





**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE: APRIL 11, 2025**

[REDACTED]  
Executive Director, Administrator  
600 Paoli Pointe Drive Operations LLC  
600 Paoli Pointe Drive  
Paoli, Pennsylvania 19301

RE: Highgate at Paoli Pointe  
License #: 136101

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 17 and 18, 2024, November 14, 15, and 18, 2024, and November 26, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 136100 dated October 2, 2024 to October 2, 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) ;(4) 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 April 11, 2025 to October 11, 2025.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
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65b	III	55	\$3	\$165	15 calendar days from mailing date of this letter
65f	III	55	\$3	\$165	15 calendar days from mailing date of this letter
65g	III	55	\$3	\$165	15 calendar days from mailing date of this letter
88a	II	55	\$5	\$275	5 calendar days from mailing date of this letter
187b	II	55	\$5	\$275	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a FIRST 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 FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

, 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]

[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*

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summary  
(Emergency Removal Order)

cc:

[REDACTED]

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

**Facility Information**

Name: *HIGHGATE AT PAOLI POINTE* License #: *13610* License Expiration: *10/02/2024*  
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA 19301*  
County: *CHESTER* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*  
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA, 19301*  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *05/15/1996* Issued By: *Commonwealth of Pennsylvania, L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *101* Waking Staff: *76*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Complaint, Incident* Exit Conference Date: *09/18/2024*

**Inspection Dates and Department Representative**

09/17/2024 - On-Site: [REDACTED]  
09/18/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *124* Residents Served: *54*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Homestead* Capacity: *30* Residents Served: *21*

**Hospice**

Current Residents: *5*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *53*  
Diagnosed with Mental Illness: *5* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *47* Have Physical Disability: *2*

Inspections / Reviews

09/17/2024 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *10/18/2024*

11/18/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *12/27/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *11/22/2024*

02/21/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *12/27/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

18 - Compliance With Laws

1. 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

On Saturday, 09/07/24 and on Tuesday 09/17/24 from 4:00 PM to 7:00 PM, no staff present in the kitchen were ServSafe certified.

The PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class. The certified employee must be available during all hours of operation. The certified employee is the Person-in-Charge (PIC) when in the facility.

Plan of Correction

Accept ( [redacted] - 11/18/2024)

To address the absence of Sersafe certified employees during the specified hours on Saturday and Tuesday, we have implemented the following plan of correction:

1. Immediate Staffing Review dietary manager or designee. will conduct a thorough review of the current staffing schedule to identify any gaps in Servsafe coverage.
2. Certified Employee Scheduling dietary manager or designee will ensure that at least one Sersafe certified employee is scheduled for every shift when meals are prepared and served.
3. Training and Certification dietary manager or designee will provide additional training sessions for staff to ensure that more employees are certified in Servsafe. Dietary manager or designee aim to have all relevant staff certified within the next three weeks Oct. 24, 2024.
4. Dietary manager or designee will implement regular audits of staffing schedules to ensure compliance. Dietary manager or designate.will be responsible for this oversight.
5. Documentation and Reporting All certified employees' and new hires schedules will be documented and reviewed. Dietary Director was trained by Administrator set up Servsafe training on 9/20/2024 Audits will be conducted by Dietary Director or designee for the next three months or until compliance is achieved, to address . New hires must have Servsafe Certified before being hired. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI)

Proposed Overall Completion Date: 11/15/2024

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

Not Implemented ( [redacted] - 02/20/2025)

[Redacted]

[Redacted]

[Redacted]

WITHDRAWN  
each resident

[Redacted]

[Redacted]

[Redacted]

[Redacted]



25b - Contract Signatures (continued)

1. Contact Residents:

- Schedule individual meetings with Resident Two and Resident Three to discuss the importance of signing their contracts.
- Provide copies of the contract's addend for review prior to the meeting.

2. Educate Residents:

- Explain the contents and significance of the contracts, addressing any concerns or questions they may have.

3. Facilitate Signing:

- Arrange a convenient time for both residents to sign their contracts, ensuring that it's in a private environment they feel comfortable and understood.

Step 3: Audit Process

1. Documentation Review:

- Verify all resident contracts are signed and dated.
- Maintain a checklist of contracts signed by each resident.

2. Monthly Audits:

- Conduct monthly audits for the next three months to ensure all new residents have signed contracts within 3 days of admission.
- Review contracts of current residents to confirm compliance.

Sales and Marketing Director and Business office Manager/HR was trained by Administrator on how to get contracts training on 9/20/2024 Audits will be conducted by Sale and Marketing Director or designee for the next three months or until compliance is achieved, to address residents contracts. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI)team

Proposed Overall Completion Date: 11/15/2024

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

Not Implemented (█ - 02/20/2025)

41e - Signed Statement

4. Requirements

2600.

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

Description of Violation

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

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

Plan of Correction

Accept (█ - 11/18/2024)

Ensure that all resident contracts include a signed acknowledgement from residents confirming receipt of information regarding their rights, right to refuse and complaint procedures.

Step 2: Immediate Actions

41e - Signed Statement (continued)

1. Review Current Contracts:

- Conduct a review of all current resident contracts to identify those lacking the acknowledgment statement.

2. Prepare Updated Contract:

- Update the resident contract with an addendum to include a clear statement for residents to sign or addendum noting refusal/inability to sign, acknowledging receipt of their rights and complaint procedures.

-3. Notify Affected Residents and resident families:

- Inform residents whose contracts are missing the acknowledgment of the need for an updated signing process.

Step 3: Implement Signing Process

1. Meeting with Residents:

- Schedule individual or group meetings with affected residents to explain the importance of the acknowledgment and provide updated contracts. Hosted Ad Hoc residents council meeting on 9/27/24 to cover residents right, right to refuse and complaint procedures.

2. Facilitate Signing:

- Ensure that new residents sign the contracts in a supportive and understanding environment.

Step 4: Audit Process

1. Documentation Verification:

- Maintain a checklist to confirm that each resident has signed the updated contract with the acknowledgment statement.

2. Monthly Audits:

- Conduct monthly audits for the next three months to ensure all new resident contracts include the acknowledgment statement and are signed within 3 days of admission. Sales and Marketing Director or Business office Manager/HR was trained by Administrator on how to get contracts training on 9/20/2024 Audits will be conducted by Sale and Marketing Director or designee for the next three months or until compliance is achieved, to address residents contracts. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

Proposed Overall Completion Date: 11/15/2024

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

Not Implemented (█) - 02/20/2025)

63a - First Aid/CPR Training

5. Requirements

2600.

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

Description of Violation

On 09/01/24, from 3:00 PM to 7:00 AM on 09/02/24, over 50 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On 09/02/24, from 3:00 PM to 7:30 PM, over 50 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR and from 7:30 PM to 7:00 AM on 09/03/24, zero staff present were certified in first aid, obstructed airway techniques and CPR.

63a - First Aid/CPR Training (continued)

On 09/16/24, from 3:00 PM to 7:30 PM, over 50 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR and from 7:30 PM to 7:00 AM on 09/17/24, zero staff present were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction

Accept ( [redacted] ) - 11/18/2024

Ensure that all staff members are CPR certified to guarantee the safety of residents in the home.

Step 2: Immediate Actions

1. Assess Current Staff Certifications:

- Conduct an immediate review of all staff members' CPR certifications to identify gaps and determine who needs certification.

2. Schedule CPR Training:

- Arrange for CPR training sessions on 10/9/24 for all staff members who are not currently certified
- Partner with a certified trainer or organization to provide training sessions as needed.

3. Communicate with Staff:

- Inform all staff about the training sessions, emphasizing the importance of CPR certification for resident safety.

Step 3: Implement Training Plan

1. Mandatory Training Sessions:

- Schedule multiple training sessions to accommodate all staff, ensuring that shifts are covered and everyone can attend.

- Include a refresher course for those whose certifications are nearing expiration.

2. Certification Documentation:

- Ensure that all certifications are documented and updated in staff personnel files upon completion of the training.

Step 4: Audit Process

1. Certification Tracking:

- Create a tracking system or spreadsheet to monitor the CPR certification status of all staff members.

- Include expiration dates for certifications to ensure timely renewals.

2. Monthly Audits:

- Conduct monthly audits for the next six months to verify that all staff members are CPR certified and that new hires receive training within their first month of employment.

Staff members attended CPR training sessions on 10/9/24 by Mainline Family Education LLC. New hires will be trained during a 4 day orientation. Business office Manager/HR was trained by Administrator on how to set up CPR training classes on 9/20/2024 Audits will be conducted by Nursing Manager or designee for the next three months or until compliance is achieved, to address orientation and annual training. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

Proposed Overall Completion Date: 11/15/2024

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

Not Implemented ( [redacted] ) - 02/20/2025

65a - FS Orientation 1st Day

6. 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:

65a - FS Orientation 1st Day (*continued*)

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

**Description of Violation**

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

*Repeat Violation: 07/02/24 et al.; 11/27/23.*

**Plan of Correction**

**Accept ( [REDACTED] - 11/18/2024)**

*Ensure that all contracted employees receive the necessary orientation and in-service training related to personal care home operations and policies*

*Step 2: Immediate Actions*

*1. Identify Affected Employees:*

- *Review the list of contracted employees to determine who has not completed orientation and in-service training.*

*2. Schedule orientation training*

*- Contracted staff member A and other contracted staff member completed orientation training session 9/23/24 by health streams Business office Manager/HR*

*- Ensure that the training covers all essential topics related to personal care home policies, Evacuation procedures. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.*

*The designated meeting place outside the building or within the fire-safe area in the event of an actual fire. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.*

*The location and use of fire extinguishers. Smoke detectors and fire alarms.*

*Telephone use and notification of emergency services.*

*3. Communicate Expectations:*

- *Notify the contracted employee(s) about the importance of completing the orientation training the topics covered.*

*Step 3: Implement Training Plan*

*1. Develop a schedule for completing orientation and in-services - Create or update the orientation training program to encompass all necessary areas, including:*

*Evacuation procedures. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.*

*The designated meeting place outside the building or within the fire-safe area in the event of an actual fire. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.*

*The location and use of fire extinguishers. Smoke detectors and fire alarms.*

*Telephone use and notification of emergency services.*

*2. Provide update In-Service Training schedule as needed:*

### 65a - FS Orientation 1st Day (continued)

- Schedule regular and annual in-service training sessions to address ongoing education needs, including updates on policies, procedures, and best practices in personal care.

#### Step 4: Audit Process

##### 1. Training Documentation:

- Maintain records of all completed orientation and annual in-service training sessions for all contracted employees.

- Develop a checklist to ensure all required topics are covered.

##### 2. Monthly Audits:

- Conduct monthly audits for the next three months to verify that all contracted employees have completed their orientation and in-service training.

- Check for compliance with training schedules and documentation accuracy. New hires will be trained during a 4 day orientation Business office Manager/HR was trained by Administrator on 9/20/2024. New hires will be trained during a 4 day orientation. Audits will be conducted by Business office Manager or designee for the next three months or until compliance is achieved, to address orientation training.

Ensure that all staff members are CPR certified to guarantee the safety of residents in the home.

#### Step 2: Immediate Actions

##### 1. Assess Current Staff Certifications:

- Conduct an immediate review of all staff members' CPR certifications to identify gaps and determine who needs certification.

##### 2. Schedule CPR Training:

- Arrange for CPR training sessions on 10/9/24 for all staff members who are not currently certified

- Partner with a certified trainer or organization to provide training sessions as needed.

##### 3. Communicate with Staff:

- Inform all staff about the training sessions, emphasizing the importance of CPR certification for resident safety.

#### Step 3: Implement Training Plan

##### 1. Mandatory Training Sessions:

- Schedule multiple training sessions to accommodate all staff, ensuring that shifts are covered and everyone can attend.

- Include a refresher course for those whose certifications are nearing expiration.

##### 2. Certification Documentation:

- Ensure that all certifications are documented and updated in staff personnel files upon completion of the training.

#### Step 4: Audit Process

##### 1. Certification Tracking:

- Create a tracking system or spreadsheet to monitor the CPR certification status of all staff members.

- Include expiration dates for certifications to ensure timely renewals.

##### 2. Monthly Audits:

- Conduct monthly audits for the next six months to verify that all staff members are CPR certified and that new hires receive training within their first month of employment.

Staff members attended CPR training sessions on 10/9/24 by Mainline Family Education LLC. New hires will be trained during a 4 day orientation. Business office Manager/HR was trained by Administrator on how to set up CPR training classes on 9/20/2024 Audits will be conducted by Nursing Manager or designee for the next three months or until compliance is achieved, to address orientation and annual training. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

65a - FS Orientation 1st Day (continued)

Ensure that all staff members are CPR certified to guarantee the safety of residents in the home.

Step 2: Immediate Actions

1. Assess Current Staff Certifications:

- Conduct an immediate review of all staff members' CPR certifications to identify gaps and determine who needs certification.

2. Schedule CPR Training:

- Arrange for CPR training sessions on 10/9/24 for all staff members who are not currently certified
- Partner with a certified trainer or organization to provide training sessions as needed.

3. Communicate with Staff:

- Inform all staff about the training sessions, emphasizing the importance of CPR certification for resident safety.

Step 3: Implement Training Plan

1. Mandatory Training Sessions:

- Schedule multiple training sessions to accommodate all staff, ensuring that shifts are covered and everyone can attend.

- Include a refresher course for those whose certifications are nearing expiration.

2. Certification Documentation:

- Ensure that all certifications are documented and updated in staff personnel files upon completion of the training.

Step 4: Audit Process

1. Certification Tracking:

- Create a tracking system or spreadsheet to monitor the CPR certification status of all staff members.
- Include expiration dates for certifications to ensure timely renewals.

2. Monthly Audits:

- Conduct monthly audits for the next six months to verify that all staff members are CPR certified and that new hires receive training within their first month of employment.

Staff members attended CPR training sessions on 10/9/24 by Mainline Family Education LLC. New hires will be trained during a 4 day orientation. Business office Manager/HR was trained by Administrator on how to set up CPR training classes on 9/20/2024 Audits will be conducted by Nursing Manager or designee for the next three months or until compliance is achieved, to address orientation and annual training. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

Proposed Overall Completion Date: 11/15/2024

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

Implemented (█) - 02/20/2025)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.

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

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

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

**Description of Violation**

Staff person A completed [REDACTED] 40th scheduled work hour in August 2024. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Staff person B completed their 40th scheduled work hour in June 2024. However, this staff person did not complete training in reporting of reportable incidents and conditions.

Staff person C completed their 40th scheduled work hour in June 2024. However, this staff person did not complete training in reporting of reportable incidents and conditions.

Repeat Violation: 07/02/24 et al.; 11/27/23.

**Plan of Correction**

Accept ([REDACTED] - 11/18/2024)

Ensure that all contracted employees receive the necessary orientation and in-service training related to personal care home operations and policies before completing [REDACTED] 40th scheduled work hour.

**Step 2: Immediate Actions****1. Identify Affected Employees:**

- Review the list of contracted employees to determine who has not completed orientation and annual in-service training, before completing [REDACTED] 40th scheduled work hour.

**2. Schedule orientation training before completing [REDACTED] 40th scheduled work hour:**

- Contracted staff member A and other contracted staff member attended the 40th scheduled work hour orientation training session 9/23/24 by health streams Business office Manager/HR

Staff person B and C completed their training in reporting of reportable incidents and conditions 9/30/24  
Health Streams LMS/Business office Manager

- Ensure that the training covers all essential topics related to personal care home policies, Resident rights, Emergency medical plan, Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Reporting of reportable incidents and conditions.

**3. Communicate Expectations:**

- Notify the contracted employee(s) about the importance of completing the orientation training before completing his/her 40th scheduled work hour and the topics covered.

**Step 3: Implement Training Plan**

1. Develop a schedule for completing orientation and in-services before 40th scheduled work hour : - Create or update the orientation training program to encompass all necessary areas, including:

- Personal care procedures
- Safety protocols

65b - Rights/Abuse 40 Hours (continued)

- Resident rights and responsibilities
- Emergency response procedures

2. Provide update In-Service Training schedule as needed:

- Schedule regular and annual in-service training sessions to address ongoing education needs, including updates on policies, procedures, and best practices in personal care.

Step 4: Audit Process

1. Training Documentation:

- Maintain records of all completed orientation and annual in-service training sessions for all contracted employees.
- Develop a checklist to ensure all required topics are covered.

2. Monthly Audits:

- Conduct monthly audits for the next three months to verify that all contracted employees have completed their orientation and in-service training.
- Check for compliance with training schedules and documentation accuracy.

c

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

Not Implemented (█ - 02/20/2025)

65f - Training Topics

8. Requirements

2600.

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

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

Description of Violation

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

Repeat Violation: 07/02/24 et al.

Plan of Correction

Accept (█ - 11/18/2024)

Step 1: Identify the Issue

- Issue: Staff members did not complete annual training in 2023.

Step 2: Immediate Actions

1. Identify Affected Staff:

- Review training records to determine which staff members have not completed the required annual training.

65f - Training Topics (continued)

2. Schedule Training Sessions:

- Arrange for annual training staff member D attended orientation training session on 9/23/24 health streams LMS by Business office Manager/HR. sessions to be conducted within the next two weeks. - Use HeathStreams trainer or training organization to deliver the session.

3. Communicate Training Requirements:

- Notify all staff about the importance of completing annual training and the upcoming sessions.

Step 3: Implement Training Plan

1. Follow Genesis Highgate Paoli Comprehensive Training Program:

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

2. Provide Flexible Training Options:

- Offer multiple training sessions at different times to accommodate various staff schedules. - Consider virtual training options if feasible.

Step 4: Audit Process

1. Training Documentation:

- Maintain accurate records of attendance and completion for all training sessions. - Create a checklist to ensure all required components of the training are covered.

2. Monthly Audits:

- Conduct monthly audits for the next three months to verify that all staff members have completed training. - Review training records to ensure compliance with attendance requirements. New hires will be trained during a 4 day orientation. Business office Manager/HR was trained by Administrator on 9/20/2024 Audits will be conducted by Business office Manager or designee for the next three months or until compliance is achieved, to address orientation and annual training. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█) - 02/20/2025)

65g - Annual Training Content

9. Requirements

2600.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

65g - Annual Training Content (*continued*)

5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

**Description of Violation**

*Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2023.*

*Repeat Violation: 07/02/24 et al.*

**Plan of Correction**

**Accept (█ - 11/18/2024)**

*Step 1: Identify the Issue*

*- Issue: Staff members did not complete orientation and annual training in 2023.*

*Step 2: Immediate Actions**1. Identify Affected Staff:*

*- Review training records to determine which staff members have not completed the required orientation and annual training.*

*2. Schedule orientation training Sessions: staff member D attended orientation training session on 9/23/24 health streams LMS by Business office Manager/HR*

*- Arrange for orientation and annual training sessions to be conducted within the next two days. - Use health streams LMS or training organization to deliver the session.*

*3. Communicate Training Requirements:*

*- Notify all staff about the importance of completing orientation and annual training and the upcoming sessions.*

*Step 3: Implement Training Plan**1. Follow Genesis Highgate Paoli Comprehensive Training Program:*

*- Ensure that the orientation and annual training program covers critical topics, including:*

*Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.*

*Emergency preparedness procedures and recognition and response to crises and emergency situations.*

*Resident rights.*

*The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*

*Falls and accident prevention.*

*New population groups that are being served at the home that were not previously served, if applicable.*

*2. Provide Flexible Training Options:*

*- Offer multiple training sessions at different times to accommodate various staff schedules.*

*- Consider virtual training options if feasible.*

*Step 4: Audit Process**1. Training Documentation:*

*- Maintain accurate records of attendance and completion for all training sessions.*

*- Create a checklist to ensure all required components of the training are covered.*

*2. Monthly Audits:*

*- New hires will be trained during a 4 day orientation. Business office Manager/HR was trained by Administrator on the importance of completing orientation and annual training 9/20/2024*

*Audits will be conducted by Business office Manager or designee for the next three months or until compliance is*

65g - Annual Training Content (continued)

achieved, to address orientation and annual training completion. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█ - 02/20/2025)

88a - Surfaces

10. 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

In April 2024 the home had a substantial leak above the "Paoli Local" room which is above the main dining room. The leak caused significant damage to both rooms.

An inspection of the room found a small leak in the new dry wall and water on the floor.

An inspection of the dining room shows the wall and window sills across from the entrance remain in disrepair and in need of painting.

Repeat Violation: 07/02/24 et al.

Plan of Correction

Accept (█ - 11/18/2024)

1. Ceiling Repair in Paoli Local

Action: Secure Contractor, repair leak and complete the carpentry work.

Responsible Party: Administrator/ Designee

Timeline: Complete by Nov. 15th , 2024.

- Steps:

- Assess the extent of the leak and damage.
- Order necessary materials.
- Schedule contractor for installation.
- Ensure quality control during installation.

2. Main Dining Room Improvements\*\*

- Action: Complete painting and carpentry work.

- Responsible Party: Facilities Manager.

- Timeline: Complete by Nov. 1, 2024.

- \*\*Steps\*\*:

- Finalize paint color and materials.
- Schedule painting and carpentry teams.
- Conduct walkthrough after completion for quality assurance.

Audits will be conducted by Maintenance person or designee for the next three months or until compliance is achieved, Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█ - 02/20/2025)

## 88a - Surfaces (continued)

## 95 - Furniture and Equipment

**11. Requirements**

2600.

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

**Description of Violation**

*The urinal in the public men's room on the Terrace Floor, outside the main dining room, is covered with plastic. Staff were questioned as to how long the urinal has been out of service and staff responded, "at least two months".*

*The home's dishwasher, located in the kitchen, has been inoperable since 09/01/24.*

**Plan of Correction**

Accept (█) - 11/18/2024

*1. The urinal in the public men's room on the Terrace Floor was repaired on 10/4/2024*

**2. Education:**

- *Conduct staff town hall meeting to discuss the importance of reporting maintenance issues promptly.*
- *Provide in-service training on how to identify and report operational issues, emphasizing the impact on resident and guest satisfaction.*

**3. Follow-Up Audit:**

- *Perform a follow-up audit of the public men's restroom bi-weekly for three months to ensure all fixtures are in proper working order. Town Hall meeting hosted by the Administrator on 9/20/2024. New hires will be trained during a 4 day orientation. Audits will be conducted by Maintenance or designee for the next three months or until compliance is achieved, to address Furniture and equipment must be in good repair, clean and free of hazards. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team*

**1. Immediate Repairs:**

- *Schedule a service technician to repair the dishwasher within 24 hours. Schedule date for installation of the new dishwasher on 10/14/24*

**2. Alternative Measures:**

- *Implement a temporary manual dishwashing procedure to ensure hygiene and cleanliness.*
- *In-serviced on 9/23/24 staff on proper manual dishwashing techniques to prevent any health risks.*

**3. Monitoring:**

- *Maintain a log of equipment issues as they arise and track resolution times.*
- *Designate a staff member to perform weekly checks of kitchen equipment, including the dishwasher.*

**5. Follow-Up Audit:**

- *Conduct a follow-up audit of the kitchen equipment bi-weekly for three months to ensure functionality and compliance with health standards. Town hall meeting hosted by the Administrator on 9/23/2024. for kitchen staff on the importance of equipment maintenance and timely reporting of issues. New hires will be trained during a 4 day orientation. Audits will be conducted by Maintenance or designee for the next three months or until compliance is achieved, to address Furniture and equipment must be in good repair, clean and free of hazards. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team*

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

95 - Furniture and Equipment (continued)

Not Implemented (█) - 02/20/2025)

96a - First Aid Kit

12. Requirements

2600.

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

Description of Violation

The first aid kit in the memory care nurse's station did not include a thermometer, a breathing shield or eye coverings.

Plan of Correction

Accept (█) - 11/18/2024)

1. Inventory Assessment:

- Conduct an immediate inventory assessment of all first aid kits in the facility, including those in the memory care nurse's station and on the bus.

2. Restock First Aid Kits:

- Purchase and replenish the following items in each kit:

- Thermometers

- Breathing shields

- Eye coverings

- Ensure that all first aid kits comply with current health and safety regulations.

3. Education:

In serviced staff on the proper use of first aid supplies, focusing on the importance of having complete kits.

4. Documentation:

- Create a checklist for the contents of each first aid kit to ensure compliance and completeness.

- Document the restocking process, including dates and items added, in the facility's nursing log.

5. Monitoring:

- Designate a staff member responsible for checking the contents of the first aid kits monthly.

- Keep a record of these checks, noting any items that need replenishment.

6. Follow-Up Audit:

- Conduct a follow-up audit of all first aid kits quarterly for six months to ensure that they remain stocked and compliant.

- Review the documentation from the monthly checks to identify any recurring issues. First Aid Kit in-service by the Director of Health and Wellness and on 9/20/2024. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health and Wellness or designee for the next three months or until compliance is achieved, to address complete first aid kits . Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█) - 02/20/2025)

101j7 - Lighting/Operable Lamp

13. Requirements

2600.

101j7 - Lighting/Operable Lamp (continued)

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

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

The resident in room #213 does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation: 02/26/24.

**Plan of Correction**

Accept (█) - 11/18/2024)

1. Installation of Lighting:

- A bedside light that can be easily turned on and off by the resident.
- Ensure that the light is positioned within easy reach and meets safety standards.

2. Communication:

- Inform the resident of the changes made and ensure they are comfortable with the new lighting solution.
- Provide instructions on how to operate the new light source.

3. Education:

In service staff on the importance of resident comfort and accessibility, focusing on the role of adequate lighting in enhancing quality of life.

4. Monitoring:

- Designate a staff member to check the lighting in each resident's room monthly to ensure all residents have adequate access to light sources.
- Maintain a log of lighting assessments and any subsequent actions taken.

5. Follow-Up Audit:

- Perform a follow-up audit of room #213 and other resident rooms to ensure continued compliance with lighting accessibility.
- Review feedback from residents regarding their comfort and accessibility at bedside. Bedside light in-service by the Director of Health and Wellness and on 9/20/2024. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health and Wellness or designee for the next three months or until compliance is achieved, to address bedside light. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█) - 02/20/2025)

103f - Refrigerator/Freezer Temps

14. 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**

There was no thermometer in the ice cream freezer in the main kitchen.

**Plan of Correction**

Accept (█) - 11/18/2024)

1. Immediate Corrective Action

Action Taken:

- Thermometer replaced in the ice cream freezer immediately 9/18/24.
- Ensure that the thermometer is easily visible and accessible for regular monitoring.

103f - Refrigerator/Freezer Temps (continued)

2. Staff Education

- **Education Sessions:**

- In-serviced kitchen staff on 9/25/24 the importance of maintaining proper food temperatures, specifically for ice cream and other frozen items.

- Topics to cover:

- Food safety regulations regarding temperature control.
- How to properly use and read thermometers.
- The importance of recording temperatures regularly.

- Materials:

3. Follow the Genesis Highgate Monitoring Procedures

- Daily Temperature Checks:

- Assign a staff member to check and record the temperature of the ice cream freezer at the beginning and end of each shift.

- Create a temperature log sheet to document the daily readings.

4. Audit Plan

- **Regular Audits:**

- Conduct weekly audits for the first month to ensure compliance with the new thermometer usage and temperature logging procedures.

- After the initial month, shift to bi-weekly audits for the next three months.

- Audit Checklist:

- Verify the presence and accuracy of the thermometer.
- Review temperature log sheets for completeness and accuracy.
- Ensure staff are following the new procedures. Thermometer in-service by Director of Food Services on 9/20/2024 for dietary staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Food Services or designee for the next three months or until compliance is achieved, to address the thermometer in the ice-cream freezer . Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Implemented ( ) - 02/21/2025)

104b - Dishes/Glassware/Utensils

15. Requirements

2600.

104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

The home's dishwasher broke on 09/01/24. Since then, the home has been using disposable plates, bowls, and cups on a regular basis.

Plan of Correction

Accept ( ) - 11/18/2024)

1. Immediate Corrective Action

- Action Taken:

- Assess the dishwasher for repair or replacement options immediately.

104b - Dishes/Glassware/Utensils (continued)

- Contact a professional repair service to evaluate the dishwasher and schedule repairs within 48 hours.
- If repair is not feasible, initiate the process to purchase a new dishwasher without delay.

2. Staff Education

- Education Sessions:

- In-service on 10/4/24 kitchen staff regarding the temporary use of disposable items, highlighting the importance of maintaining sanitation standards and minimizing waste.

- Topics to cover:

- Proper sanitation practices when using disposable items.
- Environmental impact of disposables and the importance of transitioning back to reusable items.

- Materials:

- Provide a handout detailing sanitation best practices and guidelines for the temporary use of disposables.

4. Audit Plan

- Regular Audits:

- Conduct weekly audits for the first month to ensure compliance with sanitation practices and proper usage of disposable items.

- After the initial month, shift to bi-weekly audits for the next three months. Disposable dishes and utensils in-service by the Director of Food Services on 9/20/2024 for dietary staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Food Services or designee for the next three months or until compliance is achieved, to address the disposable dishes and utensils. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Implemented (█) - 02/20/2025)

107d - Procedure Emergency Management Agency Submission

16. Requirements

2600.

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

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 06/07/23.

Plan of Correction

Accept (█) - 11/18/2024)

1. Immediate Corrective Action

- Action Taken:

- Reviewed and updated the current written emergency procedures to ensure they are comprehensive and compliant with local regulations.

- Submit the updated emergency procedures to the local emergency management agency on 9/27/24 .

2. Staff Education

- Education Sessions:

- In-service maintenance staff 9/30/24 on the importance of emergency preparedness and the role of the written emergency procedures being mailed to the county in a timely manner.

- Audit Checklist:

- Verify that the emergency procedures are up-to-date and have been submitted to the local emergency

107d - Procedure Emergency Management Agency Submission (continued)

management agency annually in the month of Sept. Emergency Procedures in-service by Administrator on 9/28/2024 for Maintenance staff . New hires will be trained during a 4 day orientation. Audits will be conducted by the Maintenance or designee for the annually or until compliance is achieved, to address the Emergency Procedures mailed in a timely manner. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█ - 02/20/2025)

131f - Fire Extinguisher Inspection

17. Requirements

2600.

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

Description of Violation

The fire extinguisher in the home's bus has not been inspected by a fire safety expert since 08/2022.

Plan of Correction

Accept (█ - 11/18/2024)

1 Action:

Contacted a certified fire safety expert and arranged for the inspection of the fire extinguisher on 9/22/24.

2. Documentation

- Responsibility: Maintenance staff coordinated the inspection monthly on fire extinguishers.
- Action: The inspection results were documented, Maintained records on the extinguisher's log.

3. Establish Regular inspection Schedule

- Responsibility: Maintiances
- Action: Created a calendar for regular fire extinguisher inspections.
- Timeline: Implemented monthly extinguisher inspection schedule.

4. Ongoing Audits

- Responsibility : Facility Maintenance Manager.
- Action: Conduct quarterly audits of all fire safety equipment, including fire extinguishers.

Fire Extinguisher inspection in-service by Administrator on 9/28/2024 for Maintenance staff . New hires will be trained during a 4 day orientation. Audits will be conducted by the Maintenance or designee for the next three months or until compliance is achieved, to address the fire extinguisher. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█ - 02/20/2025)

132c - Fire Drill Records

**18. 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 drills conducted on 08/20/24, 07/19/24, and 06/13/24 do not include the exit route used, and the number of residents evacuated from the home at the time of the drill.*

**Plan of Correction**

Accept (█ - 11/18/2024)

**A. Staff Training on Recordkeeping**

- Responsibility: Maintenance

- Action: In service Maintenance staff on 9/27/24 involved in fire drills on proper documentation procedures, emphasizing the importance of recording exit routes and resident counts.

- Timeline: Created Fire Drill Schedule with Fire Safety Company (new contract)

- Materials: Provide written guidelines and checklists for completing drill records.

**B. Implement Standard Operating Procedures (SOP)**

- Responsibility: Facility Manager.

- Action: In services Maintenance staff 9/27/24 on SOP for conducting fire drills, including detailed instructions for documentation.

**C. Establish a Review and Audit Process**

- Responsibility: Maintenance staff .

- Action: Contact Fire Safety Company to set up monthly fire drills, audits of fire drill records to ensure compliance with the regulations .

*Fire drill documentation in-service by Administrator on 9/28/2024 for Maintenance staff . New hires will be trained during a 4 day orientation. Audits will be conducted by the Maintenance or designee for the next three months or until compliance is achieved, to address the fire drill documentation. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team*

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

Not Implemented (█ - 02/20/2025)

**132e - Fire Drill Sleeping Hours**

**19. Requirements**

2600.

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

**Description of Violation**

*The last fire drill conducted during sleeping hours was on 06/30/24 at 11:20 PM. The previous sleeping hours fire drill was conducted on 11/29/23 at 11:59 PM.*

**Plan of Correction**

Accept (█ - 11/18/2024)

1. To ensure that fire drills conducted during sleeping hours are performed in compliance with state regulations, specifically by increasing the frequency of drills during these hours.

**2. Action Steps**

**A. Immediate Scheduling of Additional Fire Drills**

- Responsibility: Maintiances staff.

**132e - Fire Drill Sleeping Hours (continued)**

- Action: Schedule and conduct at least one fire drill during sleeping hours (between 10 PM and 6 AM) within the month.

-Timeline: Schedule the drill and conduct it within one week.

Maintenance Director or designatee in-service the staff on emergency Procedures

- Action: Conduct training for all staff on procedures for conducting fire drills during sleeping hours, including how to effectively communicate with residents and ensure their safety. - Timeline: Within a week of this plan.

- Materials: Provide training materials that outline emergency procedures and communication strategies.

- Implement a Review and Audit Process

Action: Establish a quarterly audit of fire drill records to ensure compliance with the updated drill schedule and documentation of resident responses during drills. -Documentation Keep records of audit findings and any necessary corrective actions.

Update Fire Drill Schedule

- Responsibility: Maintenance staff.

- Action: Develop a fire drill schedule that includes at least one fire drill during sleeping hours every three months.

- Timeline: Finalize the updated schedule. Review the effectiveness of the schedule plan and overall compliance with the fire drill schedule within three months. Adjust schedule and procedures as necessary based on findings. Fire drill during sleeping hours in-service by Administrator on 9/28/2024 for Maintenance staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Maintenance or designee for the next three months or until compliance is achieved, to address the fire drill during sleeping hours. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

**132e - Fire Drill Sleeping Hours (continued)**

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

Not Implemented (█) - 02/20/2025

**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**

Residents #3's initial medical evaluation was not completed within 60 days prior to admission or within 30 days after admission of the residents.

## 141a - Medical Evaluation (continued)

**Plan of Correction**

Accept (█ - 11/18/2024)

1. To ensure that all residents have a documented medical evaluation by a qualified healthcare provider within the specified timeframes completed within 60 days prior to admission or within 30 days after admission of the residents.prior to or following admission, in compliance with state regulations.

## 2. Action Steps

## A. Immediate Review of Current Residents

- Responsibility: Director of Health and Wells or Admission Coordinator

- Action: Conduct an immediate review of all residents' files to identify those who lack the required medical evaluation documentation.

## C. Staff Training on Document Requirements

- Responsibility: Director of Health and Wellness .

- Action: In service staff involved in the admissions process 10/3/24 on the documentation requirements for medical evaluations completed within 60 days prior to admission or within 30 days after admission of the residents., including the specific forms mandated by the DHS.

-Materials: Provide handouts detailing the documentation process and the required forms.

## E. Ongoing Audits of Documentation

- Responsibility: Director of Health and Wells.

- Action: Establish a bi-monthly audit process to review resident files for compliance with medical evaluation documentation requirements and to ensure all forms are correctly completed.

- Documentation: Record audit findings and any corrective actions required.

- Timeline: Begin audits month after training completion. Medical Evaluation Documentation in-service by Director of Health and Wellness on 10/2/2024 for Department Heads . New hires will be trained during a 4 day orientation.

Audits will be conducted by the Medical Evaluation Documentation or designee for the next three months or until compliance is achieved, to address the medical evaluation documentation. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

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

Not Implemented (█ - 02/20/2025)

## 141a 1-10 Medical Evaluation Information

**21. 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. 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**

## 141a 1-10 Medical Evaluation Information (continued)

Resident #4's initial medical evaluation did not include body positioning and movement stimulation for residents, if appropriate.

**Plan of Correction**

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/23/2024 by the Director of Health and Wellness to Immedated action was taken 1. Updated resident's medical evaluations to include comprehensive assessments of body positioning and movement stimulation.2. Nursing staff and Memory Care Director was educated on the importance of these assessments.3. Implement regular audits to monitor compliance with the evaluation standards.

Body positioning and movement in-service by Director of Health and Wellness on 9/23/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address the body positioning and movement. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

To enhance the currently compliant operations, on 09/23/2024 the Director of Health and Wellness will DHW or designee will review and update evaluation residents assessment for bed rails. - Action: Review the initial medical evaluation form to check the sections for body positioning and movement stimulation and add an addendum as needed. Staff Educated by DHW on the following - Importance of body positioning and movement stimulation for resident health. - Best practices for assessing and documenting these factors in evaluations. - Techniques for developing individualized movement plans and bed and mobility aids. - Format:In-person training sessions and online modules , with a completion date of 11/15/2024.

Effective 09/24/2024 the Director of Health and Wellness will perform during admission, weekly for 1 month and then monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring each resident has 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, and to ensure the evaluation includes a general physical examination by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by DHSwithin 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

A general physical examination by a physician, physician's assistant or nurse practitioner.

Medical diagnosis including physical or mental disabilities of the resident, if any.

Medical information pertinent to diagnosis and treatment in case of an emergency.

Special health or dietary needs of the resident.

Allergies.

Immunization history.

Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Body positioning and movement stimulation for residents, if appropriate.

Health status.

Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information (continued)

Body positioning and movement in-service by Director of Health and Wellness on 9/23/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address the body positioning and movement. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team

A general physical examination by a physician, physician's assistant or nurse practitioner.

Medical diagnosis including physical or mental disabilities of the resident, if any.

Medical information pertinent to diagnosis and treatment in case of an emergency.

Special health or dietary needs of the resident.

Allergies.

Immunization history.

Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Body positioning and movement stimulation for residents, if appropriate.

Health status.

Mobility assessment, updated annually or at the Department's request.

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

Not Implemented ( ) - 02/20/2025)

141b1 - Annual Medical Evaluation

22. Requirements

2600.

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

Description of Violation

Resident #2's most recent medical evaluation was completed on [REDACTED].

Resident #5's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Plan of Correction

Accept ( ) - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/25/2024 by the Director of Health and Wellness to Immedated action was taken DHW review the medical evaluation protocol to clarify the required frequency for evaluations, ensuring compliance with regulatory standards.Outline schedule when evaluations are due and follow the regulation to process for timely completion.DHW has in-serviced nursing staff and Memory Care Director on the following- Importance of timely medical evaluations in maintaining the health and safety of residents.- Procedures for completing and documenting evaluations, including how to track due dates effectively.- Best practices for communication among staff regarding evaluation schedules and findings.- Format:In-person training sessions and online modules, accompanied by handouts for future reference.

To enhance the currentl compliant operations, on 09/25/2024 the Director of Health and Wellness or the designee will documentation of due dates and reminders for upcoming evaluations. Alerts for nursing staff to ensure evaluations are completed on schedule. Continued education for current and new nursing staff, with a completion date of 11/15/2024.

141b1 - Annual Medical Evaluation (continued)

Effective 09/25/2024 the Director of Health and Wellness will perform m audits through [ ] to maintain ongoing compliance with Ensuring each resident has a medical evaluation at least annually. Conduct audits to ensure compliance with updated medical evaluation regualtions. Audits will include: - Review of medical evaluation records for all residents to confirm adherence to required timelines. - Identification of any discrepancies or lapses in the evaluation process and add the addendum. Completing medical evaluation in a timely manner in-service by Director of Health and Wellness on 9/25/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address the Completing medical evaluation in a timely manner Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented ( [REDACTED] - 02/20/2025)

183d - Prescription Current

23. Requirements

2600.

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

Description of Violation

On 09/18/24, Bisacodyl 10 MG Suppository prescribed for individual #7, was in the home's locked medication refrigerator; however, this individual passed away on [REDACTED]

On 09/18/24, Loperamide HCL 2 MG Caps prescribed to resident #8- Take 1 capsule by mouth every 8 hours as needed for diarrhea, was on the 2nd floor med cart. This medication is not on the current order summary.

Plan of Correction

Accept ( [REDACTED] - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/27/2024 by the Director of Health and Wellness to Immedated action taken was DHW review medication management regulation protocol: - Review and follow medication management regulation protocols, with clear understanding of the guidelines for handling medications related to residents who have passed away.- Establish a procedure for timely removal of discontinued or expired medications from storage. Nursing Staff will remove medication off the cart onces the residents has been pronounced deceased DHW in-serviced nursing staff on the following: - Importance of accurate medication management, including proper disposal of medications for deceased residents. - Procedures for verifying current medication orders and ensuring that medications on the cart match those on the order summary. - Best practices for communication between nurse to nurse, nursing and pharmacy teams regarding medication changes. - Format: In-person training sessions and online modules. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home in-service by the Director of Health and Wellness on 9/27/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address the only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team.

183d - Prescription Current (continued)

To enhance the currently compliant operations, on 09/27/2024 the Director of Health and Wellness will The DHW or designee will Review and enforce medication reconciliation process: - Follow the state regulation standardized process for regular medication reconciliation to ensure that: - All prescribed medications are current and accurately reflected in the order summary. - Medications found on the med cart are verified against orders before administration.- Conduct cart audits to ensure compliance with the updated medication management protocols, with a completion date of 11/15/2024.

Effective 09/27/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring only current residents' prescription, OTC, sample and CAM for individuals living in the home will be kept in the home. - Review of medication storage practices, focusing on the removal of medications for residents who have passed away.- Verification of medications on the med cart against current orders. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█ - 02/20/2025)

183e - Storing Medications

24. Requirements

2600.

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

Description of Violation

On 09/18/24 Lorazepam Intensol 2 MG/ML prescribed to resident #9, was kept in the 2nd floor med cart narcotics drawer. According to the manufacturer's instructions this medication should be stored at cold temperatures between 36 and 46 degrees Fahrenheit.

On 09/18/24, two insulin pens, Humalog and Lantus, for resident #10 were open and undated on the home's 1st floor med cart. These medications should be destroyed 28 days after opening per manufacturer's instructions.

Repeat Violation: 06/07/23.

Plan of Correction

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/30/2024 by the Director of Health and Wellness to Immedated action taken 1. DHW reviewed and followed step by step Medication Storage regulations Protocol: - Review medication storage protocols follow specific guidelines for temperature-sensitive medications, such as Lorazepam Intensol. - Establish designated storage areas for medications that require refrigeration and enforce compliance with temperature monitoring.

183e - Storing Medications (continued)

To enhance the currently compliant operations, on 09/30/2024 the Director of Health and Wellness will 2. Staff Education Sessions: DHW in-serviced staff on the following:- Importance of adhering to manufacturer storage instructions for all medications.- Procedures for properly storing temperature-sensitive medications and identifying storage requirements. - Best practices for managing open medications, including tracking expiration dates and disposal protocols. - Format: In-person training sessions and online modules, supplemented with handouts for future reference, with a completion date of 11/15/2024.

Effective 09/30/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring prescription medications, OTC medications and CAM will be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer’s instructions.The DHW or designee will conduct audits to ensure compliance with updated medication storage and handling protocols. - Audits will include: - Review of storage conditions for all medications, particularly those requiring temperature control. - Verification of proper labeling and disposal of open medications, including insulin pens, and continuous education.Medication Storage in-service by the Director of Health and Wellness on 10/1/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address Medication Storage. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█) - 02/20/2025)

184a - Resident's Meds Labeled

25. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident’s name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4's Clonazepam 0.5 MG Tablet has a current prescriber's order of 1 tablet at bedtime but the blister pack and narcotics log instructions read "Take 1 tablet by mouth every 8 hours for anxiety".

The pharmacy label for resident #8's Lorazepam 0.5 MG Tab reads "Take 1 tablet by mouth every 12 hours as needed for anxiety". However, the resident's September 2024 Medication Administration Record (MAR) reads "1 tablet by mouth every 12 hours" and has been confirmed as the current prescriber's order.

On 09/18/24, two insulin pens, Humalog and Lantus, for resident #10 did not have pharmacy labels.

184a - Resident's Meds Labeled (continued)

Plan of Correction

Accept (█) - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/04/2024 by the Director of Health and Wellness to Immedated action was taken DHW reviewed regulation Medication Labeling Protocol: - Review medication labeling regulation protocols to ensure that all medications match the current prescriber's orders, including dosage and administration instructions. - Establish a clear procedure for labeling medications that includes regular checks by nursing staff upon receipt from the pharmacy.

To enhance the currently compliant operations, on 10/04/2024 the Director of Health Wellness will DHW in-serviced nursing staff on the following: - Importance of accurate medication labeling and documentation, including the consequences of discrepancies. - Procedures for verifying medication orders against pharmacy labels and MAR entries. - Best practices for the administration of medications, particularly for controlled substances and insulin. - Format: In-person training sessions and online modules, with handouts for future reference, with a completion date of 11/15/2024.

Effective 10/04/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring the original container for prescription medications will be labeled with a pharmacy label that includes, including the resident's name, and the name of the medication, and the date the prescription was issued, and the prescribed dosage and instructions for administration, and the resident's name, and the name of the medication, and the date the prescription was issued, and the prescribed dosage and instructions for administration, and the resident's name, and the name of the medication, and the date the prescription was issued, and the prescribed dosage and instructions for administration, and the resident's name, and the name of the medication, and the date the prescription was issued, and the prescribed dosage and instructions for administration, and the name and title of the prescriber. The DHW or designee conduct audits to ensure compliance with updated medication management protocols. - Audits will include: - Review of medication labeling practices to confirm alignment with prescriber's orders. - Verification of the presence of pharmacy labels on all medications, especially high-risk medications like insulin. Medication Labeling in-service by the Director of Health and Wellness on 10/4/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address Medication Labeling. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█) - 02/20/2025)

185a - Implement Storage Procedures

26. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #8 is prescribed Albuterol Sulfate as needed. On 09/18/24 this medication was not available in the home.

**185a - Implement Storage Procedures (continued)**

Repeat Violation: 06/07/23.

**Plan of Correction**

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/08/2024 by the Director of Health Wellness to Immediate action taken was DHW reviewed and Update Medication Inventory: - Review medication inventory management protocols to ensure that medications prescribed on an as-needed basis, like Albuterol Sulfate, are consistently stocked and available. - Follow Genesis policy and procedures for reordering medications. Medication not available in-service by the Director of Health and Wellness on 10/4/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address Medication not available. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team.

To enhance the currently compliant operations, on 10/07/2024 the Director of Health and Wellness will in-services nursing staff on the following: - Importance of ensuring the availability of medications, particularly those prescribed on an as-needed basis. - Procedures for monitoring medication inventory and reporting shortages. - Best practices for tracking medication usage and communicating with pharmacy staff regarding restocking needs. - Format: In-person training sessions and online modules, supplemented with handouts for future reference. The DHW or designee will provide continuous education as scheduled and needed, - Follow regulation guidelines and procedures monitoring medication inventory levels, specifically for as-needed medications. - Assign specific staff members to oversee inventory checks and ensure timely reordering of medications. (LPN, Med Tech), with a completion date of 11/15/2024.

Effective 10/08/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. - Conduct audits to ensure compliance with medication inventory protocols. - Audits will include: - Review of medication availability for all residents, focusing on as-needed medications like Albuterol Sulfate. - Assessment of the effectiveness of the inventory tracking system and adherence to reordering procedures. Medication not available in-service by the Director of Health and Wellness on 10/4/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address Medication not available. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█ - 02/20/2025)

**27. Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

**Description of Violation**

On 09/15/24, resident #8 was prescribed Cephalexin 500 MG Tab - take one tablet twice a day for seven days, 14 tablets were received. Between 09/15/24 and 09/18/24 at the time of the medication audit, seven tablets were documented as being administered, however only six tablets remain. One tablet is missing.

185a - Implement Storage Procedures (continued)

Resident #10's glucometer is not calibrated to the correct date and time.

Resident #11's glucometer is not calibrated to the correct date and time.

Plan of Correction

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/23/2024 by the Director of Health and Wellenss to Immediate action taken The DHW or designatee conduct an investigation to identify the cause of the missing tablet for Resident #8.- Review documentation practices and interview staff involved in medication administration during the relevant period.- Review medication administration protocols to ensure accurate documentation of administered medications.- Enforced the double-check process for high-risk medications to prevent discrepancies.

To enhance the currently compliant operations, on 09/23/2024 the Director of Health and Wellness (DHW) will DHW or designatee will in-serviced the nursing staff - Importance of accurate medication administration and documentation, including the impact of missing medications on resident care. - Procedures for handling and documenting administered medications accurately. - Best practices for calibrating glucometers and maintaining equipment. - Format: In-person training sessions and online modules, supplemented with handouts.- Enforced the double-check process for high-risk medications to prevent discrepancies,Implementation of a Glucometer Calibration Protocol: - Develop a standardized protocol for regularly calibrating glucometers, including: - Daily checks for date and time accuracy. - Documentation of calibration in the equipment maintenance log, with a completion date of 11/15/2024.

Effective 09/21/2023 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring the home will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.Audits and Compliance Monitoring: - Conduct audits to ensure compliance with updated medication administration protocols and glucometer calibration practices. - Audits will include: - Review of medication administration records to confirm accuracy. - Verification of glucometer calibration logs for all residents. The safe storage, access, security, distribution and Glucometer Calibration in-service by the Director of Health and Wellness on 10/4/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address the safe storage, access, security, distribution and Glucometer Calibration . Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█ - 02/20/2025)

█  
█  
█



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

187a - Medication Record

29. Requirements

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

## 187a - Medication Record (continued)

**Description of Violation**

*Resident #8 is prescribed Remedy Phytoplex Skin Cream, Cephalexin 500 MG Tab, Vitamin D3 5,000 Unit Tablet, Labetolol HCL 100 MG Tab. However, resident's September 2024 medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN).*

*Resident #10 is prescribed Ferosul 325 MG Tablet, Torseamide 20 MG Tablet, Amlodipine Besylate 10 MG Tab, Aspirin 81 MG Tablet, Docusate Sodium 100 MG Softgel, Atorvastatin 10 MG Tablet, Melatonin Extra Strength 10 MG, and Trazadone 50 MG Tablet. However, resident's September 2024 medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN).*

**Plan of Correction**

Accept (█) - 11/18/2024)

*In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/30/2024 by the Director of Health and Wellness to Immediate action taken 1. DHW review and update MAR Documentation Protocol: - Review MAR documentation protocols to require the inclusion of the diagnosis or purpose for each medication, including PRN medications. - Follow the regulation for documenting this information that staff can easily reference.*

*To enhance the currently compliant operations, on 10/30/2024 the Director of Health and Wellness or designee will in-service nursing staff on the following - Importance of complete and accurate documentation in medication administration, including legal and clinical implications.- Procedures for documenting the diagnosis or purpose for each medication in the MAR.- Best practices for ensuring that all PRN medications are clearly documented with their intended use.- Format: In-person training sessions and online modules, supplemented with handouts for future reference. - Follow the regulation and process for nursing staff to verify that all medications administered are documented correctly in the MAR, including:- A designated nurse or supervisor reviewing MARs weekly to ensure completeness of documentation.(LPN Med Tech) - A protocol for addressing any missing information promptly, with a completion date of 11/15/2024.*

*Effective 09/25/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with keeping a medication record, for each resident for whom medications are administered, that includes: resident's name, and drug allergies, and name of medication, and strength, and dosage form, and dose, and route of administration, and frequency of administration, and administration times, and duration of therapy, if applicable, and special precautions, if applicable, and diagnosis or purpose for the medication, including pro re nata (PRN), and date and time of medication administration, and name and initials of the staff person administering the medication, and resident's name, and drug allergies, and name of medication, and strength, and dosage form, and dose, and route of administration, and frequency of administration, and administration times, and duration of therapy, if applicable, and special precautions, if applicable, and diagnosis or purpose for the medication, including pro re nata (PRN), and date and time of medication administration, and name and initials of the staff person administering the medication. Conduct audits to ensure compliance with updated MAR documentation protocols. - Audits will include: - Review of MARs for both Residents #8 and #10 to confirm that diagnosis or purpose is documented for all medications. - Assessment of overall MAR accuracy across all residents. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.*

*Medication administration record in-service by the Director of Health and Wellness on 10/4/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address medication administration record.*



187a - Medication Record (*continued*)

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

Not Implemented (█ - 02/20/2025)

## 187b - Date/Time of Medication Admin.

## 30. 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**

*On 09/03/24 at 8:00 PM, resident #8's September 2024 MAR indicates the resident was administered Lorazepam 0.5 MG Tablet. However, the resident's "Controlled Drug Record Count" does not indicate this medication was administered. No discrepancy in the narcotic count is documented.*

*Resident #8's September 2024 MAR does not indicate who administered the resident's Metoprolol Succ ER 50 MG Tab on 09/05/24 at 8:00 PM or the resident's Pravastatin Sodium 20 MG Tab at 8:00 PM on 09/05/24 and 09/11/24.*

*Resident #10's September 2024 MAR does not indicate who administered the following medications/treatments at 8:00 AM on 09/02/24: Ave Elastic Bandage, Diclofenac Sodium 1% Gel (missing 12:00 PM also), TED Knee Stockings, Duloxetine HCL DR 60 MG Cap, Ferosul 325 MG Tablet, Humalog 100 Unit/ML Vial (also missing 11:30 AM), Hydralazine 25 MG Tablet and Insulin Lispro U-100/1 ML Sliding Scale.*

Repeat Violation: 06/07/23.

**Plan of Correction**

Accept (█ - 11/18/2024)

*In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/14/2024 by the Director of Health and Wellness to Immediate action taken DHW review MAR documentation - Reviiewed MAR documentation protocols to require that the administering staff member's name is recorded for all medications, especially controlled substances. - Create a standardized checklist for staff to ensure that all necessary documentation is completed before leaving the medication administration area.*

*To enhance the currently compliant operations, on 10/07/2024 the Director of Health and Wellness or designatee education nursing staff on the following : - Importance of accurate documentation in medication administration, including legal and clinical implications of missing entries. - Procedures for logging administered medications and ensuring that all documentation requirements are met. - Best practices regarding the administration of controlled substances, including the importance of maintaining accurate records in the Controlled Drug Record Count. - \*\*Format: In-person training sessions and online modules, supplemented with handouts for future reference. - Verification process for nursing staff to confirm that all medications administered are recorded accurately in the MAR, including: - A designated nurse or supervisor reviewing the MAR daily to ensure completeness of documentation. - A protocol for addressing any missing information immediately after administration, with a completion date of 11/15/2024.*

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

Effective 9/23/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring the information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. - Conduct audits to ensure compliance with updated MAR documentation protocols. - Audits will include: - Review of MARs for Residents #8 and #10 to confirm that all medications are properly documented, including the identity of the administering staff. - Assessment of overall MAR accuracy across all residents. Subsection recorded at the time the medication is administered in-service by the Director of Health and Wellness on 10/6/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address the safe storage, access, Subsection recorded at the time the medication is administered. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█) - 02/20/2025)

187d - Follow Prescriber's Orders

31. Requirements

2600.

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

Description of Violation

Resident #8 is prescribed Lorazepam 0.5 MG Tablet - 1 tablet by mouth every 12 hours. However, resident's "Controlled Drug Record Count" shows this medication was not administered on 09/03/24 at 8:00 PM, even though it is signed off on the MAR as being administered. No discrepancy in the narcotics count is documented.

Repeat Violation: 07/02/24 et al.; 11/27/23; 06/07/23.

Plan of Correction

Accept (█) - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/09/2024 by the Director of Health and Wellness to Immediate action taken DHW reviewed MAR documentation protocols to require that the administering staff member's name is recorded for all medications, especially controlled substances.- Create a standardized checklist for staff to ensure that all necessary documentation is completed before leaving the medication administration area.

To enhance the currently compliant operations, on 10/09/2024 the Director of Health and Wellness will DHW staff education nursing staff on the following - Importance of accurate documentation in medication administration, including legal and clinical implications of missing entries. - Procedures for logging administered medications and ensuring that all documentation requirements are met. - Best practices regarding the administration of controlled substances, including the importance of maintaining accurate records in the Controlled Drug Record Count. - Format: In-person training sessions and online modules, supplemented with handouts for future reference. - Develop a standardized verification process for nursing staff to confirm that all medications administered are recorded accurately in the MAR, including: - A designated nurse or supervisor reviewing the MAR daily to ensure completeness of documentation. - Enforcing protocol for addressing any missing information immediately after administration, with a completion date of 11/15/2024.

187d - Follow Prescriber's Orders (continued)

Effective 10/09/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring the home must follow the directions of the prescriber Audits and Compliance Monitoring: - Conduct audits to ensure compliance with updated MAR documentation protocols.- Audits will include: - Review of MARs for Residents #8 and #10 to confirm that all medications are properly documented, including the identity of the administering staff. Follow the directions of the prescriber in-service by the Director of Health and Wellness on 10/9/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the Director of Health Wellness or designee for the next three months or until compliance is achieved, to address following the directions of the prescriber. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. - Assessment of overall MAR accuracy across all residents. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█ - 02/20/2025)

191 - Resident Right to Refuse

32. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted █, and resident #3, admitted █, have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/10/2024 by the Director of Sales and Marketing to Immediate action taken DHW review resident education protocols to include explicit information about the right to refuse medication and the process for doing so. - Hosted educational materials (ad hoc residents council , posters) outlining residents' rights regarding medication administration, including whom to contact if they have concerns.

To enhance the currently compliant operations, on 10/10/2024 the Director of Health and Wellness or designee will education on the following - Importance of educating residents about their rights regarding medication, including the right to refuse if they suspect an error. - Procedures for communicating this information to residents during activities. - Strategies for staff to assess and address residents' concerns about medications. - Format:In-person training sessions and online modules, supplemented with handouts for future reference. - Develop a standardized process for activities staff to educate residents upon admission and during subsequent medication reviews about their rights concerning medication. - Ensure that all new residents are educated within 24 hours of admission, with a completion date of 11/15/2024.

191 - Resident Right to Refuse (continued)

Effective 10/1/2024 the Director of Sales and Marketing will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring the home must educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education must be kept - Conduct audits to ensure compliance with the resident education protocols regarding the right to refuse medication. - Audits will include: - Review of resident education records to confirm that residents have been informed of their rights. - Assessment of nursing documentation to ensure that education was provided and acknowledged by residents. Residents Education in-service by the Director of Sales and Marketing on 9/24/2024 for nursing staff and adhoc resident council meeting. New hires will be trained during a 4 day orientation. Audits will be conducted by the Admission Director or designee for the next three months or until compliance is achieved, to address residents education. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█ - 02/20/2025)

224a - Preadmission Screen Form

33. Requirements

2600.

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

Description of Violation

Resident #2 was admitted to the home on █ however, the resident's preadmission screening form was completed on █

Plan of Correction

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/11/2024 by the Director of Health and Wellneww to Immediate action taken - Reviewed the preadmission screening protocol to clarify timelines for completing the screening form relative to admission dates. - Establish procedures for ensuring that all necessary information is gathered and documented before admission.

To enhance the currently compliant operations, on 10/11/2024 the Director of Health and Wellness will DHW or designatee will education department heads on the following - Importance of timely preadmission screenings in ensuring appropriate care and support for new residents. - Procedures for completing and reviewing the preadmission screening form, including all required assessments and documentation. - Best practices for communication between admissions, nursing, and other relevant departments during the preadmission process. - Format:In-person training sessions and online modules, supplemented with handouts for future reference. - Develop a standardized checklist to be used during the preadmission process to ensure that all required steps are completed before a resident's admission. - Include specific timelines for completing the screening and finalizing admission documentation, with a completion date of 11/15/2024.

224a - Preadmission Screen Form (continued)

Effective 10/1/2024 the DHW will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring a determination is made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home Audits and Compliance Monitoring; Preadmission screening in-service by the Director of Health and Wellness on 10/9/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the DHW or designee for the next three months or until compliance is achieved, to address preadmission screening. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. - Conduct audits to ensure compliance with updated preadmission screening protocols. - Audits will include: - Review of preadmission screening forms for all residents admitted to confirm adherence to timelines and completeness of documentation. - Assessment of any gaps in the screening process and identification of areas for improvement. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented (█ - 02/20/2025)

225c - Additional Assessment

34. Requirements

2600.

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

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

Description of Violation

Resident #2's most recent assessment was completed on █.

Resident #5's most recent assessment, marked annual, was completed on █. Another assessment, also marked as an annual, was completed on █. However, the previous assessment to these was completed on █, also an annual.

Plan of Correction

Accept (█ - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/14/2024 by the Director of Health and Wellness to Immediate action taken DHW review and enforces assessment protocol:- Reviewed the assessment protocol to clearly define the frequency and requirements for resident assessments, ensuring compliance with regulatory standards. - Develop a calendar system for tracking assessment due dates and sending reminders to relevant nursing staff.Enforce of an Assessment Tracking System: - Develop and implement a standardized tracking system for assessments that includes: - Documentation of due dates for assessments. - Alerts for upcoming assessments to ensure timely completion.

225c - Additional Assessment (continued)

To enhance the currently compliant operations, on 10/14/2024 the Director of Health and Wellness or designee will educate the staff education - Importance of timely and accurate resident assessments, including the impact on care planning and resident outcomes. - Procedures for completing and documenting assessments, including how to accurately mark them as annual or otherwise. - Best practices for utilizing the new tracking system for assessments. - Format:\*\* In-person training sessions and online modules, supplemented with handouts for future reference, with a completion date of 11/15/2024.

Effective 10/1/2024 the Director of Healt and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring each resident has additional assessments, including annually, and if the condition of the resident significantly changes prior to the annual assessmentAudits and Compliance Monitoring - Conduct audits to ensure compliance with updated assessment protocols. - Audits will include: - Review of assessment records for all residents to confirm adherence to required timelines. - Identification of any discrepancies or lapses in the assessment process and development of corrective actions., and at the request of the Department upon cause to believe that an update is required, and annually, and if the condition of the resident significantly changes prior to the annual assessment, and at the request of the Department upon cause to believe that an update is required, and annually, and if the condition of the resident significantly changes prior to the annual assessment, and at the request of the Department upon cause to believe that an update is requiredAssessments type in-service by the Director of Health and Wellness on 10/13/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the DHW or designee for the next three months or until compliance is achieved, to address assessment type. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented ( [REDACTED] - 02/21/2025)

227d - Support Plan Medical/Dental

35. 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.

Description of Violation

The assessment and support plan for resident #6, dated [REDACTED], does not indicate a need for bed rails; however, the resident has half rails on each side of their bed. At a minimum, the resident's support plan should include the following:

- The specific need for the device,
- The intended Use,
- Any risks associated with the device,
- The resident's ability to use the device safely for the intended purpose,
- Identification of the specific device to be used,

**227d - Support Plan Medical/Dental (continued)**

- *If a cover is required to meet FDA guidelines.*

*Repeat Violation: 02/26/24.*

**Plan of Correction**

**Accept (█ - 11/18/2024)**

*In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/14/2024 by the Director of Health and Wellness to Immediate action taken DHW Review and Revise Support Plan Documentation : - Revise the support plan documentation protocol to include specific requirements for documenting the use of safety devices, such as bed rails. - Documentation includes sections for the specific need, intended use, associated risks, resident's ability to use the device, identification of the device, and any guidelines for covers.*

*To enhance the currently compliant operations, on 10/14/2024 the Director of Health and Wellness or designee will in-service staff on the following: - Importance of accurately documenting the use of safety devices in resident support plans. - Detailed training on the specific requirements for documenting bed rails or other safety devices, including how to assess a resident's need for such devices. - Compliance with FDA guidelines regarding safety devices and the necessity of covers where applicable. - Format: In-person training sessions and online modules, supplemented with handouts for future reference. - implementation of a Device Assessment Process: - Complete bed mobile assessment process for evaluating residents who use safety devices, ensuring that all necessary documentation is completed. - Include a checklist for nursing staff to follow when assessing the need for bed rails or similar devices, with a completion date of 11/15/2024.*

*Effective 11/15/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with documenting 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 Bed rails in-service by the Director of Health and Wellness on 10/13/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the DHW or designee for the next three months or until compliance is achieved, to address bed rails. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.*

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

**Not Implemented (█ - 02/21/2025)**

**231c - Preadmission Screening****36. Requirements**

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

## 231c - Preadmission Screening (continued)

**Description of Violation**

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's written cognitive preadmission screening was completed on [REDACTED].

**Plan of Correction**

Accept ( [REDACTED] - 11/18/2024)

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/14/2024 by the Director of Health and Wellness to Immediate action taken DHW review and update preadmission screening with addendum: - Revise the preadmission screening protocol to specify the required timelines for completing cognitive assessments relative to admission dates. - Establish clear guidelines for documentation to ensure that all necessary information is gathered before admission.

To enhance the currently compliant operations, on 10/14/2024 the Director of Health and Wellness or designee educate staff on the following:- Importance of timely and accurate cognitive preadmission screenings for residents entering the SDCU. - Procedures for completing and reviewing the cognitive preadmission screening form, including all required assessments and documentation. - Best practices for communication between admissions, nursing, and other relevant departments during the preadmission process. - Format: In-person training sessions and online modules, supplemented with handouts for future reference. Implementation of a Preadmission Checklist: - Develop a standardized checklist to be used during the preadmission process to ensure that all required steps are completed before a resident's admission, including timely cognitive assessments. - Include specific timelines for completing the screening and finalizing admission documentation, with a completion date of 11/15/2024.

Effective 10/14/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring a written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form is completed for each resident within 72 hours prior to admission to a secured dementia care unit Audits and Compliance Monitoring: - Conduct audits to ensure compliance with updated preadmission screening protocols. - Audits will include: - Review of preadmission screening forms for all residents admitted to confirm adherence to timelines and completeness of documentation. - Assessment of any gaps in the screening process and identification of areas for improvement. 72 hours SDCU preadmission screening in-service by the Director of Health and Wellness on 10/13/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the DHW or designee for the next three months or until compliance is achieved, to address 72 hours SDCU preadmission screening. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

Not Implemented ( [REDACTED] - 02/21/2025)

## 231f - Assessed Annually

**37. Requirements**

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

**Description of Violation**

231f - Assessed Annually (continued)

Resident #2 was assessed for the need for Secure Dementia Care Unit (SDCU) on [REDACTED] and has not been assessed again.

**Plan of Correction**

**Accept ( [REDACTED] - 11/18/2024)**

In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/13/2024 by the Director of Health and Wellness to Immediate action DHW review and updated assessment addendum - Revise the assessment protocol to establish clear guidelines on the frequency of reassessments for residents in the SDCU. - Ensure that the protocol includes criteria for when an assessment should be conducted, such as changes in behavior, health status, or care needs.

To enhance the currently compliant operations, on 10/13/2024 the Director of Health and Wellness or designee will educate staff - Importance of regular reassessments in the SDCU to ensure that care plans are current and reflective of residents' needs. - Procedures for conducting and documenting assessments, including how to recognize when a reassessment is necessary. - Best practices for communication among staff regarding assessment schedules and findings. - Format: In-person training sessions and online modules, supplemented with handouts for future reference, - Enforce using the PCC tracking system to monitor assessment due dates for all residents in the SDCU. - Include alerts for nursing staff to remind them of upcoming reassessments to ensure timely completion, with a completion date of 11/15/2024.

Effective 10/13/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring that in addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident is assessed annually for the continuing need for the secured dementia care unit. Audits and Compliance Monitoring: - Conduct audits to ensure compliance with updated assessment protocols. - Audits will include: - Review of assessment records for all residents in the SDCU to confirm that required reassessments are completed on schedule. - Identification of any discrepancies or lapses in the assessment process and development of corrective actions. Assessed annually on 10/13/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the DHW or designee for the next three months or until compliance is achieved, to address assessed annually. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

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

**Not Implemented ( [REDACTED] - 02/21/2025)**

234a - Admission Support Plan

**38. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

**Description of Violation**

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] However, the resident's initial support plan was completed on [REDACTED]

Repeat Violation: 06/07/23.

## 234a - Admission Support Plan (continued)

**Plan of Correction**

Accept (█ - 11/18/2024)

*In response to the violation on 09/17/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 10/13/2024 by the Director of Health and Wellness to Immediate action was taken DHW review and update support plan with addendum : - Revise the support plan protocol to establish clear timelines for completing initial support plans for new residents, ensuring they are completed within 48 hours of admission. - Develop a checklist to guide staff in gathering necessary information for the support plan during the admission process.*

*To enhance the currently compliant operations, on 10/13/2024 the Director of Health and Welllness or designee will educate staff on the following : - Importance of timely development and implementation of support plans to ensure appropriate care for residents. - Procedures for completing and documenting support plans, emphasizing the need for prompt action following admission. - Best practices for communication among staff regarding support plan timelines and responsibilities. - Format: In-person training sessions and online modules, supplemented with handouts for future reference. - Develop a standardized admission checklist that includes steps for completing the initial support plan within the required timeframe. - Ensure that the checklist is easily accessible to nursing staff during the admission process, with a completion date of 11/15/2024.*

*Effective 10/13/2024 the Director of Health and Wellness will perform monthly audits through 11/15/2024 to maintain ongoing compliance with ensuring that within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan is developed, implemented and documented in the resident record Audits and Compliance Monitoring: - Conduct audits to ensure compliance with updated support plan protocols. - Review of support plans for all new residents in the SDCU to confirm that initial plans are completed within the required timeframe. - Identification of any discrepancies or lapses in the support plan process and development of corrective actions. Initial support plan on 10/13/2024 for nursing staff. New hires will be trained during a 4 day orientation. Audits will be conducted by the DHW or designee for the next three months or until compliance is achieved, to address initial support plan. Findings will be reported to the Quality Assessment and Performance Improvement (QAPI) team. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.*

*Proposed Overall Completion Date: 11/15/2024*

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

Not Implemented (█ - 02/21/2025)

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

**Facility Information**

Name: *HIGHGATE AT PAOLI POINTE* License #: *13610* License Expiration: *10/02/2025*  
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA 19301*  
County: *CHESTER* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*  
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA, 19301*  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *05/15/1996* Issued By: *Commonwealth L & I*

**Staffing Hours**

Resident Support Staff: Total Daily Staff: *101* Waking Staff: *76*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Complaint* Exit Conference Date: *11/18/2024*

**Inspection Dates and Department Representative**

11/14/2024 - On-Site: [REDACTED]nes  
11/15/2024 - Off-Site: [REDACTED]  
11/18/2024 - Off-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *124* Residents Served: *54*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *3rd floor* Capacity: *22* Residents Served: *21*

**Hospice**

Current Residents: *5*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *54*  
Diagnosed with Mental Illness: *5* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *47* Have Physical Disability: *2*

Inspections / Reviews

11/14/2024 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *12/13/2024*

12/20/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/16/2025*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *12/24/2024*

12/30/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/16/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *01/07/2025*

02/21/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *01/16/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

[REDACTED]

[REDACTED]

[REDACTED]

**WITHDRAWN** [REDACTED] **4/7/25**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**WITHDRAWN** [REDACTED] **4/7/25**

[REDACTED]

[REDACTED]

42b - Abuse

3. Requirements

2600.

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

## 42b - Abuse (continued)

**Description of Violation**

The home failed to provide adequate heat or hot water for the residents from 10/30/24 through 11/18/24. On 11/14/24 the temperature in 31 resident bedrooms was below 70 degrees, with lows of 54 degrees Fahrenheit in some of the rooms. This included 19 SDCU rooms and 12 rooms in the personal care section of the home. The average temperature, on 11/13-11/18/24, overnight was 33 degrees Fahrenheit with a high of 50 degrees and low of 36 degrees.

Lack of hot water and frigid temperatures prevented residents in rooms 14, 217, 302, 305, 308, 309, 317, and 322 from bathing or completing personal hygiene during the utility outages.

Repeat Violation: 2/26/2024, 11/27/2023

**Plan of Correction**

Accept (████) - 12/30/2024)

Hot water and heat were restored on 11/19/24. The community's EPP was completed and put into place with instructions on who to contact and what to do in case an emergency of this magnitude happens again. The maintenance director will be responsible for maintaining compliance and will be completing weekly hot water checks beginning 12/1/24 and they will continue for 3 months or until Highgate can maintain compliance. Our HVAC units will be connected to a yearly contract with a company to help maintain their efficiency throughout the year ( every 6 months ) The interim ED will conduct training for all staff with a completion date of 1/22/25. The DHW will continue to discuss this at their monthly staff meeting for 6 months or until Highgate maintains compliance with a start date of 1/15/2025

Proposed Overall Completion Date: 02/16/2025

Licensee's Proposed Overall Completion Date: 07/16/2025

## 42s - Privacy

**4. Requirements**

2600.

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

**Description of Violation**

Since 4/12/23 the home installed a camera system in all resident rooms in the personal care section of the home that is activated to detect a change in motion within the resident rooms regardless of the activity. The waiver was issued to place the cameras in rooms specifically for individuals with cognitive impairment. These residents do not have a cognitive impairment.

**Plan of Correction**

Accept (████) - 12/30/2024)

Our Safely You system is being discontinued throughout as of 2/1/2025. A 30-day notice will be sent to families and residents on 1/1/25 to inform them of the change. Safely You themselves, will need to come and remove all cameras from our communities with a finish date of 6/1/2025. Residents that did not meet the criteria, had their cameras will be turned off on 1/1/25. The interim ED will be the contact person for this step and will be responsible for ensuring systems have been turned off. The ED will check in with Safely You during their weekly calls to ensure continued compliance until all cameras have been removed

Licensee's Proposed Overall Completion Date: 06/01/2025



86b - Bathroom (continued)

Licensee's Proposed Overall Completion Date: 03/13/2025

Not Implemented ( ) - 4/7/2025)

89b - Hot Water Temperature

8. Requirements

2600.

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

Description of Violation

From 11/12/24 to 11/14/24 resident bedrooms were without any hot water preventing the residents from bathing or completing personal hygiene in rooms 14, 217, 302, 305, 308, 309, 317, and 322.

Plan of Correction

Accept ( ) - 12/17/2024)

Hot water and heat were restored on 11/19/24. The community's EPP was completed and put into place with instructions on who to contact and what to do in case an emergency of this magnitude happens again. The maintenance director will be responsible for maintaining compliance and will be completing weekly hot water checks beginning 12/1/24 and they will continue for 3 months or until Highgate can maintain compliance

Licensee's Proposed Overall Completion Date: 03/01/2025

Implemented ( ) - 3/5/2025)

95 - Furniture and Equipment

9. Requirements

2600.

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

Description of Violation

The heating system was inoperable in 31 resident rooms from 10/30/24 through 11/18/24.

Plan of Correction

Accept ( ) - 12/30/2024)

Hot water and heat were restored on 11/19/24. The community's EPP was completed and put into place with instructions on who to contact and what to do in case an emergency of this magnitude happens again. The maintenance director will be responsible for maintaining compliance and will be completing weekly hot water checks beginning 12/1/24 and they will continue for 3 months or until Highgate can maintain compliance. Our HVAC units will be connected to a yearly contract with a company to help maintain their efficiency throughout the year ( every 6 months ) The interim ED will conduct training for all staff with a completion date of 1/22/25. The DHW will continue to discuss this at their monthly staff meeting for 6 months or until Highgate maintains compliance with a start date of 1/15/2025

Proposed Overall Completion Date: 02/11/2025

Licensee's Proposed Overall Completion Date: 06/11/2025

102e - Privacy - Doors/Partitions

10. Requirements

2600.

102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

Resident rooms 217, 308, and 309 do not have doors on their bathrooms.

102e - Privacy - Doors/Partitions (continued)

Plan of Correction

Accept (█) - 12/20/2024)

The doors have been replaced and are now functioning in every room. door handles have been ordered and will be installed by maintenance. Maintenance will be responsible for doing monthly audits on all doors to maintain privacy within the community for 3 months or until we are in compliance

Licensee's Proposed Overall Completion Date: 03/08/2025

Not Implemented (█) - 4/7/2025)

107a - Emergency Preparedness

11. Requirements

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person A, the designated acting administrator was not familiar with the emergency preparedness plan for the local municipality. The staff did not activate their emergency procedures as they were unfamiliar with any related documentation.

Plan of Correction

Accept (█) - 12/20/2024)

The emergency plan has been submitted to the local emergency management by the acting admin is aware. The acting administrator completed an in-service on 11/25/24 with all staff to review the location of the EPP and the acting ED will be responsible for maintaining compliance for the next 3 months or until we remain in compliance

Proposed Overall Completion Date: 03/01/2025

Licensee's Proposed Overall Completion Date: 03/01/2025

Implemented (█) - 3/5/2025)

107d - Procedure Emergency Management Agency Submission

12. Requirements

2600.

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

Description of Violation

The home's written emergency procedures submitted to the county Emergency Management Agency for 2024 were illegible and could not be approved. The homes staff did not activate their emergency procedures as they were unfamiliar with any related documentation.

Plan of Correction

Accept (█) - 12/20/2024)

The emergency plan has been submitted to the local emergency management and the acting admin is aware. An in-service was completed on 11/25/24, by the acting administrator with all staff to review the location of the EPP and the acting ED will be responsible for maintaining compliance for the next 3 months or until we remain in compliance

Proposed Overall Completion Date: 03/08/2025

Licensee's Proposed Overall Completion Date: 03/08/2025

Not Implemented (█) - 4/7/2025)

127a - Portable Space Heaters

13. Requirements

2600.

127a - Portable Space Heaters (continued)

127.a. Portable space heaters are prohibited.

**Description of Violation**

On 11/14/24 at 9:15am a portable space heater was in use in room 15.

**Plan of Correction**

Accept ( [REDACTED] - 12/20/2024)

The portable space heater was removed from the resident's room, by maintenance staff and an audit was completed on 11/22/24 to ensure that no other rooms had one by the DHW. Maintenance will be responsible for weekly walk-throughs to ensure no other portable space heaters in the community. This will continue throughout the winter months or until compliance is met.

Proposed Overall Completion Date: 04/12/2025

Licensee's Proposed Overall Completion Date: 04/12/2025

252 - Record Content

14. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

**Description of Violation**

Resident #1's record does not include their religion.

Resident #2's record does not include their eye color.

**Plan of Correction**

Accept ( [REDACTED] - 12/20/2024)

An audit is in process, by the acting administrator and business manager, to ensure all resident records are completed properly. It began on 11/22/24 and will be completed by 12/31/24. The admissions director will be responsible for maintaining compliance

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: 12/31/2024

Not Implemented ( [REDACTED] - 02/21/2025)

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

**Facility Information**

Name: *HIGHGATE AT PAOLI POINTE* License #: *13610* License Expiration: *10/02/2025*  
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA 19301*  
County: *CHESTER* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*  
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA, 19301*  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *05/15/1996* Issued By: *COPA L & I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *79* Waking Staff: *59*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Monitoring* Exit Conference Date: *11/26/2024*

**Inspection Dates and Department Representative**

11/26/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *124* Residents Served: *55*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Homestead* Capacity: *30* Residents Served: *21*

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *55*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*  
Have Mobility Need: *24* Have Physical Disability: *0*

Inspections / Reviews

11/26/2024 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *Bypass Document  
Submission*

02/21/2025 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: *02/20/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

## 23a - Activities of Daily Living Assistance

## 1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

## Description of Violation

The assessment and support plan, dated [REDACTED] for resident 1 indicates the resident requires assistance with prompting/cueing for toileting, transferring in and out of bed, personal hygiene and ambulating. On 11/26/2024, the resident pushed [REDACTED] call bell for assistance at 3:17 pm and by 3:57 pm staff did not provide assistance with toileting. On this same day, the resident reported not receiving assistance with ambulating to the dining room and did not eat breakfast or lunch.

## Plan of Correction

Directed ([REDACTED] - 01/27/2025)

By 2/17/25: The administrator or designated staff person will provide training to all direct care staff on providing care on resident specific support plans. Administrator will audit call bell times weekly and address long wait times with staff. Training will be documented and kept in staff records.

Beginning 2/1/25: The administrator or designated staff person will interview 3 residents a week for two months then 1 resident a week thereafter to discuss care provided by staff. Documentation of interviews will be kept. [REDACTED]

Directed Completion Date: 02/17/2025

Not Implemented ([REDACTED] - 02/20/2025)

## 54a - Direct Care Staff

## 2. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

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

## Description of Violation

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

## Plan of Correction

Directed ([REDACTED] - 01/27/2025)

Immediately: Staff person C will not be permitted to provide direct care services in the home until they have met the educational qualifications or a waiver is approved.

By 2/17/25: The administrator or designee will review all current direct care staff records to ensure all direct care staff persons meet the qualifications in accordance with regulation 2600.54(a) to include a Diploma issued by the Pennsylvania Department of Education or Department of Education in another state. Documentation will be kept in the staff records. Only those staff persons who meet the direct care staff qualifications will provide direct care services.

By 2/17/25: All staff persons involved in the hiring and retention of staff including the administrator will be educated on the direct care staff educational qualifications. Documentation of training shall be kept. [REDACTED]

54a - Direct Care Staff (continued)

Directed Completion Date: 02/17/2025

Not Implemented (████) - 02/20/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.

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

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

Description of Violation

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

Repeat violation: 11/27/23, 7/2/24 et al

Plan of Correction

Directed (████) - 01/27/2025)

By 2/17/25: The administrator or designee will review all training records for staff hired within the past year to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions in accordance with regulation 2600.65(b). Documentation of the training will be placed in the employee's record.

Starting 2/1/25: The administrator or designee will audit staff training records quarterly to ensure all staff persons received orientation in resident rights, emergency medical plans, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions in accordance with regulation 2600.65b within the first 40 scheduled working hours. Audits will be kept. █████

Directed Completion Date: 02/17/2025

Not Implemented (████) - 02/20/2025)

65f - Training Topics

4. Requirements

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

65f - Training Topics (*continued*)

5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

**Description of Violation**

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

*Repeat violation: 7/2/24 et al.*

**Plan of Correction**

**Directed (█ - 01/27/2025)**

*By 2/17/25: Direct care staff persons B and C will receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home. Documentation will be kept in staff records.*

*By 2/17/25: The administrator will review all current staff training records to ensure all direct care staff have received the required training on all topics in accordance with regulation 2600.65(f) during the 2024 training year. The review will include interviewing all staff persons to measure which training topics were actually provided to each staff person. If any staff has not completed the required training topics in accordance with regulation 2600.65(f), the training will be completed immediately.*

*Starting 2/1/25: The administrator or designee will audit staff training records quarterly to ensure all staff persons received orientation in resident rights, emergency medical plans, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions in accordance with regulation 2600.65b within the first 40 scheduled working hours. Audits will be kept. █*

**Directed Completion Date: 02/17/2025**

**Not Implemented (█ - 02/20/2025)**

## 65g - Annual Training Content

**5. Requirements**

2600.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

65g - Annual Training Content (continued)

- 3. Resident rights.
- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 5. Falls and accident prevention.
- 6. New population groups that are being served at the home that were not previously served, if applicable.

**Description of Violation**

*Staff persons B and C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2023.*

*Repeat violation: 7/2/24 et al.*

**Plan of Correction**

**Directed (█ - 01/27/2025)**

*By 2/17/25: Staff persons B and C will receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Documentation will be kept in staff records.*

*By 2/17/25: The administrator will review all current direct care staff, ancillary staff, substitute staff and volunteers training records to ensure all staff have received the required training on all topics in accordance with regulation 2600.65(g) during the 2024 training year. If any staff has not completed the required training topics in accordance with regulation 2600.65(g), the training will be completed immediately.*

*Starting 2/1/25: The administrator or designee will audit staff training records quarterly to ensure all staff persons received the required training in accordance with regulation 2600.65g. Audits will be kept. █*

**Directed Completion Date: 02/17/2025**

**Not Implemented (█ - 02/20/2025)**

81b - Resident Personal Equipment

**6. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**Description of Violation**

*Resident 2's bedside mobility device is not appropriately secured to the structure of the bed; the device moved 6 inches, with minimal effort, away from the right side of the bed.*

**Plan of Correction**

**Directed (█ - 01/27/2025)**

*Immediately: The administrator or designee will cover resident 2's bedside mobility device.*

*2/17/25: The administrator or designee will audit all resident rooms that require bedside mobility devices to ensure they meet the required measurements or are covered and securely attached to the bed.*

*2/17/25: All staff will be trained in the safety risk of unsecured, and uncovered bedside mobility devices with large openings. Documentation of training will be kept.*

*Starting 2/1/25: The administrator or designated staff persons will check all bedside mobility devices during each shift to ensure they are secure and covered. █*

**Directed Completion Date: 02/17/2025**

**Not Implemented (█ - 02/20/2025)**

82c - Locking Poisonous Materials

7. Requirements

2600.

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

Description of Violation

Head and Shoulders Dry Scalp Hydration Shampoo and Crest Pro Health Toothpaste, with a manufacture's label indicating "If swallowed get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in the cabinet underneath the bathroom sink in room 310. Not all the residents of the home, including resident 3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Directed (█) - 01/27/2025

Starting 2/1/25: The administrator or designated staff person will check the home daily on each shift to ensure poisonous materials are locked and inaccessible to residents.

By 2/17/25: All staff persons will be educated concerning the safe storage of poisonous materials and the risks to residents. Documentation of education shall be kept. █

Directed Completion Date: 02/17/2025

Not Implemented (█) - 02/20/2025

85a - Sanitary Conditions

8. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/26/2024, at 12:29 PM, room 202 had a strong odor of urine.

Plan of Correction

Directed (█) - 01/27/2025

By 2/17/25: All staff persons shall be trained on maintaining sanitary conditions including immediately correcting or reporting any unsanitary conditions. Documentation of training shall be kept.

2/1/25: The administrator or designated staff will check daily during each shift to ensure sanitary conditions are maintained. █

Directed Completion Date: 02/17/2025

Not Implemented (█) - 02/20/2025

85d - Trash Receptacles

9. Requirements

2600.

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

Description of Violation

On 11/26/2024, at 12:29 pm, the trash can in the bathroom of room 202 was uncovered and filled with used incontinence products.

85d - Trash Receptacles (continued)

On 11/26/2024, at 12:39 pm, the trash can in the bathroom of room 213 was uncovered and full.

Plan of Correction

Directed (████ - 01/27/2025)

By 2/17/25: The administrator or designee will develop and implement a process and procedure to check the bathroom trash receptacles on each shift to ensure the trash receptacle is covered. All staff persons shall be trained on the process and procedure on ensuring trash in the bathrooms shall be kept in covered containers that prevent the penetration of insects and rodents. Documentation of training will be kept.

Starting 2/1/25: A designated staff person shall check all trash receptacles in the bathrooms daily during each shift to ensure each has a lid in place. Audits will be kept. █████

Directed Completion Date: 02/17/2025

Not Implemented (████ - 02/20/2025)

86b - Bathroom

10. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathrooms in rooms 18, 202, 208, 210, 211, 213, 314, 315 and 321, do not have an operable window or ventilation fan. The ventilation fan is inoperable and there is no window in the bathroom.

Plan of Correction

Directed (████ - 01/27/2025)

By 2/17/25: The administrator or designee will check all bathrooms to ensure there is an operable window or an operable exhaust fan. Any bathrooms without an operable or exhaust fan will be repaired immediately.

Starting 2/1/25: A designated staff person will check all bathrooms weekly to ensure there is an operable outside window or an operable exhaust fan. If the exhaust fan is inoperable and there is no outside window; repairs to the exhaust fan will be made immediately. █████

Directed Completion Date: 02/17/2025

Not Implemented (████ - 02/20/2025)

88a - Surfaces

11. 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 11/26/2024:

- the ceiling tiles in stairwell A/3 were water stained.
- 

Repeat violation: 7/2/24 et al.

88a - Surfaces (continued)

Plan of Correction

Directed (█) - 01/27/2025)

By 2/17/25: All staff persons shall be educated on reporting and or correcting any floors, walls, ceilings and other surfaces that are not clean, not in good repair or are hazardous. Documentation of education shall be kept. Starting 2/1/25: The administrator or designee shall check the home daily on each shift to ensure floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Hazardous conditions will be corrected immediately. █

Directed Completion Date: 02/17/2025

Not Implemented (█) - 02/20/2025)

95 - Furniture and Equipment

12. Requirements

2600.

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

Description of Violation

The garbage disposal in the Main Kitchen has been inoperable for over a month.

The bathroom cabinet door under the sink in room 310 is broken off at the left upper hinge.

Plan of Correction

Directed (█) - 01/27/2025)

By 2/17/25: All staff persons shall be educated on the requirements of regulation 2600.95 and reporting or repairing furniture and equipment that is not in good repair, not clean or is hazardous. Any hazards will be immediately corrected. If furniture or equipment is in disrepair and cannot be repaired immediately, it will be immediately removed from service. Documentation of education shall be kept.

Starting 2/1/25: The administrator or designated staff shall check the home daily during each shift to ensure furniture and equipment is in good repair, clean and free of hazards. Any hazards will be immediately reported to maintenance to be corrected. If furniture or equipment is in disrepair and cannot be repaired immediately it will be immediately removed from service. █

Directed Completion Date: 02/17/2025

Not Implemented (█) - 02/20/2025)

96a - First Aid Kit

13. Requirements

2600.

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

Description of Violation

The first aid kit in the Terrace Level medication room does not include a breathing shield.

Plan of Correction

Directed (█) - 01/27/2025)

Starting 2/1/25: The administrator or designated staff person will check each first aid kit in the home twice per month and after each use to ensure all required items are included and usable for all first aid kits.

96a - First Aid Kit (continued)

By 2/17/25: All staff persons will be educated on the need to maintain proper first aid kit contents and the uses for each item in the event of an emergency. Documentation of training shall be kept. [REDACTED]

Directed Completion Date: 02/17/2025

Not Implemented ([REDACTED] - 02/20/2025)

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

2600.

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

- 3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for resident 4 has bedsheets that are stained with what appears to be dried urine.

The bed for resident 5 does not have bed sheets.

Plan of Correction

Directed ([REDACTED] - 01/27/2025)

By 2/17/25: All staff persons will be educated on the requirements of regulation 2600.101(j)(3) and reporting and or correcting pillows, bed linens and blankets that are not clean or not in good repair. Documentation of education shall be kept.

Starting 2/1/25: A designated staff person on each shift will check residents' pillow, bed linens and blankets to ensure the pillow, bed linens and blankets are clean and in good repair. Any pillows, bed linens and blankets that are not clean and in good repair will be replaced immediately. [REDACTED]

Directed Completion Date: 02/17/2025

Not Implemented ([REDACTED] - 02/20/2025)

101j7 - Lighting/Operable Lamp

15. Requirements

2600.

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

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 6 does not have access to a source of light that can be turned on/off at bedside.

Repeat violation: 2/26/24

Plan of Correction

Directed ([REDACTED] - 01/27/2025)

Starting 2/1/25: A designated staff person shall check the home daily during each shift to ensure all resident beds have an operable bedside lamp or source of lighting that can be turned on/off from bedside.

By 2/17/25: All staff persons shall be educated on the importance of operable bedside lighting and that each resident shall have an operable lamp or other source of lighting that can be turned on/off from bedside. Documentation of education shall be kept. [REDACTED]

Directed Completion Date: 02/17/2025

101j7 - Lighting/Operable Lamp (continued)

Not Implemented ( ) - 02/20/2025

101o - Walls, Floors, Ceilings

16. Requirements

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The ceiling is cracked in the bedroom of room 211.

Plan of Correction

Directed ( ) - 01/27/2025

By 2/17/25: All staff persons shall be educated on the requirements of regulation 2600.101(o) and reporting and or repairing bedroom walls, floors and ceilings, which are not clean or are in disrepair. Documentation of education shall be kept.

Starting 2/1/25: designated staff person will check the home on a daily basis during each shift to ensure all bedroom walls, floors and ceilings, which are finished, are clean and in good repair. Any issues will be reported to maintenance immediately. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

102e - Privacy - Doors/Partitions

17. Requirements

2600.

102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

On 11/26/2024, room 208 and room 18 which is shared by residents ( ) and ( ) did not have a bathroom door to provide privacy.

Plan of Correction

Directed ( ) - 01/27/2025

Immediately: A door will be installed to the bathroom of rooms 208 and 18.

By 2/17/25: The administrator or designee will check all bathrooms to ensure there are doors present that provide privacy. Any bathroom without a door will have one installed immediately. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

107d - Procedure Emergency Management Agency Submission

18. Requirements

2600.

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

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 06/07/23.

107d - Procedure Emergency Management Agency Submission (continued)

Plan of Correction

Directed ( ) - 01/27/2025

By 2/17/25: The administrator or designee will update and submit the home's written emergency procedures to the local emergency management agency. Documentation of submission will be kept. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

130a - Smoke Detector 15 ft Bedroom

19. Requirements

2600.

130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

There is no smoke detector in resident room 213.

Plan of Correction

Directed ( ) - 01/27/2025

By 2/17/25: Maintenance will install a smoke detector within 15 feet of room 213. The administrator or designee will check all resident rooms to ensure there are smoke detectors with 15 feet of every room. Any rooms without smoke detectors will have one installed immediately. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

183d - Prescription Current

20. Requirements

2600.

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

Description of Violation

On 11/26/2024, at 12:27 pm, Lorazepam .5 mg tablets, qty 20, and Morphine 5 mg .25 ml syringes, qty 14, prescribed for resident 7, were in the home's medication cart; however, the resident passed away on ( )

Plan of Correction

Directed ( ) - 01/27/2025

Starting 2/1/25: A staff person qualified to administer medications will audit the medication cart daily during each shift. Any medications belonging to residents that no longer reside in the home will be removed from the medication cart and destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. Audits will be kept. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

183e - Storing Medications

21. Requirements

2600.

183e - Storing Medications (continued)

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

Description of Violation

On 11/26/2024:

- there were 3 loose pills found in the Homestead medication cart.
- there were 2 loose pills found in the Terrace Level medication cart.
- the back of the bubble pack for resident 8's prescription of Alprazolam .25 mg tabs had a tear/puncture at spot 6.
- 

Plan of Correction

Directed ( ) - 01/27/2025)

Starting 2/1/25: Two staff persons qualified to administer medications will audit the narcotics in medication cart daily at the start and the end of each shift.

By 2/17/25: The administrator will review and update the policy and procedures for the safe and secure storage of medications and controlled substances, including that all medications are properly packaged and stored and that there are no unpackaged or loose medications in the medication cart. All staff qualified to administer medications will be trained on the policy and procedures. Documentation of training will be kept in staff records. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025)

184a - Resident's Meds Labeled

22. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 11/26/2024:

- there was a pill organizer, containing medication, found in the Terrace Level medication cart without a resident's name and/or pharmacy label.
-

184a - Resident's Meds Labeled (continued)

**Plan of Correction**

**Directed (█ - 01/27/2025)**

By 2/17/25: A designated staff person qualified to administer medications will complete an initial audit and monthly audit thereafter of the medication carts and any other medication storage areas to ensure all prescription medications are labeled with a pharmacy label, to include: the resident's name, medication name, date prescription issued, prescribed dosage and instructions for administration and name and title of the prescriber and match the prescription. Documentation of audits shall be kept.

By 2/17/25: All staff persons qualified to administer medications will be educated, that all prescription medications are to be properly labeled with a pharmacy label, to include: the resident's name, medication name, date prescription issued, prescribed dosage and instructions for administration, and name and title of the prescriber. Staff persons administering medications will be instructed to check the medication label prior to administering medication. Documentation of education will be kept. █

**Directed Completion Date: 02/17/2025**

**Not Implemented (█ - 02/20/2025)**

185a - Implement Storage Procedures

**23. Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

**Description of Violation**

On 11/26/2024, resident 10's glucometer was not calibrated; at 11:30 am, resident 10's glucometer indicated the date and time as 11/25/24 at 10:48 pm.

The following readings from resident 10's glucometer were recorded incorrectly on resident 10's medication administration record (MAR):

- on 11/23/2024 at 8 pm, the glucometer reading was 263, but was documented in the MAR as 265.
- on 11/24/2024 at 4 pm, there was no reading in the glucometer, but was documented in the MAR as 165.
- on 11/25/2024 at 11:30 am. the glucometer reading was 344, but was documented in the MAR as 346.
- on 11/25/2024 at 8 pm, the glucometer reading was 215, but there was no reading documented in the MAR.

**Plan of Correction**

**Directed (█ - 01/28/2025)**

By 2/17/25: All staff qualified to administer medications will be trained on proper documentation of glucometer readings and calibrating glucometers. Documentation of training will be kept in staff records.

185a - Implement Storage Procedures (continued)

By 2/17/25: A designated staff person qualified to administer medications will conduct an initial audit and monthly audits thereafter of glucometer logs to ensure correct documentation is completed. Audits will be kept. [REDACTED]

Directed Completion Date: 02/17/2025

Not Implemented ([REDACTED] - 02/20/2025)

187b - Date/Time of Medication Admin.

24. 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 11 is prescribed Tamsulosin .4mg, Colace 10 mg, and Guaifenesin Liquid 100mg/5ml. Resident 11's November 2024 medication administration record does not include the initials of the staff person who administered Tamsulosin .4mg, Colace 10 mg, and Guaifenesin Liquid 100mg/5ml on 11/25/24 at 8:00 pm.

Resident 12 is prescribed Acetaminophen 500 mg, 2 tablets by mouth every 8 hours. Resident 12's November 2024 medication administration record does not include the initials of the staff person who administered Acetaminophen 500 mg, 2 tablets on 11/21/24 at 8:00 am, and on 11/8/24, 11/9/24, 11/10/24, 11/14/24, 11/19/24, 11/20/24, and 11/23/24 at 8:00 pm.

Repeat violation: 6/7/23

Plan of Correction

Directed ([REDACTED] - 01/28/2025)

By 2/17/25: The administrator or designee qualified to administer medications will complete an initial audit and monthly thereafter of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b). Audits will be kept.

By 2/17/25: All staff persons qualified to administer medications will be trained on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of training will be kept. [REDACTED]

Directed Completion Date: 02/17/2025

Not Implemented ([REDACTED] - 02/20/2025)

187d - Follow Prescriber's Orders

25. Requirements

2600.

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

Description of Violation

Resident 10 is prescribed Insulin Lispro U-100/1ml on a sliding scale: 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 4 times daily, with meals and nightly. However, resident 10 was administered the following:

- On 11/22/24 at 4:00 pm, glucose reading 354, 6 units administered instead of 8
- On 11/24/24 at 8:00 pm, glucose reading 256, 5 units administered instead of 4
- On 11/25/24 at 8:00 am, glucose reading 346, 0 units administered instead of 6

187d - Follow Prescriber's Orders (continued)

- On 11/25/24 at 11:30 am, glucose reading 243, 6 units administered instead of 2

Resident 12 is prescribed Acetaminophen 500 mg, 2 tablets by mouth every 8 hours. However, resident 12 was administered Acetaminophen 500 mg, 2 tablets by mouth, twice a day, at 8:00 am and 5:00 pm since 11/7/2024.

Repeat violation: 6/7/23, 11/27/23 et al, 7/2/24 et al

Plan of Correction

Directed ( ) - 01/28/2025

By 2/17/25: The administrator or designee qualified to administer medications shall complete an initial audit and monthly thereafter of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b).

By 2/17/25: All staff persons qualified to administer medications will be trained on the proper procedure for medication administration, including documentation of medication administration, following the orders of the prescriber and reporting medication errors. Documentation of training will be kept. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

224a - Preadmission Screen Form

26. Requirements

2600.

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

Description of Violation

Resident 6's pre admission screening form, dated ( ) does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction

Directed ( ) - 01/28/2025

By 2/17/25: The administrator or designated staff person will review all resident records to ensure all residents have a preadmission screening completed, including documentation that the home can meet the needs of the resident, and the Department's preadmission screening form is present in each resident record. The administrator or designated staff person will review all new resident preadmission screening forms for accuracy and completion including the staff person completing the form has determined the home can meet the needs of the resident. ( )

Directed Completion Date: 02/17/2025

Not Implemented ( ) - 02/20/2025

## 227g -Support Plan Signatures

## 27. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

## Description of Violation

Resident 2 participated in the development of [REDACTED] support plan on [REDACTED]. However, the resident did not sign the support plan.

## Plan of Correction

Directed ( [REDACTED] - 01/28/2025)

By 2/17/25: The administrator or designee will review resident 2's support plan and give resident 2 an opportunity to sign. If resident is unable or refuses to sign document on the support plan.

By 2/15/25: The administrator or designee will conduct an initial audit and monthly thereafter of all resident support plans to ensure completion including signatures of those involved in the development of the plan. [REDACTED]

Directed Completion Date: 02/17/2025

Not Implemented ( [REDACTED] - 02/20/2025)

## 252 - Record Content

## 28. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.

252 - Record Content (continued)

- 24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
- 25. A copy of the resident-home contract.
- 26. A termination notice, if any.

**Description of Violation**

*Resident 1's record does not include a photograph of the resident that is no more than 2 years old.*

**Plan of Correction**

*Directed (█ - 01/28/2025)*

*Starting 2/1/25: The administrator or designee will conduct an initial review of all resident records and quarterly thereafter to ensure all required documentation in accordance with regulation 2600.252 is present in each resident's record.*

**Directed Completion Date: 02/17/2025**

*Not Implemented (█ - 02/20/2025)*