



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 18, 2025

[REDACTED]
Personal Care at Evergreen Inc.
336 North Main Street
Washington, Pennsylvania 15301

RE: Personal Care at Evergreen
License/COC #: 405782

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 21, 2024, November 22, 2024, and January 8, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), mistreatment or abuse of residents being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your Provisional certificate of compliance (license number 405781) dated October 11, 2024 – April 11, 2025, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from March 18, 2025 to September 18, 2025.

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



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

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
15(a)	II	25	\$5	\$125	5 calendar days from mailing date of this letter
15(b)	II	25	\$5	\$125	5 calendar days from mailing date of this letter
16(c)	II	25	\$5	\$125	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 PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

, Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Room 631, Health and Welfare Building
 625 Forster Street
 Harrisburg, Pennsylvania 17120


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,

A handwritten signature in black ink that reads "Juliet Marsala". The signature is written in a cursive style with a large, looping initial 'J'.

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *PERSONAL CARE AT EVERGREEN* License #: *40578* License Expiration: *04/11/2025*
Address: *336 NORTH MAIN STREET, WASHINGTON, PA 15301*
County: *WASHINGTON* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *PERSONAL CARE AT EVERGREEN INC*
Address: *336 NORTH MAIN STREET, WASHINGTON, PA, 15301*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C 2 LP* Date: *01/12/1999* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *32* Waking Staff: *24*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Provisional, Incident* Exit Conference Date: *12/09/2024*

Inspection Dates and Department Representative

11/21/2024 On Site: [REDACTED]
11/22/2024 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *5* Are 60 Years of Age or Older: *23*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *5* Have Physical Disability: *0*

Inspections / Reviews

11/21/2024 - Partial

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *12/21/2024*

12/17/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 12/23/2024

12/23/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 02/28/2025

01/06/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 02/28/2025

03/04/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/28/2025

Reviewer: [REDACTED]

Follow Up Type: Enforcement

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On or around 10/11/24, staff person E reported to staff person [redacted] administrator, that on 10/4/24, direct care staff person B refused to assist resident #1 with a shower and was verbally abusive towards resident #1; however, this allegation of abuse was not reported to the local Area Agency on Aging.

REPEAT VIOLATION: 9/16/2024

Plan of Correction

Directed ([redacted] - 12/23/2024)

Incident was reported to Area Agency on Aging on 11/7/24.

Staff Person B was terminated on [redacted] by Facility Administrator and Facility CEO.

Facility Administrator had OSPTA- RN [redacted] (Home Health and Hospice) conduct Abuse Training with all staff including the Administrator on 10/16/24, documentation was kept.

Facility Administrator had a staff meeting on 12/9/24 informing staff the proper way to file for abuse and gave them handouts with instructions, documentation was kept.

Facility Administrator has been re-educated on abuse reporting on 11/25/24 by [redacted] CEO.

Act 13 Abuse forms and Incident Report forms have also been hung in the breakroom for staff to utilize.

Facility administrator has devised a monitoring sheet for all med techs/person in charge to utilize daily for potential abuse. Sheet is attached and will begin on 12/17/24.

Facility Administrator scheduled a training with [redacted] with Older Adult Protective Services on 12/31/24 for Abuse/Neglect with staff. Documentation will be kept. At the next Quality Management Meeting (1/3/2025) we will review all items specified in 2600.15a. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [redacted] 12/23/24).

Facility Administrator and/or designee will begin monitoring incident reports daily for two months starting 12/23/24 to ensure it is being reported timely and immediate to AAA and DHS for Abuse Allegations.

Facility Administrator or Staff Designee will interview 3 residents each week for 2 months, then 3 residents monthly for 2 months for abuse & safety concerns. Starting 12/23/2024 and documentation will be kept.

Facility Administrator or designee will also conduct interviews with staff members - 3 staff members each week for 2 months and then 3 staff members monthly for 2 months. Starting 12/23/24 and documentation will be kept.

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented ([redacted] - 03/04/2025)

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On or around 10/11/24, staff person E reported to staff person [REDACTED] administrator, that on 10/4/24, direct care staff person B refused to assist resident #1 with a shower and was verbally abusive towards resident #1; however, staff person B continued to work in the home unsupervised on numerous occasions until 11/8/24.

REPEAT VIOLATION: 9/16/2024

Plan of Correction

Directed ([REDACTED] - 12/23/2024)

Incident was reported to Area Agency on Aging on 11/7/24.

Staff Person B was terminated on [REDACTED] by Facility Administrator and Facility CEO.

Facility Administrator had OSPTA- RN [REDACTED] (Home Health and Hospice) conduct Abuse Training with all staff including the Administrator on 10/16/24.

Facility Administrator had a staff meeting on 12/9/24 informing staff the proper way to file for abuse and gave them handouts with instructions.

Facility Administrator has been re-educated on abuse reporting on 11/25/24 by [REDACTED] CEO.

Facility Administrator and/or designee will begin monitoring incident reports daily or two months starting 12/23/24 to ensure immediate suspension/plan of supervision for any staff persons alleged in abuse.

Facility Administrator scheduled a training with [REDACTED] with Older Adult Protective Services on 12/31/24 for Abuse/Neglect with our employees. Documentation will be kept. (DIRECTED: The training shall also include re-education on 2600.15b to ensure the immediate suspension/implementation of a plan of supervision for all staff persons named in abuse allegations. [REDACTED] 12/23/24).

At the next Quality Management Meeting (1/3/2025) we will review all items specified in 2600.15b. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [REDACTED] 12/23/24).

Facility Administrator or Staff Designee will interview 3 residents each week for 2 months, then 3 residents monthly for 2 months for abuse & safety concerns. Starting 12/23/2024 and documentation will be kept.

Facility Administrator or designee will also conduct interviews with staff members - 3 staff members each week for 2 months and then 3 staff members monthly for 2 months. Starting 12/23/24 and documentation will be kept.

15b - Supervisor Plan (continued)

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented (█ - 03/04/2025)

16c - Written Incident Report

3. Requirements

2600.

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

Description of Violation

On or around 10/11/24, staff person E reported to staff person █ administrator, that on 10/4/24, direct care staff person B refused to assist resident #1 with a shower and was verbally abusive towards resident #1; however, this allegation of abuse was not reported to the Department until 11/7/24.

REPEAT VIOLATION: 9/16/2024

Plan of Correction

Directed (█ - 12/23/2024)

Incident was reported to Area Agency on Aging on 11/7/24.

Staff Person B was terminated on █ by Facility Administrator and Facility CEO.

Facility Administrator had OSPTA- RN █ (Home Health and Hospice) conduct Abuse Training with all staff including the Administrator on 10/16/24.

Facility Administrator had a staff meeting on 12/9/24 informing staff the proper way to file for abuse and gave them handouts with instructions.

Facility Administrator has been re-educated on abuse reporting on 11/25/24 by █ CEO.

Facility Administrator scheduled a training with █ with Older Adult Protective Services on 12/31/24 for Abuse/Neglect Reporting with Administrator and staff. Documentation will be kept.

At the next Quality Management Meeting (1/3/2025) we will review all items specified in 2600.16c. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. █ 12/23/24).

Facility Administrator and/or designee will begin monitoring incident reports daily or █ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. █ 12/23/24) starting 12/23/24 to ensure timely reporting of all incidents specified in 2600.16c to the Department within 24hours.

16c - Written Incident Report (continued)

Facility Administrator or Staff Designee will interview 3 residents each week for 2 months, then 3 residents monthly for 2 months for abuse & safety concerns. Starting 12/23/2024 and documentation will be kept. Facility Administrator or designee will also conduct interviews with staff members - 3 staff members each week for 2 months and then 3 staff members monthly for 2 months. Starting 12/23/24 and documentation will be kept.

DIRECTED: By 1/8/25: The administrator shall reeducate all staff persons on all reportable incidents specified in 2600.16a, and that all reportable incidents specified in 2600.16a shall be reported to the Department within 24 hours in accordance with 2600.16c. Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 12/23/24

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/08/2025

Not Implemented [REDACTED] - 03/04/2025

42b - Abuse

4. Requirements

2600.

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

Description of Violation

Numerous residents and staff persons indicate direct care staff person B intimidates and is verbally abusive to numerous residents on an almost daily basis. Direct care staff person B frequently uses vulgar and profane language, name calling, makes sexually inappropriate comments and is aggressive with residents.

Prior to a medical appointment on 10/4/24, resident #1 requested assistance with a shower from direct care staff person B. Direct care staff person B refused to assist resident #1 and told resident #1, "I am not wiping any of your [REDACTED] which made resident #1 upset.

According to numerous staff persons, direct care staff person B is repeatedly aggressive and mean to resident #2 on regular basis. During the home's Halloween party, direct care staff person B transferred resident #2 by grabbing

42b Abuse (continued)

resident #2's shirt and forcefully lifted resident #2 by [REDACTED] shirt while transferring [REDACTED] into [REDACTED] wheelchair. During the transfer, direct care staff person B told resident #2 to, "shut up" and said, "I am sick of you".

Direct care staff person F indicated on 11/20/24 at approximately 12:00 AM, resident #5 reported to [REDACTED] that resident #4 was bleeding and that there was blood in residents #4 and #5's shared jack and jill bathroom. Direct care staff person F indicated [REDACTED] checked the bathroom, saw dried blood on the bathroom floor and attempted to clean it up; however, never checked on resident #4. At approximately 5:50 AM, resident #4 came out of [REDACTED] bedroom with a bloody right wrist and reported to direct care staff person F that [REDACTED] cut [REDACTED] wrist and wanted to die. Emergency services were contacted at this time; however direct care staff person F did not check on resident #4 after receiving the initial report from resident #5 at approximately 12:00 AM.

Plan of Correction**Directed [REDACTED] - 12/23/2024)**

Incident was reported to Area Agency on Aging on 11/7/24.

Staff Person B was terminated on [REDACTED] by Facility Administrator and Facility CEO.

Facility Administrator had OSPTA RN [REDACTED] (Home Health and Hospice) conduct Abuse Training with all staff including the Administrator on 10/16/24.

Facility Administrator had a staff meeting on 12/9/24 informing staff the proper way to file for abuse and gave them handouts with instructions.

Facility Administrator has been re educated on abuse reporting on 11/25/24 by [REDACTED] CEO.

The facility has placed informational sheets around the facility for how abuse is to be reported and the timeline for when to report. Act 13 Abuse forms and Incident Report forms have also been hung in the breakroom for staff to utilize.

Facility administrator has devised a monitoring sheet for all med techs/person in charge to utilize daily for potential abuse. Sheet is attached and will begin on 12/17/24.

Facility Administrator scheduled a training with Sarah with Older Adult Protective Services on 12/31/24 for Abuse/Neglect with our employees. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 12/23/24).

At the next Quality Management Meeting (1/3/2025) we will review all items specified in 2600.42b. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [REDACTED] 12/23/24).

Facility Administrator or Staff Designee will interview 3 residents each week for 2 months, then 3 residents monthly for 2 months for abuse & safety concerns. Starting 12/23/2024 and documentation will be kept.

Facility Administrator or designee will also conduct interviews with staff members 3 staff members each week for 2 months and then 3 staff members monthly for 2 months. Starting 12/23/24 and documentation will be kept.

42b - Abuse (continued)

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented (█ - 03/04/2025)

58a - Awake Staff 16 or More

5. Requirements

2600.

58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

Numerous staff persons and residents indicate direct care staff person C has been observed sleeping in common areas of the home on numerous occasions during the 11:00pm-7:00am shift. On 11/21/24 and 11/22/24, the home served 27 residents.

Plan of Correction

Directed (█ - 12/23/2024)

Facility Administrator was made aware of the photo that was taken by a staff member of Staff Person C sleeping on 10/25/24 @6:42 am.

Facility Administrator had disciplined the staff member on 10/29/24 and took the staff member down to 1 day a week working.

Facility Administrator will educate all staff on regulation 58a by 12/31/24. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65. █ 12/23/24).

At the next Quality Management meeting (1/3/2025) will review all items specified in 2600.58a. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. █ 12/23/24).

Beginning 12/23/24 Facility Administrator/Designee will conduct daily rounds for one month and then weekly for one month to ensure direct care staff persons are awake while working. Documentation will be kept. (DIRECTED: The daily rounds shall include a daily walkthrough on each shift to ensure compliance with 2600.58a. █ 12/23/24).

Proposed Overall Completion Date: 12/17/2024

58a - Awake Staff 16 or More (continued)

Directed Completion Date: 01/03/2025

Not Implemented () - 03/04/2025

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:

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

Description of Violation

Direct care staff person D, hired on (), did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction

Directed () - 12/23/2024

Facility Administrator had initially educated Staff Person D on () during new hire orientation, the form to prove the initial training was complete was not signed. Administrator re-educated staff person D on regulation 65a on 11/27/24. Documentation of education was kept.

At the next Quality Management meeting (1/3/2025) they will review all items specified in 2600.65a. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. () 12/23/24).

Facility Administrator or designee will review the next 10 new hires within 24hours of hire to make sure proper training is completed during the hiring process starting 12/16/2024. Documentation will be kept.

Facility Administrator or designee will check current employee training records monthly for the next 4 months, starting January 1, 2025.

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Implemented () - 03/04/2025

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

Direct Care Staff person D, hired on [REDACTED], did not receive orientation on any of the topics specified in 2600.65b. Staff person D completed [REDACTED] 40th hour of work on or around [REDACTED]

Plan of Correction

Directed ([REDACTED] - 12/23/2024)

Facility Administrator had initially educated Staff Person D on [REDACTED] during new hire orientation, the form to prove the initial training was complete was not signed. Administrator re educated staff person D on regulation 65b on 11/27/24. Documentation of education was kept.

At the next Quality Management meeting (1/3/2025) they will review all items specified in 2600.65b. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [REDACTED] 12/23/24).

Facility Administrator or designee will review the next 10 new hires within 24hours of hire to make sure proper training is completed during the hiring process starting 12/16/2024. Documentation will be kept.

Facility Administrator or designee will check current employee training records monthly for the next 4 months, starting January 1, 2025.

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Implemented ([REDACTED] - 03/04/2025)

95 - Furniture and Equipment

8. Requirements

2600.

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

Description of Violation

On 11/22/24, resident #3's shower stall was in disrepair. There is an approximate 3" hole in the floor of the shower stall near the drain and a large crack where the flooring meets the shower wall, which is approximately 18" long by approximately 6" wide and is covered with brown fiberglass. Also, there is a hole covered with white tape on the back wall of the shower stall.

95 Furniture and Equipment (continued)

Plan of Correction**Directed (█ - 12/23/2024)**

Contractor assessed the shower stall replacement on 11/25/24.

Resident is currently utilizing another bathroom for █ showers.

Currently waiting on invoice of what repairs will be completed on the shower. Shower completion date is anticipated for 2/28/2025.

All staff will be educated by █ (UNACCEPTABLE DATE IN PLAN OF CORRECTION). The education for all staff persons shall be conducted by the administrator on 12/23/24. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 12/23/24) on notifying administrator if there are any repairs that need done in resident rooms.

At the next Quality Management meeting (1/3/2025) will review all items specified in 2600.95. Documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. █ 12/23/24).

Facility Administrator or designee will complete walking rounds 2 times a week for 2 months to inspect resident rooms and bathrooms for any further maintenance repairs. Starting 12/23/24 and documentation will be kept. (DIRECTED: Immediately following the weekly rounds, the administrator/designee shall inspect the home monthly to ensure all furniture and equipment is clean, in good repair and free of hazards. █ 12/23/24).

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 02/28/2025

Not Implemented (█ - 03/04/2025)

141b1 - Annual Medical Evaluation

9. 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 █; however, resident #2's previous medical evaluation was completed on █.

Plan of Correction**Directed (█ - 12/23/2024)**

Facility Administrator will review each chart to make sure medical evaluations are up to date by 1/1/25. Please see audit tool attached.

Facility Administrator will review each medical evaluation prior to submission to the MD and also after receiving the medical evaluation back from MD starting 12/17/24.

On the next Quality Management meeting (1/3/2025) will review of all items specified in 2600.141b1. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 12/23/24).

Facility Administrator or designee will review the next 10 annual medical evaluations to make sure they are

141b1 Annual Medical Evaluation (continued)

completed promptly. Starting 1/1/25 and documentation will be kept.

DIRECTED: By 1/3/25: The administrator shall develop and implement a tracking system which includes the names of all current residents, as well as the date of each resident's current medical evaluation. The tracking system shall be reviewed and updated by the administrator monthly to ensure the timely completion of resident medical evaluations. ■ 12/23/24

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented (■ - 03/04/2025)

142a - Secure Medical Care**10. Requirements**

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

Direct care staff person F indicated on 11/20/24 at approximately 12:00 AM, resident #5 reported to ■ that resident #4 was bleeding and that there was blood in residents #4 and #5's shared jack and jill bathroom. Direct care staff person F indicated ■ checked the bathroom, saw dried blood on the bathroom floor and attempted to clean it up; however, never checked on resident #4. At approximately 5:50 AM, resident #4 came out of ■ bedroom with a bloody right wrist and reported to direct care staff person F that ■ cut ■ wrist and wanted to die. Emergency services were contacted at this time; however direct care staff person F did not check on resident #4 after receiving the initial report from resident #5 at approximately 12:00 AM.

Plan of Correction

Directed (■ - 12/23/2024)

Facility Administrator spoke with Staff Person F stated that when ■ received the report from resident #5 ■ went in the bathroom and found that the blood was dried. ■ assumed it was left over from the shift before. Facility Administrator educated the staff member on 11/22/24, that anytime bodily fluids are found that all the residents in the surrounding area of the bodily fluids should be assessed.

Facility Administrator will hold a mandatory staff meeting on 12/31/24 and ■ will re educate all staff members on the policy for timely medical care. Documentation will be kept.

At the next Quality Management meeting (1/3/2025) will review all items specified in regulation

2600.142a. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ■ 12/23/24).

Facility Administrator and/or designee will begin monitoring incident reports daily for two months starting 12/23/24 to ensure timely medical care is provided to residents.

Facility Administrator or Staff Designee will interview 3 residents each week for 2 months, then 3 residents monthly for 2 months for abuse & safety concerns. Starting 12/23/2024 and documentation will be kept.

Facility Administrator or designee will also conduct interviews with staff members 3 staff members each week for

142a - Secure Medical Care (continued)

2 months and then 3 staff members monthly for 2 months to review change of status of residents starting 12/23/24 and documentation will be kept.

Proposed Overall Completion Date: 01/03/2025

Directed Completion Date: 01/03/2025

Not Implemented ([REDACTED] - 03/04/2025)

187c - Refusal of Medication**11. Requirements**

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #4 frequently refuses medications, to include the following medications on the following dates/times; however, resident #4's prescriber was not notified of the medication refusals until 11/21/24:

Atorvastatin 20 mg tablet-Take 1 tablet by mouth at bedtime, which resident #4 refused on the following dates:

- 8/1/24 through 8/17/24, 8/19/24 through 8/22/24, and 8/24/24 through 8/31/24
- 9/1/24 thru 9/30/24
- 10/1/24 through 10/21/24, 10/23/24 through 10/29/24, and on 10/31/24
- 11/1/24 through 11/19/24

Cetirizine 10 mg tablet-Take 1 tablet by mouth daily, which resident #4 refused on the following dates:

- 8/1/24, 8/2/24, 8/4/24 through 8/10/24, and 8/12/24 through 8/31/24
- 9/1/24 through 9/18/24, 9/20/24 through 9/24/24, and 9/26/24 through 9/30/24
- 10/1/24 through 10/31/24
- 11/1/24 through 11/16/24, and 11/18/24 through 11/20/24

Losartan 25 mg tablet-Take 1 tablet by mouth daily, which resident #4 refused on the following dates:

- 8/1/24, 8/2/24, 8/4/24 through 8/10/24, and 8/12/24 through 8/31/24
- 9/1/24 through 9/18/24, 9/20/24 through 9/24/24, and 9/26/24 through 9/30/24
- 10/1/24 through 10/31/24
- 11/1/24 through 11/16/24, and 11/18/24 through 11/20/24

Plan of Correction

Directed ([REDACTED] - 12/23/2024)

Resident #4 no longer resides at the facility, was discharged on [REDACTED]
Facility Administrator has made a Medication Refusal Document that will be reviewed and faxed daily to the resident MD with a list of medication that was refused and a reason why starting 12/23/24.

187c Refusal of Medication (continued)

The MD will have the option of selecting to be notified daily, weekly or monthly considering the order. Please see document attached.

Facility Administrator or designee will continue to monitor the refusal of medication on each resident daily starting 12/23/24 and documentation will be kept.

Facility Administrator will educate all medication technicians on regulation 2600.187c and this new form by 12/23/24 and documentation will be kept.

At the next Quality Management meeting (1/3/2025) will review all items specified in regulation 2600.187c and documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [REDACTED] 12/23/24).

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented ([REDACTED] - 03/04/2025)

225a - Assessment 15 Days

12. Requirements

2600.

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

Description of Violation

Resident #4's assessment, dated [REDACTED] indicates resident #4 requires no supervision in the home, has a minimal problem with agitation and has no problem with aggression. However, according to numerous staff persons and resident #4's progress notes, resident #4 has displayed numerous behaviors in the home, to include the following:

- Resident #4 cut [REDACTED] right wrist on 11/20/24 in an attempt to self harm
- Numerous physical altercations with staff persons, including on 11/14/24 when resident #4 hit a staff person with a hot coffee pot and threw a coffee pot filter basket at a resident on 11/11/24
- Numerous instances of yelling and using vulgar language towards numerous residents and staff persons

Resident #6's medical evaluation, dated [REDACTED] includes diagnoses of Thyroid hormone replacement, Irritable Bowel Syndrome, Sleep Disorders, Overactive Bladder, Asthma, Constipation and stomach acid; however, these diagnoses are not indicated on resident #6's assessment, dated [REDACTED]

REPEAT VIOLATION: 4/2/2024, et. al.

225a Assessment 15 Days (continued)

Plan of Correction

Directed (█) - 12/23/2024)

Resident #4 no longer resides in the facility; resident was discharged on █.

Resident #6 RASP was updated on 12/20/2024, by the Facility Administrator. Please see attached.

Facility Administrator will review each chart to make sure current resident assessments are up to date by 1/1/25. Please see audit tool attached.

Facility Administrator is responsible for updating RASP's as resident care needs change, that is the home's policy. (DIRECTED: By 1/2/25: The administrator shall develop and implement a system to ensure resident assessment and support plans are updated as resident care needs change. Documentation of the system shall be kept. █ 12/23/24).

At the next Quality Management meeting (1/3/2025) will review all items specified in regulation 2600.225a and documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. █ 12/23/24).

Facility Administrator or designee will also conduct interviews with staff members 3 staff members each week for 2 months and then 3 staff members monthly for 2 months to review change of status of residents starting 12/23/24 and documentation will be kept.

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented (█) - 03/04/2025)

225c - Additional Assessment

13. Requirements

2600.

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

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's most recent assessment, dated █ indicates resident #2 has minimal problems with judgment and irritability and has no problems with agitation and aggression. However, according to numerous staff persons, resident #2 has displayed numerous behaviors in the home, to include being verbally abusive towards staff persons and residents, frequently refuses care and often times hits and scratches staff persons while they attempt to provide resident #2 with care.

Plan of Correction

Directed (█) - 12/23/2024)

Resident #2 RASP was updated on 12/20/2024, by the Facility Administrator. Please see attached.

Facility Administrator will review each chart to make sure current resident assessments are up to date by 1/1/25. Please see audit tool attached.

Facility Administrator is responsible for updating RASP's as resident care needs change, that is the home's policy. (DIRECTED: By 1/2/25: The administrator shall develop and implement a system to ensure resident assessment and support plans are updated as resident care needs change. Documentation of the system shall be kept. █ 12/23/24).

At the next Quality Management meeting (1/3/2025) will review all items specified in regulation 2600.225c and

225c - Additional Assessment (continued)

documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [REDACTED] 12/23/24).

Facility Administrator or designee will also conduct interviews with staff members - 3 staff members each week for 2 months and then 3 staff members monthly for 2 months to review change of status of residents starting 12/23/24 and documentation will be kept.

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented ([REDACTED] - 03/04/2025)

227a - Support Plan 30 Days

14. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #4's assessment, dated [REDACTED], indicates resident #4 cannot self-administer medications; however, resident #4's support plan, dated [REDACTED], indicates "N/A" for the description and plan to meet resident #4's medication needs. Also, resident #4 has refused medications on numerous occasions, which is not indicated on resident #4's support plan.

Plan of Correction

Directed ([REDACTED] - 12/23/2024)

Resident #4 no longer resides in the facility; resident was discharged on [REDACTED]. Facility Administrator will review each chart to make sure current resident support plans are up to date by 1/1/25. Please see audit tool attached.

Facility Administrator is responsible for updating RASP's as resident care needs change, that is the home's policy. (DIRECTED: By 1/2/25: The administrator shall develop and implement a system to ensure resident assessment and support plans are updated as resident care needs change. Documentation of the system shall be kept. [REDACTED] 12/23/24).

At the next Quality Management meeting (1/3/2025) will review all items specified in regulation 2600.227a and documentation will be kept. (DIRECTED: The quality management review scheduled for 1/3/25 shall include a review of all items specified in 2600.26b. [REDACTED] 12/23/24).

Facility Administrator or designee will also conduct interviews with staff members - 3 staff members each week for 2 months and then 3 staff members monthly for 2 months to review change of status of residents starting 12/23/24

227a - Support Plan 30 Days (continued)

and documentation will be kept.

Proposed Overall Completion Date: 12/23/2024

Directed Completion Date: 01/03/2025

Not Implemented ([REDACTED] - 03/04/2025)

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

Facility Information

Name: PERSONAL CARE AT EVERGREEN **License #:** 40578 **License Expiration:** 04/11/2025
Address: 336 NORTH MAIN STREET, WASHINGTON, PA 15301
County: WASHINGTON **Region:** WESTERN

Administrator

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

Legal Entity

Name: PERSONAL CARE AT EVERGREEN INC
Address: 336 NORTH MAIN STREET, WASHINGTON, PA, 15301
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C 2 LP **Date:** 01/12/1999 **Issued By:** Labor and Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 29 **Waking Staff:** 22

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint, Provisional **Exit Conference Date:** 01/08/2025

Inspection Dates and Department Representative

01/08/2025 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 48 **Residents Served:** 25

Secured Dementia Care Unit

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

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 5 **Are 60 Years of Age or Older:** 22
Diagnosed with Mental Illness: 4 **Diagnosed with Intellectual Disability:** 2
Have Mobility Need: 4 **Have Physical Disability:** 0

Inspections / Reviews

01/08/2025 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 01/31/2025

Inspections / Reviews *(continued)*

01/31/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/03/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 02/06/2025

02/06/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/03/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 02/21/2025

03/04/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/03/2025

Reviewer: [REDACTED]

Follow Up Type: Enforcement

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

At 10:27 AM, the basement storage room where past resident medical records are kept was unlocked, unattended and accessible. Numerous boxes of resident records were stored in the unlocked room.

Plan of Correction

Accept (█) - 02/06/2025)

The basement storage room locks were repaired on 1/27/25. Please see attached picture.

All staff will be educated on regulation 17 record confidentiality by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator/Designee will walk through the facility Monday through Friday for one month and then two times a week for one month after to ensure records are kept confidential beginning Monday 2/17/25.

Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Implemented (█) - 03/04/2025)

25a - Written Contract and Review

2. Requirements

2600.

- 25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

No resident-home contract is present for resident #1, who was admitted to the home on 7/31/23.

Plan of Correction

Accept (█) - 02/06/2025)

Resident #1 contract was completed on 1/9/25. Please see attached.

All staff will be educated on regulation 25a written contract and review by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator/Designee will audit current resident files to ensure all contracts are signed by 1/31/25.

Documentation will be kept.

Facility Administrator/Designee will review the next 10 admission files and ensure the contract is signed on the initial admission day starting 2/17/2025. Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

25a Written Contract and Review (continued)

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Not Implemented ([REDACTED] - 03/04/2025)

51 - Criminal Background Check

3. Requirements

2600.

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

Description of Violation

No Pennsylvania criminal background check is present for direct care staff person A, who was hired on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 02/06/2025)

Staff Person A has obtained a background check on 1/8/25. Please see attached.

All staff will be educated on regulation 51 Criminal Background Check by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator/Designee will audit current employee files by 1/31/25. Documentation will be kept.

Facility Administrator/Designee will review the next 10 new hires within 24 hours of hire to make sure criminal background checks are completed during the hiring process starting 2/17/25. Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

DIRECTED: By 1/10/25: The administrator shall ensure criminal background checks are present on the new hire checklist to ensure timely completion of background checks for all newly hired staff persons in accordance with 2600.51. The completed new hire checklists shall be kept in each staff person's record. [REDACTED] 2/6/25.

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Not Implemented ([REDACTED] - 03/04/2025)

54a - Direct Care Staff

4. Requirements

2600.

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

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

No high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry is present for direct care staff person B, who was hired on [REDACTED]

[Redacted]

[Redacted]

[Redacted] Violation withdrawn [Redacted] 3/12/2025

[Redacted]

[Redacted]

96a - First Aid Kit

6. 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

At approximately 3:15 PM, no adhesive tape was present in the first aid kit, located in the kitchen.

Plan of Correction

Accept [Redacted] - 02/06/2025)

Facility Administrator bought a new first aid kit to ensure all appropriate items were present on 1/10/25. Please see attached.

All staff will be educated on regulation 96a First Aid Kit by Facility Administrator on 2/14/25. Documentation will be kept.

Facility Administrator/Designee will check the first aid kit daily Monday through Friday for one month and then monthly for two months starting 2/17/25, Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025. Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Implemented [Redacted] - 03/04/2025)

101j7 - Lighting/Operable Lamp

7. Requirements

101j7 - Lighting/Operable Lamp (continued)

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

At 10:41 AM, no operable lamp or other source of lighting was present at resident #1's bedside.

At 11:02 AM, resident #2's bedside lamp was inoperable.

REPEAT VIOLATION: 6/14/2024

Plan of Correction

Accept (█) - 02/06/2025)

Facility Administrator fixed the violation at the time of inspection and plugged Resident #2's lamp in to the outlet on 1/8/25.

Resident #1 had an operable lamp placed bedside on 1/8/25.

All staff will be educated on regulation 101j7 Lighting/Operable Lamp by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator completed an in-house audit of all resident rooms to check if they had an operable lamp at bedside on 1/15/25. Please see attached.

Facility Administrator/Designee will check all resident rooms daily for one month and then weekly for two months and then monthly indefinitely to ensure there are operable lamps/lighting at resident's bedside starting 2/17/25.

Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Implemented (█) - 03/04/2025)

102i - Soap Dispenser**8. Requirements**

2600.

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

Description of Violation

At 10:57 AM, there was no dispenser with soap within reach of the sink in the shared bathroom of bedroom #127-A.

Plan of Correction

Accept (█) - 02/06/2025)

Shared Bathroom #127A had soap dispenser placed in bathroom on 1/8/25.

All staff will be educated on regulation 102i Soap Dispenser by Facility Administrator on 2/14/25. Documentation

102i - Soap Dispenser (continued)

will be kept.

Facility Administrator/Designee will do an audit of every resident bathroom by 2/7/25 to ensure soap dispenser are placed.

Facility Administrator/Designee will check all resident bathroom's daily Monday through Friday for one month and then weekly for one month and then monthly indefinitely to ensure every bathroom has a soap dispenser starting 2/17/25. Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025. Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Not Implemented ([REDACTED] - 03/04/2025)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.

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

Description of Violation

At 10:15 AM, the temperature in freezer #4 was 5 degrees Fahrenheit. By 3:22 PM, the freezer had been emptied and was being defrosted, because according to numerous staff persons, the freezer was unable to maintain proper food handling temperatures.

REPEAT VIOLATION: 6/14/2024, 4/2/2024, et. al.

Plan of Correction

Accept ([REDACTED] - 02/06/2025)

Freezer temp was restored by 1/9/25. Please see attached documents.

All staff will be educated on regulation 103f Refrigerator/Freezer Temps by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator/Designee will check the temperatures on all freezer/refrigerators daily for two months and then weekly indefinitely to ensure proper temperatures are kept starting 2/10/25. Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Not Implemented ([REDACTED] - 03/04/2025)

130g - Smoke Detector Repair

10. Requirements

130g - Smoke Detector Repair (continued)

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 1/6/25 at approximately 7:40 AM, the home's fire alarm was activated due to smoke from use of the home's toaster. Immediately following the incident, the home's fire alarm became inoperable and staff person C, the home's administrator, placed the home's fire alarm system in "silence" mode; however, repairs were still not made to the home's fire alarm by the conclusion of the inspection on the afternoon of 1/8/25. Also, the home's Fire Safety policies and procedures, dated 5/7/14, indicate, "If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative."

Plan of Correction**Directed (█ - 02/06/2025)**

Facility Administrator did not make CEO aware of the alarm being silenced until 1/8/25 when DHS was present.

Alarm was silenced due to toast being burnt and setting the alarm off, fire company was not dispatched.

Administrator silenced the alarm.

Facility CEO contacted an outside company to complete that task of repairing the fire alarm. Facility Administrator instructed staff to do 15-minute fire checks in the building until the alarm is fixed. Please see attached.

Alarm was fixed on 1/10/25 @ 3pm. Please see attached.

All staff will be educated on regulation 130g Smoke Detector Repair and Evergreen Smoke Detector Policy by Facility Administrator on 2/14/25. Documentation will be kept.

Facility Administrator/Designee will monitor the fire alarm system daily for one month then once a day weekly for two months and then weekly indefinitely starting 2/7/25. Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

DIRECTED: By 2/17/25: The home's CEO shall re-educate all current staff persons, including the home's administrator, on the home's procedures for immediate reporting if the home's fire panel/system or smoke detectors become inoperable. The education shall also include the immediate implementation of 15 minute fire watches until repairs are made in accordance with the home's policy and in accordance with 2600.130h, and to ensure repairs are made to the fire panel/system or smoke detectors within 48 hours in accordance with 2600.130g. Documentation of the education shall be kept in accordance with 2600.65i. █ 2/6/25

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Not Implemented (█ - 03/04/2025)**130h - Inoperable Smoke Detector****11. Requirements**

2600.

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

Description of Violation

The home's Fire Safety policies and procedures, dated 5/7/14, indicate, "If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative. 15 min fire checks will be performed until smoke detectors/fire alarms are repaired or replaced."

130h Inoperable Smoke Detector (continued)

On 1/6/25 at approximately 7:40 AM, the home's fire alarm was activated due to smoke from use of the home's toaster. Immediately following the incident, the home's fire alarm became inoperable and staff person C, the home's administrator, placed the home's fire alarm system in "silence" mode. At the time of inspection on 1/8/25, the home's fire alarm was still inoperable and in silence mode; however, 15 minute fire watches did not begin until the afternoon of 1/8/25, at the request of an agent of the Department.

Plan of Correction

Directed (████) - 02/06/2025)

Facility Administrator did not make CEO aware of the alarm being silenced until 1/8/25 when DHS was present. Alarm was silenced due to toast being burnt and setting the alarm off, fire company was not dispatched. Administrator silenced the alarm.

Facility CEO contacted an outside company to complete that task of repairing the fire alarm. Facility Administrator instructed staff to do 15 minute fire checks in the building until the alarm is fixed. Please see attached.

Alarm was fixed on 1/10/25 @ 3pm. Please see attached.

All staff will be educated on regulation 130h Inoperable Smoke Detector and Evergreen Smoke Detector Policy by Facility Administrator on 2/14/25. Documentation will be kept.

Facility Administrator/Designee will monitor the fire alarm system daily for one month then once a day weekly for two months and then weekly indefinitely starting 2/7/25. Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

DIRECTED: By 2/17/25: The home's CEO shall re educate all current staff persons, including the home's administrator, on the home's procedures for immediate reporting if the home's fire panel/system or smoke detectors become inoperable. The education shall also include the immediate implementation of 15 minute fire watches until repairs are made in accordance with the home's policy and in accordance with 2600.130h, and to ensure repairs are made to the fire panel/system or smoke detectors within 48 hours in accordance with 2600.130g. Documentation of the education shall be kept in accordance with 2600.65i. (████) 2/6/25

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Not Implemented (████) - 03/04/2025)

132d - Evacuation

12. Requirements

2600.

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

Description of Violation

On 1/6/25 at approximately 7:40 AM, the fire alarm was activated due to smoke from use of the home's toaster;

132d - Evacuation (continued)

however, no residents evacuated the building to a public thoroughfare or to a fire-safe area designated in writing within the past year by a fire safety expert.

REPEAT VIOLATION: 4/2/2024, et. al.

Plan of Correction

Directed (████ - 02/06/2025)

The residents were not fully evacuated because the Administrator was present next to the toaster when the toast begin to burn and immediately removed the toast from the toaster and notified the fire department of what had happened prior to dispatch.

All staff will be educated on regulation 132d Evacuation and also include ensuring all residents are immediately evacuated outside or to a designated firesafe area every time the fire alarm is activated by Facility Administrator on 2/14/25. (DIRECTED: The education shall include ensuring all residents immediately evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, every time the fire alarm is activated. Documentation of the staff education shall be kept in accordance with 2600.65i. █████ 2/6/25). Documentation will be kept.

Facility Administrator/Designee will monitor the next 10 times the fire alarm is activated to ensure the resident's and staff evacuate to a fire-safe area starting 2/17/2025. Documentation will be kept. Anytime the fire alarm is activated the Facility Administrator is to be notified immediately.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025. Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Not Implemented (████ - 03/04/2025)

132f - Alternate Exit Routes

13. Requirements

2600.

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

Description of Violation

According to the home's fire drill records, the same exit routes of "R, L, and F" were used during each of the following fire drills:

- 12/11/24 at 10:00 AM
- 11/7/24 at 3:30 PM
- 10/30/24 at 11:05 PM
- 9/25/24 at 1:00 PM
- 8/23/24 at 4:45 PM
- 7/1/24 at 1:50 PM

132f - Alternate Exit Routes (continued)

Plan of Correction**Directed (█ - 02/06/2025)**

A fire drill was completed on 1/23/25 utilizing alternate exit routes. Please see attached.

All staff will be educated on regulation 132f Alternate Exit Routes by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator/Designee will monitor fire drills monthly for one year to ensure alternate exit routes are being utilized starting 2/17/25. Documentation will be kept. (DIRECTED: The monthly monitoring of the fire drill records shall also include ensuring all residents evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within the period of time specified in writing within the past year by a fire safety expert during each fire drill. █ 2/6/25).

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Implemented (█ - 03/04/2025)

132g - Fire Drills Days/Times

14. Requirements

2600.

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

Description of Violation

The home routinely schedules 2 staff persons in the home during the 11:00 PM through 7:00 AM shift; however, the home has not conducted an unannounced fire drill using only 2 staff persons within the past year.

Plan of Correction**Directed (█ - 02/06/2025)**

A fire drill was completed on 1/23/25 at 6:41am utilizing 2 staff persons, all 20 residents in house were evacuated during the drill. Please see attached.

All staff will be educated on regulation 132g Fire Drills Days/Times by Facility Administrator on 2/14/25.

Documentation will be kept.

Facility Administrator/Designee will monitor fire drills monthly for one year to ensure fire drills are conducted on midnight shift with appropriate staffing starting 2/17/25. Documentation will be kept. (DIRECTED: The monthly monitoring of the fire drill records shall also include ensuring all residents evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within the period of time specified in writing within the past year by a fire safety expert during each fire drill. █ 2/6/25).

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

132g Fire Drills Days/Times (continued)

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Implemented (█) - 03/04/2025)

183b - Meds and Syringes Locked

15. Requirements

2600.

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

Description of Violation

At 10:52 AM, resident #3's Aspercreme with lidocaine was unlocked, unattended and accessible on top of resident #3's bedside table.

Plan of Correction

Directed (█) - 02/06/2025)

Facility Administrator removed the medication from the room in front of surveyor at the time of the visit on 1/8/25. Facility Administrator spoke to resident and then to resident's family member on 1/9/25 and informed them that unless a prescription to self administer medication from physician is written resident is not allowed to keep anything in their room.

Facility Administrator/Designee will audit every resident room by 2/7/25.

All medication technicians will be educated on regulation 183b Meds and Syringes Locked by Facility Administrator on 2/14/25. Documentation will be kept.

Facility Administrator/Designee will do daily Monday through Friday rounds in resident rooms to check for medications for one month and twice a week for one month and then monthly indefinitely to ensure compliance starting 2/17/25. (DIRECTED: At least 3 different resident bedrooms shall be checked during each audit to ensure compliance with 2600.183b. █ 2/6/25). Documentation will be kept.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025. Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Not Implemented (█) - 03/04/2025)

184a - Resident's Meds Labeled

16. Requirements

2600.

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

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed Lorazepam 0.5 MG tablet Take 1 tablet by mouth 2 times a day as needed; however,

184a - Resident's Meds Labeled (continued)

resident #2's pharmacy label indicates Lorazepam 0.5 MG tablet-Take 1 tablet by mouth every 6 hours as needed.

REPEAT VIOLATION: 6/14/2024, 4/2/2024, et. al.

Plan of Correction

Accept (█) - 02/06/2025)

Facility Administrator fixed this order by having Resident #2 hospice nurse write the correct order to send to pharmacy and fix the label on 1/8/25. Please see attached.

Med Cart Reviews were completed on the carts on 1/21/25 by Health Direct Pharmacy. Please see Attached.

All medication technicians will be educated on regulation 184a Resident's Meds Labeled and facility policy on medication labels by facility Administrator on 2/14/25. Documentation will be kept. When new orders are sent to the facility the Facility Administrator is to check the pharmacy label to order to ensure accuracy.

Beginning 2/17/25 Three Residents will be selected from each medication cart (four carts total) and will be audited biweekly for two months and then monthly indefinitely by Facility Administrator/Designee to ensure medications are labeled correctly per physician order.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Licensee's Proposed Overall Completion Date: 02/21/2025

Not Implemented (█) - 03/04/2025)

187b - Date/Time of Medication Admin.**18. 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 #4 is prescribed Gabapentin 600 MG-Take 1 tablet by mouth 3 times a day. However, resident #4's January 2025 MAR does not include the initials of the staff person who administered this medication to resident #4 on 1/4/25 at 3:00 PM.

REPEAT VIOLATION: 4/2/2024, et. al.

Plan of Correction

Directed (█) - 02/06/2025)

All medication technicians will be educated on regulation 187a Date/Time of Medication Admin by Facility Administrator on 2/14/25. (DIRECTED: The education shall also include ensuring accurate and complete documentation is obtained at the time of medication administration in accordance with 2600.187b. Documentation of the education shall be kept in accordance with 26000.65i. (█) 2/6/25). Documentation will be kept.

Beginning 2/17/25 10 resident MAR's will be audited biweekly for two months and then monthly indefinitely by Facility Administrator/Designee to ensure medications are recorded properly.

All items specified in 2600.26b will be reviewed at the next quality management review on February 21st, 2025.

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

Documentation will be kept.

Proposed Overall Completion Date: 02/21/2025

Directed Completion Date: 02/21/2025

Not Implemented ([REDACTED] - 03/04/2025)