



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 21, 2025

██████████, Owner
Dunlevy Manor Living LLC
2218 PA-88
Dunlevy, Pennsylvania 15432

RE: Dunlevy Manor Living
License/COC #: 455972

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 12, 2024, and February 19, 2025, 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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 SECOND PROVISIONAL license is enclosed and is valid from March 21, 2025 to September 21, 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: *DUNLEVY MANOR LIVING* License #: *45597* License Expiration: *01/31/2025*
Address: *2218 PA-88, DUNLEVY, PA 15432*
County: *WASHINGTON* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *DUNLEVY MANOR LIVING LLC*
Address: *2218 PA-88, DUNLEVY, PA, 15432*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/03/2024* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *14* Waking Staff: *11*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Provisional* Exit Conference Date: *12/04/2024*

Inspection Dates and Department Representative

11/12/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* Residents Served: *8*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *8*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *6* Have Physical Disability: *0*

Inspections / Reviews

11/12/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/20/2024*

Inspections / Reviews (*continued*)

12/20/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 01/24/2025
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/27/2024

01/07/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 01/24/2025
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 01/21/2025

02/27/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 01/24/2025
Reviewer: [REDACTED] Follow-Up Type: Enforcement

16b - Incident Policies

1. Requirements

2600.

16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home does not have written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Plan of Correction

Directed ([redacted] - 01/07/2025)

This violation was completed on 11/13/24.

On 11/12/24 the new policy and procedure binder that the new administrator placed in the building was misplaced and could not be found. On 11/13/24 the administrator made a new policy and procedure binder and placed it for all staff to see. (DIRECTED: By 1/10/25: The administrator shall ensure the policy and procedure binder includes the home's procedures for the prevention, reporting, notification, investigation and management of reportable incidents and conditions. [redacted] 1/7/25).

Moving forward all staff will be educated on regulation 16.b during a staff quality management review being held on 12/30/24 by the administrator which documentation will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/7/25).

There will be weekly checks by the administrator or designated person to ensure this binder is available at all times. These checks will start on 01/07/25 by the administrator or designated person and will be done weekly for 30 days to ensure the policy and procedure handbook is visible for everyone to see.

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/10/2025

Implemented ([redacted] - 02/27/2025)

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

The influenza poster was not posted in a conspicuous and public place in the home in accordance with the Influenza Awareness Act, which was enacted in July, 2016.

Plan of Correction

Directed ([redacted] - 01/07/2025)

This violation was completed on 11/13/24.

18 - Compliance With Laws (continued)

The influenza poster was placed in a conspicuous place for everyone to see on 11/13/24 by the new administrator.

Moving forward all staff will be educated on this regulation during a staff training/quality management plan review being held 12/30/24 by the administrator. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

The administrator or designated person will check weekly for 30 days to ensure the poster is in its proper place for everyone to see. These checks will start on 12/23/24 by the administrator or designated person. (DIRECTED: At the conclusion of the weekly audits, the administrator shall inspect the home monthly to ensure the Influenza poster is posted in a public and conspicuous place in the home. [REDACTED] 1/7/25).

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Implemented ([REDACTED] - 02/27/2025)

26a - Quality Management Plan

3. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home has not established and implemented a quality management plan.

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

The new administrator started [REDACTED] so there is not way to determine when the most recent quality management plan meeting was held. Our quality management staff meeting was conducted on 09/23/24. Information included in our QA meeting are incident summaries, medication issues, reportable incidents, inspection reviews, fire drills, all trainings, etc. Attached for submission will be the form we used to document our QA meetings. Documentation is kept.

All staff will be educated on this regulation during another staff training/quality management plan being held 12/30/24 by the administrator. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

Moving forward the administrator or designated person will check monthly to gather all the information to talk about at each quarterly meeting. A check list made by the administrator.

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Not Implemented ([REDACTED] - 02/27/2025)

26a - Quality Management Plan (continued)

51 - Criminal Background Check

4. 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

A Pennsylvania criminal background check was requested on [REDACTED] for staff person A, who was hired on [REDACTED] however, the background check indicates "request under review for control". The home never received and reviewed the results, and staff person A has been working unsupervised in the home.

A Pennsylvania criminal background check was requested on [REDACTED] for staff person B, who was hired on [REDACTED] however, the background check indicates "request under review for control". The home never received and reviewed the results, and staff person B has been working unsupervised in the home.

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

Staff A, a criminal background check was completed on 11/13/24. (DIRECTED: Documentation of staff person A's new Pennsylvania criminal background check shall be kept in staff person A's record. [REDACTED] 1/7/25)

Staff B, a criminal background check was completed on 11/13/24. (DIRECTED: Documentation of staff person B's new Pennsylvania criminal background check shall be kept in staff person B's record. [REDACTED] 1/7/25)

A QA meeting will be held on 12/30/24 (a sign in sheet will be kept) and regulation 51 will be addressed with all staff. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

An audit will be completed on 1/7/25 of all staff files to ensure there are no missing background or FBI clearance. After the audit moving forward the administrator or designated person will audit staff files monthly to ensure nothing is missing and when a new staff is hired the administrator or designated person will have the criminal background checks done within the first 30 days of hire and staff will not be left alone with a resident until the background check is back. New hire files will be checked weekly for the first 30 days to ensure everything is in the files.

DIRECTED: By 1/21/25: The administrator shall develop and implement a new hire checklist to ensure timely and complete background checks are completed for all newly-hired staff persons in accordance with 2600.51. Copies of the completed checklists shall be kept in each newly-hired staff person's record. [REDACTED] 1/7/25

All documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/21/2025

Not Implemented ([REDACTED] - 02/27/2025)

65a - FS Orientation 1st Day

5. 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

Direct care staff person A was hired on [REDACTED]; however, did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

Staff A was hired on [REDACTED] and the 40 hour training was completed on 1/20/24 through 2/03/24 according to [REDACTED] training days which was in [REDACTED] file on [REDACTED] (DIRECTED: By 1/12/24: The administrator shall ensure staff person A received training on all topics specified in 2600.65a. Documentation of staff person A's training shall be kept in accordance with 2600.65i and shall be kept in staff person A's record. [REDACTED] 1/7/25).

A QA meeting will be held on 12/30/24 (a sign in sheet will be kept) and regulation 51 will be discussed with all staff. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b.

Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

An audit will be completed by 1/7/25 of all staff files to ensure there are no missing trainings in the first 40 hours (documentation will be kept). After the audit moving forward the administrator or designated person will audit staff files monthly to ensure nothing is missing and when a new staff is hired the administrator or designated person will have weekly staffing checks to ensure the first 40 hours is completed and is collected within the first day of hire. New hire files will be checked weekly for the first 30 days to ensure everything is in the files This will start on 1/7/25.

DIRECTED: By 1/21/25: The administrator shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65a on or before their first work day. Copies of the completed checklists shall be kept in each newly-hired staff person's record. [REDACTED] 1/7/25

All documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/21/2025

Not Implemented ([REDACTED] - 02/27/2025)

65b - Rights/Abuse 40 Hours

6. Requirements

65b - Rights/Abuse 40 Hours (continued)

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

Direct care staff person A was hired on [REDACTED] however, did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

Staff A was hired on [REDACTED] and the 40 hour training was completed on 1/20/24 through 2/03/24 according to [REDACTED] training days which is in [REDACTED] file on [REDACTED] (DIRECTED: By 1/12/24: The administrator shall ensure staff person A received training on all topics specified in 2600.65b. Documentation of staff person A's training shall be kept in accordance with 2600.65i and shall be kept in staff person A's record. [REDACTED] 1/7/25).

A QA meeting will be held on 12/30/24 (a sign in sheet will be kept) and regulation 51 will be discussed with all staff. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

An audit will be completed by 1/7/25 of all staff files to ensure there are no missing trainings in the first 40 hours (documentation will be kept). After the audit moving forward the administrator or designated person will audit staff files monthly to ensure nothing is missing and when a new staff is hired the administrator or designated person will have weekly staffing checks to ensure the first 40 hours is completed and is collected within the first day of hire. New hire files will be checked weekly for the first 30 days to ensure everything is in the files This will start on 1/7/25.

DIRECTED: By 1/21/25: The administrator shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65b within 40 scheduled working hours. Copies of the completed checklists shall be kept in each newly-hired staff person's record. [REDACTED] 1/7/25

All documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/21/2025

Not Implemented ([REDACTED] - 02/27/2025)

95 - Furniture and Equipment

7. Requirements

2600.

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

Description of Violation

The following 3 white rocking chairs, located on the front porch, are in need of repair:

95 - Furniture and Equipment (continued)

- 1 rocking chair had a back leg entirely out of the rocker bottom, and had gray duct tape holding on the top side support
- 1 rocking chair had a back leg entirely out of the rocker bottom, and the right arm rest was out of the wooden frame
- 1 rocking chair had a back leg entirely out of the rocker bottom

Plan of Correction

Directed () - 01/07/2025

All broken furniture was thrown away on 11/13/24 by the new administrator. An audit was completed on 11/13/24 to ensure there were no broken or unsafe furniture in the building. Documentation is kept.

A QA meeting will be conducted on 12/30/24. and regulation 95 will be addressed with all staff. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. () 1/7/25).

Moving forward all staff will be educated on this regulation during a staff training on 12/30/24 by the administrator. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. () 1/7/25).

The administrator will check weekly to ensure the home is free of any broken unsafe furniture. These checks will be done for 30 days by the administrator or designated person. These checks will start on 12/23/24 by the administrator. (DIRECTED: At the conclusion of the weekly checks, the administrator shall inspect the home monthly to ensure all furniture and equipment is clean, in good repair and free of hazards. () 1/7/25). Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Not Implemented () - 02/27/2025

101j1 - Mattress Fire Retardant

8. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

At 10:59 AM, the head of resident #1's bed was approximately 4 inches lower than the foot of the bed. Resident #1 indicated it is like sleeping upside down and it is difficult for resident #1 to get out of bed.

Plan of Correction

Directed () - 01/07/2025

Resident #1 had () legs elevated while in the bed, () is able to get in and out of bed by () When this was brought to the administrators attention that the foot of the bed was higher than the head () immediately went in

101j1 - Mattress Fire Retardant (continued)

the room and lowered the foot of the bed and notified the inspectors that it was fixed.

An audit was conducted by the administrator on 11/13/24 to ensure all resident beds were in working and good condition.

Moving forward the staff will be educated on this regulation by the administrator during a staff training held on 12/30/24. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. █ 1/7/25). Staff will check daily for 30 days to ensure all beds are level and in working order. These checks will start on 12/23/24 by scheduled staff. (DIRECTED: At the conclusion of the daily checks, the administrator shall check all resident beds and mattresses monthly to ensure compliance with 2600.101j1. █ 1/7/25).

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Implemented (█ - 02/27/2025)

130h - Inoperable Smoke Detector

9. Requirements

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm becomes inoperable.

Plan of Correction

Directed (█ - 01/07/2025)

Smoke alarm/Fire detectors not working policy and procedure was located in the Dunlevy Manor Living policy and procedure binder on the entrance table. The binder was placed flat on the counter so everyone can see it on 11/13/24 by the administrator. Documentation is kept. (DIRECTED: By 1/10/25: The administrator shall ensure the policy and procedure binder includes the procedures that will be immediately implemented if the fire alarm or smoke detectors become inoperable. █ 1/7/25).

A QA meeting will be conducted on 12/30/24 and regulation 130h will be discussed with all staff to ensure all staff know where the policy is and what the policy is. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/7/25). The administrator or designated person will check 2 times a week to ensure that the polices are in the binder and available for staff to look at. (DIRECTED: The weekly checks shall begin on 1/13/25. █ 1/7/25). Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/13/2025

Implemented (█ - 02/27/2025)

131f - Fire Extinguisher Inspection

10. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

Numerous fire extinguishers in the home have not been inspected by a fire safety expert within the past year, to include the following:

- The fire extinguisher in the main lobby has not been inspected since August, 2021
- The fire extinguisher in the pantry has not been inspected since July, 2021
- The fire extinguisher in the laundry room has not been inspected since August, 2022
- The fire extinguisher near bedroom #2 has not been inspected since July, 2021
- The fire extinguisher near bedroom #11 has not been inspected since August, 2022

Plan of Correction

Directed (█ - 01/07/2025)

The fire extinguishers were not up to date with being inspected by a fire safety expert. The new administrator will have all fire extinguishers fully inspected by 1/15/25 by a fire safety expert. (DIRECTED: Documentation of the fire extinguisher inspections conducted by a fire safety expert shall be present on each fire extinguisher. █ 1/7/25).

A staff will be educated on 131f regulation during a QA meeting being held on 12/30/24 by the administrator. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/7/25).

The administrator will check monthly to ensure all fire extinguishers are inspected and in working condition. These checks will start on 1/15/25 by the administrator.

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/15/2025

Implemented (█ - 02/27/2025)

132c - Fire Drill Records

11. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the following fire drills do not indicate if the fire drills were conducted in the AM or PM:

- 10/10/24 at 2:45
- 9/12/24 at 11:35

132c - Fire Drill Records (continued)

- 6/10/24 at 9:30
- 5/16/24 at 7:35

Plan of Correction

Directed (█ - 01/07/2025)

All staff will be educated on fire drills and documentation during a QA meeting on 12/30/24 by the administrator on regulation 132c. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/7/25).

Moving forward the administrator will audit fire drill documentation monthly to ensure all fire drill documentation is being correctly documented. These checks will start 1/01/25 by the administrator.

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Implemented (█ - 02/27/2025)

132f - Alternate Exit Routes

12. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The fire drill records indicate the same exit routes of "A, B and C" were used during each of the following monthly fire drills:

- 10/10/24 at 2:45
- 9/12/24 at 11:35
- 8/15/24 at 6:00 AM
- 7/19/24 at 1:00 PM
- 6/10/24 at 9:30
- 5/16/24 at 7:35

Plan of Correction

Directed (█ - 01/07/2025)

All staff will be educated on fire drills and documentation during a QA meeting on 12/30/24 by the administrator. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/7/25).

Moving forward the administrator will check monthly to ensure all fire drill documentation is being correctly documented. These checks will start 1/01/25 by the administrator. (DIRECTED: The monthly administrator reviews shall also ensure alternate exits are being used during each monthly fire drill in accordance with 2600.132f. █ 1/7/25).

132f - Alternate Exit Routes (continued)

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Not Implemented (█ - 02/27/2025)

132g - Fire Drills Days/Times

13. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff persons in the home; however, the home has not conducted a fire drill with only 2 staff persons.

Plan of Correction

Directed (█ - 01/07/2025)

A fire drill was conducted on 12/13/24 by 2 working staff at 6:27 pm using exit A. (DIRECTED: Documentation of the fire drill shall be kept in accordance with 2600.132c. █ 1/7/25).

All staff will be educated on regulation 132g, fire drills and documentation during a QA meeting held on 12/30/24 by the administrator. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/7/25).

Moving forward the administrator will conduct and audit monthly to ensure all fire drill documentation is being correctly documented. These checks will start 1/01/25 by the administrator. (DIRECTED: The monthly administrator reviews shall also ensure fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. █ 1/7/25).

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Implemented (█ - 02/27/2025)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

- 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. The evaluation must include the following:
1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #2’s medical evaluation, dated [REDACTED] indicates to see “attached” under the medical diagnoses section; however, nothing is attached. Also, page 2 of resident #2’s medical evaluation is blank with a line drawn through it and does not include a list of resident #2’s current medications.

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

Resident #2’s medical evaluation came with [REDACTED] from [REDACTED] previous facility, the administrator failed to notice that the medication list was not included in the attached documents to the medical evaluation. All staff will be educated on this regulation during QA meeting held by the administrator on 12/30/24. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

The administrator had the house doctor complete a new medical evaluation for resident #2 on 12/16/24. (DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall ensure a copy of resident #2’s medical evaluation is present in the resident’s record. [REDACTED] 1/7/25).

Moving forward the administrator will audit all medical evaluations by 1/7/25 and after will check monthly to ensure all resident medical evaluations are up to date and documented correctly. Theses checks will start 1/23/24 by the administrator and will be done for 3 months.

DIRECTED: By 1/21/25: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety in accordance with 2600.141a for all newly-admitted residents. Copies of the completed checklists shall be kept in each resident’s record. [REDACTED] 1/7/25).

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/21/2025

Not Implemented ([REDACTED] - 02/27/2025)

141b1 - Annual Medical Evaluation

15. Requirements

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]; however, resident #1's previous medical evaluation was completed on [redacted]

Resident #3's most recent medical evaluation was completed on [redacted]; however, resident #3's previous medical evaluation was completed on [redacted]

Plan of Correction

Directed ([redacted] - 01/07/2025)

The new administrator did not start until [redacted] All medical evaluations should have been updated in May. The new administrator had the house doctor update the resident medical evaluations as [redacted] went through them.

All staff will be educated on this regulation 141b1 during a QA meeting being held by the administrator on 12/30/24. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/7/25).

Moving forward the administrator will audit all resident annual medical evaluations by 1/7/25. The administrator will then check monthly to ensure all resident medical evaluations are up to date and documented correctly. These checks will start 1/23/24 by the administrator and will be done for 3 months.

DIRECTED: By 1/21/25: The administrator shall develop and implement a tracking system which includes the names of all residents and the dates of each resident's most recent medical evaluation. The tracking system shall be reviewed and updated monthly by the administrator. Documentation of the tracking system shall be kept. [redacted] 1/7/25

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/21/2025

Not Implemented ([redacted] - 02/27/2025)

143a - Emergency Medical Plan

16. Requirements

2600.

143.a. The home shall have a written emergency medical plan that includes the following:

Description of Violation

The home does not have a written emergency medical plan.

Plan of Correction

Directed ([redacted] - 01/07/2025)

This violation was completed on 11/13/24.

143a - Emergency Medical Plan (continued)

On 11/12/24 the new policy and procedure binder that the new administrator placed in the building was misplaced and could not be found. On 11/13/24 the administrator made a new policy and procedure binder and placed it for all staff to see. (DIRECTED: By 1/10/25: The administrator shall ensure the policy and procedure binder includes the home's emergency medical plan. [REDACTED] 1/7/25).

Moving forward all staff will be educated on regulation 143a during a staff quality management review being held on 12/30/24 by the administrator which documentation will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

There will be an audit completed by 1/7/25 by the administrator to ensure all policies and procedures are kept in the binder. weekly checks will be made by the administrator or designated person to ensure this binder is available at all times. These checks will start on 01/07/25 by the administrator or designated person and will be done weekly for 30 days to ensure the policy and procedure handbook is visible for everyone to see.

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/10/2025

Implemented ([REDACTED] - 02/27/2025)

161d - Dietary Needs

17. Requirements

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 8/22/24, resident #4 was prescribed [REDACTED]; however, at approximately 2:15 PM on the day of inspection, resident #4 was observed [REDACTED]

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

Resident #4 is the only resident with a special diet.

Resident #4 was prescribed a [REDACTED] but refused to [REDACTED]. Hospice came in and re-evaluated the resident, they wrote a new order on 11/19/24 for a regular diet as tolerated for resident #4.

All staff will be educated on regulation 161d, special diets during a QA meeting held by the administrator on 12/30/24. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

Moving forward the administrator will audit all doctor orders to ensure staff are following orders. This audit will be

161d - Dietary Needs (continued)

completed by 1/7/25 by the administrator.

The administrator or designated person will check resident charts weekly for 30 days to ensure all orders are being followed correctly. These checks will start 12/23/24 by the administrator.

DIRECTED: By 1/14/25: The administrator shall develop and implement procedures ensuring resident diets are followed. The procedures shall include immediate notification to dietary staff/direct care staff upon receipt of a new diet order from a prescriber. Copies of resident diet orders shall be kept in each resident's record. Documentation of the procedures shall be kept. All staff persons shall be educated by the administrator on the new procedures by 1/14/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 1/7/25

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/14/2025

Not Implemented ([REDACTED] - 02/27/2025)

185a - Implement Storage Procedures

18. 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

The home does not have written procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

The policy and procedure binder that include prevention, reporting, notification, investigation and management was placed in an open and conspicuous area for everyone to see on 11/13/24 by the administrator.

The policy and procedure binder was placed in the Dunlevy Manor Living policy and procedure binder on the entrance table. The binder was placed flat on the counter so everyone can see it on 11/13/24 by the administrator. Documentation is kept. (DIRECTED: By 1/10/25: The administrator shall ensure the policy and procedure binder includes procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. [REDACTED] 1/7/25).

A QA meeting will be conducted on 12/30/24 and regulation 185a will be discussed with all staff to ensure all staff know where the policy is and what the policy is. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

The administrator or designated person will check 2 times a week to ensure that the polices are in the binder and available for staff to look at.

Documentation will be kept.

185a - Implement Storage Procedures (continued)

Moving forward there will be weekly checks by the administrator or designated person. These checks will start on 12/23/24 by the administrator or designated person and will be done weekly for 30 days to ensure the policy and procedure handbook is visible for everyone to see. Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/10/2025

Implemented (████) - 02/27/2025)

187a - Medication Record

19. Requirements

2600.

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

- 3. Name of medication.
- 4. Strength.
- 5. Dosage form.
- 6. Dose.
- 7. Route of administration.
- 8. Frequency of administration.
- 9. Administration times.
- 12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

On 8/1/24, resident #3 was prescribed ██████████ as needed; however, this medication is not present on resident #3's November 2024 medication administration record (MAR).

Plan of Correction

Directed (████) - 01/07/2025)

Resident #3 was prescribed ██████████ on 8/15/24 but somehow this medication was not on the MAR due to the pharmacy's technical error. The med tech called the pharmacy on 11/12/24 and the pharmacy did add the order back on the MAR.

All staff will be educated on this regulation during a staff training being held on 12/30/24 by the administrator. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █████ 1/7/25).

Moving forward the administrator will conduct an audit on all medication orders to ensure all orders match medication in the medication cart. This audit will be completed by 1/7/25 by the administrator. The administrator or designated person will do a medication audit once weekly for 30 days. These checks will start on 1/1/24 by the administrator. (DIRECTED: The audits shall include a review of each resident's MAR to ensure accuracy in accordance with 2600.187a. Immediately following the weekly audits, the administrator shall review at least 6 different resident MAR's monthly to ensure accuracy in accordance with 2600.187a. █████ 1/7/25).

Documentation is kept.

187a - Medication Record (continued)

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Not Implemented (█ - 02/27/2025)

223a - Description of Service

20. Requirements

2600.

223.a. The home shall have a current written description of services and activities that the home provides including the following:

- 1. The scope and general description of the services and activities that the home provides.
- 2. The criteria for admission and discharge.
- 3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home does not have a written description of services and activities that the home provides.

Plan of Correction

Directed (█ - 01/07/2025)

The policy and procedure binder that include prevention, reporting, notification, investigation and management was placed in an open for all staff to see on 11/13/24 by the administrator. (DIRECTED: By 1/10/25: The administrator shall ensure the policy and procedure binder includes the home's description of services procedures in accordance with 2600.223a. █ 1/7/25).

A QA meeting will be conducted on 12/30/24 and regulation 223a will be discussed with all staff to ensure all staff know where the policy is and what the policy is. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/7/25). The administrator or designated person will check 2 times a week to ensure that the polices are in the binder and available for staff to look at. Documentation will be kept.

Moving forward the administrator will conduct an audit to ensure the policy binder is available for anyone to see. This audit will be completed by 1/7/25

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/10/2025

Implemented (█ - 02/27/2025)

225c - Additional Assessment

21. Requirements

2600.

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

225c - Additional Assessment (continued)

1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on [REDACTED] however, resident #1's previous assessment was completed on [REDACTED]

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

Plan of Correction

Directed ([REDACTED] - 01/07/2025)

The new administrator did not start until [REDACTED]. The new administrator updated the old support plans that were not currently updated by the previous administrator for resident #1 and #3. The new administrator updated the resident support plans as [REDACTED] went through them. Initial assessments for residents #1 has since been updated on [REDACTED] and #3 has since been updated by the new administrator on [REDACTED]

All staff will be educated on this regulation 225c during a QA meeting being held by the administrator on 12/30/24. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [REDACTED] 1/7/25).

The administrator will audit all support plans by 1/7/25.

Moving forward the administrator will check monthly to ensure all resident support plans are up to date and documented correctly. Theses checks will start 1/23/24 by the administrator and will be done for 3 months. Documentation will be kept.

DIRECTED: By 1/21/25: The administrator shall develop and implement a tracking system which includes the names of all residents and the dates of each resident's most recent assessment and support plan. The tracking system shall be reviewed and updated monthly by the administrator. Documentation of the tracking system shall be kept. [REDACTED] 1/7/25

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/21/2025

Not Implemented ([REDACTED] - 02/27/2025)

227d - Support Plan Medical/Dental

22. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

227d - Support Plan Medical/Dental (continued)

Description of Violation

Resident #4 utilizes [redacted] and requires the physical assistance of 2 staff persons [redacted] however, these are not indicated on resident #4's support plan, dated [redacted]

Plan of Correction

Directed ([redacted] - 01/07/2025)

The new administrator failed to add that resident #4 [redacted] The administrator updated the resident support plan on 11/15/24.

All staff will be educated on this regulation 227d during a QA meeting being held by the administrator on 12/30/24. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/7/25).

The administrator will conduct an audit on all support plans. This audit will be completed by 1/7/24.

Moving forward the administrator will check monthly to ensure all resident support plans are up to date and documented correctly. Theses checks will start 1/7/25 by the administrator and will be done for 3 months.

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/07/2025

Not Implemented ([redacted] - 02/27/2025)

254b - Policy and Procedures

23. Requirements

2600.

254.b. Each home shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Description of Violation

The home does not have written policies and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Plan of Correction

Directed ([redacted] - 01/07/2025)

The policy and procedure was placed in the Dunlevy Manor Living policy and procedure binder on the entrance table. The binder was placed flat on the counter so everyone can see it on 11/13/24 by the administrator. Documentation is kept. (DIRECTED: By 1/10/25: The administrator shall ensure the policy and procedure binder includes the home's procedures for addressing record accessibility, security, storage, authorized use and release and who is responsible for the records. [redacted] 1/7/25).

A QA meeting will be conducted on 12/30/24 and regulation 130h will be discussed with all staff to ensure all staff know where the policy is and what the policy is. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/7/25).

254b - Policy and Procedures (continued)

The administrator will conduct an audit to make sure all policies and procedures are in the binder. Moving forward the administrator or designated person will check 2 times a week to ensure that the polices are in the binder and available for staff to look at. (DIRECTED: The weekly checks shall begin on 1/13/25. [REDACTED] 1/7/25).

Documentation will be kept.

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: 01/13/2025

Implemented ([REDACTED] - 02/27/2025)