of receipt of the accepted plan of correction: The administrator shall conduct a monthly audit of all resident medications to ensure compliance with Regulation 2600.183(d). 5/9/24

Directed Completion Date: *09/10/2024*

Licensee's Proposed Date for POC Implementation ***Implemented 11/18/2024)***

185a - Implement Storage Procedures

24. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #3 is ordered Humalog 100 units/ml Kwik pen 100 solution pen-injector – Inject SubQ 3 times daily with meals following SS: 10-150=0U, 151-200=2U, 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, >400=12U and call MD. However, on the following dates/times, the incorrect blood glucose reading was entered onto resident #3's June 2024 MAR:
6/24 at 4:39 p.m., reading on glucometer was 68; MAR entry for 6/24/24 at 5:00 p.m. was 89
6/22 at 6:24 a.m., reading on glucometer was 116; MAR entry for 6/22/24 at 9:00 a.m. was 113
6/21 – no 9:00 a.m. reading on glucometer; MAR entry for 6/21/24 at 5:00 p.m. was 116
6/20 at 12:52 p.m., reading on glucometer was 108; MAR entry for 6/20/24 at 12:00 p.m. was 121
6/17 – no 5:00 p.m. reading on glucometer; MAR entry for 6/17/24 at 5:00 p.m. was 109
6/16 at 12:54 p.m., reading on glucometer was 89; MAR entry for 6/16/24 at 12:00 p.m. was 128

*Resident #5 is ordered Novolog Flexpen syringe – Inject 4 units sub Q three times daily before meals for diabetes. ** hold if BG<70 or if meal will be missed Call PCP if BG> or = 400. However, on the following dates/times the incorrect blood glucose reading was entered onto resident #5's June 2024 medication administration record (MAR):*
6/19 8:31 a.m. reading on glucometer 114; MAR entry for 6/19/24 at 10:00 a.m. was 108
6/16 – no 10:00 a.m. reading on glucometer; MAR entry for 6/16/24 at 10:00 a.m. was 123

Plan of Correction ***Directed - 09/05/2024)***

Since the inspection on 6/25/2024 all glucometers were recalibrated and permanently labeled with names of residents on the meter. starting on 6/25/2024 the home administrator and direct care workers will check and double check that all meters are properly calibrated and that the numbers of the sugars will be documented properly and numbers on the glucometers match the numbers documented in the MAR. The home home administrator will double check weekly starting on 6/25/2024 to make sure all documentation is accurate.All staff members we re educated on calibrating the glucose monitors and the importance of documenting the correct blood sugar numbers, training was done by the home administrator.

Proposed Overall Completion Date: 08/25/2024

DIRECTED
Within one day day of receipt of the accepted plan of correction: The administrator shall maintain the staff training in accordance with Regulation 2600.65(i). 9/5/24

Directed Completion Date: *09/06/2024*

Licensee's Proposed Date for POC Implementation ***Implemented - 11/18/2024)***

187a - Medication Record

25. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.
7. Route of administration.
8. Frequency of administration.
11. Special precautions, if applicable.

187a - Medication Record *(continued)*

Description of Violation

Resident #3 is ordered Humalog 100 units/ml Kwik pen 100 solution pen-injector – Inject SubQ 3 times daily with meals following SS: 10-150=0U, 151-200=2U, 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, >400=12U and call MD. However, the resident's MAR had an entry for the 9:00 a.m. administration that indicated Insulin Lispro Kwik pen (for Humalog) – Inject SubQ 3 times daily with meals following SS: 10-150=0U, 151-200=2U, 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, >400=12U. The entry for this medication on the resident's June 2024 MAR did not include to call MD if blood glucose >400. The entries on resident #3's June 2024 MAR for the 12:00 p.m. and the 5:00 p.m. administration did not include directions for administration. Both entries indicated "Same as above."

Resident #6 is ordered Haloperidol 1mg tab – Take one tablet by mouth twice a day may take one extra pill for hallucinations. However, there only entry on the resident's medication administration record (MAR) indicates Haloperidol 1mg tab – Take 1 tablet by mouth 2 times a day.

Plan of Correction ***Directed - 09/05/2024)***

On the inspection conducted on 6/25/2024 it was brought to the attention of the staff that the MAR did not match the labeled medication. Since the inspection and on 6/25/2024 our Long term care facility pharmacy was notified and the MAR was corrected. The resident get all his medications from the VA pharmacy and our regular pharmacy just provides the MAR and not the medication, as of 6/25/2024 the pharmacy is aware of all changes that need to be made of the VA residents and MARS were corrected and sent out. Starting on 6/25/2024 monthly checks will be made by the home administrator as that is when all the medications are sent out to the resident. The Home administrator shall check any and all VA meds that are sent out and make sure that what is on the bottle matches the MAR. Audits are done with MARS our long term care pharmacy provides us with MARS for every and all residents and their medications. Medications are done accordingly to the MAR if there is a discrepancy on the MAR we contact the pharmacy and have them make corrections, this particular citation is with one VA resident and that the medications did not reflect what was on the MAR this has since been rectified. The resident is now in the hospital with no discharge date thus far, when the resident returns the home administrator will make sure weekly that all medications on the MAR match the medications in the locked Med Cart

Proposed Overall Completion Date: 08/25/2024

DIRECTED

Within five days of receipt of the accepted plan of correction: The administrator shall educate all staff persons who administer medications on Regulation 2600.187(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 9/5/24

Directed Completion Date: *09/10/2024*

Licensee's Proposed Date for POC Implementation ***Implemented 11/18/2024)***

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 #6 is ordered Sertraline HCL 50mg tablet – take one tablet by mouth every day. According to staff person A, this medication was not available in the home this date. However, staff person B documented on the resident's June

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

2024 medication administration record (MAR) that the 6/25/24 10:00 a.m. dose was administered.

Plan of Correction ***Directed 09/05/2024)***

Upon the inspection that was conducted on 6/25/2024 resident 6 did run out of his medication of sertraline. On 6/25/2024 the VA pharmacy was notified of the lapse in medication. The medication is now in the med cart. On 6/26/2024 a meeting was conducted with my staff of the importance of double checking the meds and signing the MAR accordingly to what is actually given. if a medication is not mailed in time for the va resident it needs to be noted in the MAR that the medication has not arrived yet. To avoid this from happening again weekly checks will be conducted by the administrator to ensure that if a patient is running low on their medications then emergency meds shall be sent and paid out of pocket for to our local long term care pharmacy until their full script arrives by mail from the VA.

Proposed Overall Completion Date: 08/25/2024

DIRECTED

Within one day day of receipt of the accepted plan of correction: The administrator shall maintain the staff training in accordance with Regulation 2600.65(i). 9/5/24

Within one day day of receipt of the accepted plan of correction: The administrator shall initiate the weekly checks indicated in the home's plan of correction. 9/5/24

Directed Completion Date: *09/06/2024*

Licensee's Proposed Date for POC Implementation

Implemented 11/18/2024)

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

Facility Information

Name: *H & M PERSONAL CARE HOME* **License #**: *44848* **License Expiration**: *07/07/2025*

Address: *590 BOGGS SCHOOL ROAD, MOON TOWNSHIP, PA 15108*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *H AND M PERSONAL CARE HOME INC*

Address:

Phone **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *07/25/1983* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *10/08/2024*

Inspection Dates and Department Representative

10/07/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *14* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *14* **Diagnosed with Intellectual Disability**: *2*

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

Inspections / Reviews

10/07/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/16/2024*

Inspections / Reviews *(continued)*

10/21/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/28/2024*

11/05/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/10/2024*

11/18/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/17/2024*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 9/19/24, at approximately 9:00 a.m., a medical assistance transportation program vehicle drove into the front left side of the home from the parking lot and damaged the wall. Local police and the fire department responded to the accident. However, the home did not submit a written report on a form prescribed by the Department, to the Department's personal care home Southwest Regional Office and did not send the reporting form to the Department's southwest regional office until 10/7/24 at approximately 10:55 a.m.

Plan of Correction ***Directed (- 11/05/2024)***

An incident report was submitted in accordance with the Department standards. I have no plan of action for this as it was not a violation since it was done.

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within one day of the receipt of the accepted plan of correction: The administrator shall submit an incident report for the incident to the Southwest Regional Office. 11/5/24

Within five days of the receipt of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2600.16(c), The homes policy and procedures for reporting reportable incidents and conditions including the correct means to submit incident reports to the Southwest Regional Office. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 11/5/24

Within one day of the receipt of the accepted plan of correction: The administrator shall audit all reportable incidents and conditions to ensure all reportable incidents and conditions are reported to the Department's Southwest Regional Office in accordance with Regulation 2600.16(c). 11/5/24

Directed Completion Date: *11/10/2024*
Licensee's Proposed Date for POC Implementation *Not Implemented (- 11/18/24)*

85e - Trash Outside Home

2. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 9:30 a.m. the home's smoking area contained a large garbage can and medium garbage can, neither garbage can was lidded and both garbage cans were approximately three-quarters full of trash.

Plan of Correction ***Directed (- 11/05/2024)***

Since the inspections the Trash can has since been disposed of and a training was conducted on why it is important for all trash cans to be covered. A checklist was made and it was put on the July Plan of corrections, due to the

85e - Trash Outside Home (continued)

accident and the extent of the damages done a lot of my checklists have been damaged, I have since been redoing all checklists in order to make sure this does not happen again. Another training was conducted on this matter and conducted the training on on October 12th, the training is in our compliance book and this will no longer be an issue.

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within one day of the receipt of the accepted plan of correction: The administrator shall ensure the staff education will be kept in accordance with Regulation 2600.65(i). 11/5/24

Within one day of the receipt of the accepted plan of correction: The administrator or designee shall conduct a daily audit of the home to ensure trash outside the home is kept in covered receptacles that prevent the penetration of insects and rodents. Documentation of audits shall be kept. 11/5/24

Directed Completion Date: *11/06/2024*

Licensee's Proposed Date for POC Implementation

Not Implemented (- 11/18/24)

88a - Surfaces

3. 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 9/19/24, at approximately 9:00 a.m., a medical assistance transportation program vehicle drove into the front left side of the home from the parking lot and damaged the wall. However, on 10/7/24, the interior structure of the wall remained unfinished and uncovered with exposed plywood and the exterior wall, also damaged during the incident, remained unfinished and was covered by a weather tarp.

Plan of Correction ***Directed (- 11/05/2024)***

During the 10/7/24 inspection conducted it was brought to our attention that the Walls that was damaged was not properly insulated on the inside, since then it has been properly insulated to ensure that it is safe and warm inside the house until the wall can be rebuild, we are still waiting on adjustment totals to see the extent of the damage and when it can be fixed. We are currently waiting on the insurance company of the company vehicle went through the wall once I have the information on the steps that will be taken to correct this I will send them to you, as of right now we are waiting for it to be completed

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall provide a prospective timeline for each step in the process to correct the violation to (Regional Licensing Supervisor) via email. This shall include each step in the process including obtaining permits. 11/5/24

Directed Completion Date: *11/06/2024*

Licensee's Proposed Date for POC Implementation

Not Implemented (- 11/18/24)

89c - Testing Non-Public Water

4. Requirements

2600.
89.c. A home that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is below maximum contaminant levels. A public water system is a system that provides water to the public for human consumption, which has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

Description of Violation

The home's water source is well water. The home had a coliform test completed on 6/4/24, however, the next coliform test has not been completed since that time.

Plan of Correction ***Directed - 11/05/2024)***

The coliform test conducted at the time of inspection has not been completed yet, the company did however came and picked up the water sample on 10/13/24 we are just awaiting the results and paper in which to show you. I do not have the. education sheet in front of me as I did not know the POC was already due, I did not receive any email until today that it had been looked at as soon as I can I will get you documentation. We have since put the water company responsible for doing our water testing has since been put on a 3 month schedule and has already been there right after this inspection and tested the water

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall ensure the documentation of education in maintained in accordance with Regulation 2600.65(i). 11/5/24

Within one calendar day of receipt of the accepted plan of correction: The administrator shall conduct an audit every three months to ensure the home's water is tested by a Department of Environmental Protection-certified laboratory, stating that the water is below maximum contaminant levels. Documents of audits shall be kept. 11/5/24

Directed Completion Date: *11/06/2024*
Licensee's Proposed Date for POC Implementation
Not Implemented (- 11/18/24)

101j2 - Bedroom Chairs

5. 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

At approximately 11:00 a.m., there was only one chair in resident #1's and resident #2's shared resident room #

REPEAT VIOLATION 3/29/23

Plan of Correction ***Directed - 11/05/2024)***

Since the inspection a chair has been placed in room # after the initial inspection in July a chair was placed in this room and every other room that did not have one, the resident took the chair out of the room for unknown reasons. Since the inspection on 10/7/2024 another chair has been placed in the room.Education on this was already conducted by Home Administrator and daily routines of weekly checks of patients room

101j2 - Bedroom Chairs (continued)

to make sure they have chairs will be done in a timely fashion

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall reeducate all staff persons on Regulation 2600.101(j)(2) and the home's policy and procedures to ensure compliance with the regulation. Documentation of education shall be kept in compliance with Regulation 2600.65(i). 11/5/24

Within one day of receipt of the accepted plan of correction: The administrator or designee shall conduct a weekly audit of the home to ensure compliance with Regulation 2600.101(j)(2). Documentation of audits shall be kept. 11/5/24

Directed Completion Date: *11/10/2024*
Licensee's Proposed Date for POC Implementation
Not Implemented (- 11/18/24)

133.3 - Exit Signs Letter Size

6. Requirements

2600.
133.3. Exit Signs - The following requirements apply for a home serving nine or more residents: Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

Description of Violation

The home serves 17 residents. The emergency exit door leading from the basement steps landing to the outside rear of the home has an exit sign that has letters which are only 1" X 1" maximum height.

Plan of Correction ***Directed (- 11/05/2024)***

As of the in sections in July a new EXIT was placed on the door, the size is what is required and I'm unsure why this is a violation, all of our exit signs are the same size and on every door. I am sorry but I am still unsure as to why this is a violation when new exit placards were placed on all doors at the compliance size. we had a training at the last inspection and I did provide you with documentation on that training.

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction the administrator shall audit all exit door to ensure all exit doors have an exit sign with letters that are at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide. 11/5/24

Within one calendar day of receipt of the accepted plan of correction the administrator or designee shall conduct a weekly audit to ensure compliance with Regulation 2600. 133.3. Documentation of audits shall be kept. 11/5/24

Directed Completion Date: *11/06/2024*
Licensee's Proposed Date for POC Implementation
Not Implemented (- 11/18/24)

251b - Record Entries Legible

7. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

251b - Record Entries Legible *(continued)*

Description of Violation

Resident #3's initial medical evaluation, dated 11/14/23, had corrective tape used in the area of the form to document the medical professional's name, signature, licensed number, and date; all fields had information that was written over the corrective tape.

Plan of Correction ***Directed 11/05/2024)***

All records in the MAR are completely legible and the only reason that corrective tape was place on the MAR time sheets is because they were not spaced properly by the pharmacy, the MAR has since been corrected and corrective tape will no longer be used in anyway. Home Administrator had conducted the meeting about white out and tape this was done to make sure that the MAR was legible and documentation of this exact medication was documented properly and it was, we will no longer use white out or tape we will call the long term pharmacy and have them print out a new one if one is not legible for us.

Proposed Overall Completion Date: 11/04/2024

DIRECTED
Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2600.251(b) and the home's policy and procedures to maintain compliance with the regulation. Documentation shall be maintained in compliance with Regulation 2600.65(i). 11/5/24

Within one day of receipt of the accepted plan of correction: The administrator shall audit at least five resident records a month to ensure compliance with Regulation 2600.251(b). Documentation of audits shall be kept. 11/5/24

Directed Completion Date: *11/10/2024*

Licensee's Proposed Date for POC Implementation *Not Implemented (- 11/18/24)*