CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALWAYS ON CARE LLC**
LEGAL ENTITY

To operate **ALWAYS ON CARE**
NAME OF FACILITY OR AGENCY

Located at **600 NORTH LAUREL STREET, HAZELTON, PA 18201**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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

The total number of persons which may be cared for at one time may not exceed **26**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **February 18, 2025** until **August 18, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **230061**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 18, 2025

Always On Care LLC

RE: Always On Care
600 North Laurel Street
Hazleton, Pennsylvania 18201
License: 230061

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 9, 2024, September 17, 2024, October 22, 2024, November 27, 2024, and December 27, 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 (license number 230060) dated June 3, 2024, to June 3, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being based on the violations attached to this notice and mistreatment or abuse of residents being cared for in the facility. The license dated June 3, 2024 to June 3, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 18, 2025 to August 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 or 2800 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
132d	II	21	$5	$105	5 calendar days from mailing date of this letter
183b	II	21	$5	$105	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:

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,

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: *ALWAYS ON CARE* **License #**: *23006* **License Expiration**: *06/03/2025*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name:

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/22/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *21* **Waking Staff**: *16*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *12/27/2024*

Inspection Dates and Department Representative

11/27/2024 - On-Site:

12/27/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *21* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *0* **Have Physical Disability**: *2*

Inspections / Reviews

11/27/2024 - Partial

Lead Inspector: [redacted]

Follow-Up Type: *Bypass Document Submission*

02/05/2025 - Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *01/21/2025*

Follow-Up Type: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

Upon arrival to the home on 11/27/24 staff person A was the only staff present in the home. Staff person A did not have access to resident records being stored in the locked office. Access to resident records was not available until one hour later when the administrator arrived at the home.

Plan of Correction ***Directed - 01/13/2025)***

Directed Plan of Correction:
The administrator will ensure that agents of the Department have immediate access to the home, records, and residents upon request. The home will designate a staff person to act as administrator designee at all times the administrator is not present in the home. The designee will have access to all staff and resident records. The staff schedule will indicate who is acting as administrator designee on all shifts.

Directed Completion Date: *01/28/2025*

Not Implemented - 02/05/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's contract dated 24 was not signed by the resident.

Plan of Correction ***Directed - 01/13/2025)***

Directed Plan of Correction:
Each contract will be signed by the administrator or a designee, the resident and the payer, and will be cosigned by the resident's designated person if any, if the resident agrees for residents admitted after the date shown. The administrator will audit all resident contracts for any missing required signatures. The administrator will document the audit, if the Department request it.

Directed Completion Date: *01/28/2025*

Not Implemented - 02/05/2025)

57a - Designee Present/Age

3. Requirements

2600.
57.a. At all times one or more residents are present in the home a direct care staff person who is 21 years of age or older and who serves as the designee, shall be present in the home. The direct care staff person may be the administrator if the administrator provides direct care services.

Description of Violation

According to the local Ombudsman, a visit was made to the home on 11/26/24 by the Ombudsman. During the visit, staff person A left the home for a period of time. When questioned on 11/27/24, staff person A stated they left to go

57a - Designee Present/Age (continued)

home to give their kids breakfast. No staff were present in the home while staff person A was gone.

Plan of Correction ***Directed ██ - 01/13/2025)***

Directed Plan of Correction:

The administrator will ensure that a staff person is present in the home at all times residents are present in the home or on the grounds. The administrator will review the staff schedule weekly, indicate who is the designee for each shift and document the schedule to ensure a staff person is in the home at all times when residents are present in the home or on grounds.

Directed Completion Date: *01/28/2025*

Not Implemented ██ - 02/05/2025)

91 - Telephone Numbers

5. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The required emergency numbers weren't posted near the kitchen phone or near the resident use phone in the living area.

Plan of Correction ***Directed ██ - 01/13/2025)***

Directed Plan of Correction:

The administrator will post the required emergency near the kitchen and living room phone. The administrator will check all phones in the home to ensure that the required numbers are placed on or by each phone. Staff will be instructed to monitor phones during the course of their duties and report or replace missing numbers. The administrator will keep the documented staff check list, if the Department request it.

Directed Completion Date: *01/28/2025*

Not Implemented ██ - 02/05/2025)

103e - Left Overs

6. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

A plastic Ziploc bag of frozen tomato sauce and a Ziploc bag of an unidentifiable frozen yellow mixture were found in the basement freezer. Repeat violation - 9/7/23

103e - Left Overs *(continued)*

Plan of Correction ***Directed - 01/13/2025)***

Directed Plan of Correction:

The administrator will conduct an audit of all refrigerators and freezer in the home, to make sure that food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. and leftover food shall be labeled and dated. The administrator will assign a staff person from each shift to check that leftover food are labeled and dated. The administrator will create a daily check list for staff to document. The administrator will keep the documented staff check list, if the Department request it.

Directed Completion Date: *01/28/2025*

Not Implemented 02/05/2025)

141a 1-10 Medical Evaluation Information

7. 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

Resident #1's DME dated /24 was missing health status, temperature, and cognitive functioning.

Plan of Correction ***Directed - 01/13/2025)***

Directed Plan of Correction:

The administrator will have resident #1's DME updated by the resident's doctor to include the resident's health status, temperature, and cognitive functioning. The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on DME form. Attachments will be added to the DME as needed to ensure that all actions are documented. The administrator will audit all resident DME's for missing required information and update them if needed. The administrator will keep and document the audit.

Directed Completion Date: *01/28/2025*

Not Implemented - 02/05/2025)

182c - Medication Administration

8. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
3. Remove the medication from the original container.

Description of Violation

During the site visit on 11/27/24 staff person A presented a pill organizer box with medications for resident #2 and stated that resident #2's morning medications were administered from the pill organizer. Each daily morning slot had seven medications in the slot. Resident #2 has a total of 18 morning medications listed on their Medication Administration Record (MAR). Staff person A did not administer resident #2's medications from the original container.

Plan of Correction ***Directed ██ - 01/13/2025)***

Directed Plan of Correction:
The home will administer medications in a manner consistent with these regulations. The administrator will provide medication technician staff with the resident's medications in the original bottles, bubble packs, or how the pharmacy packaged the medications. The home's administrator will train the medication staff on Medication administration includes the following activities, based on the needs of the resident:
1.
Identify the correct resident.
2.
If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3.
Remove the medication from the original container.
4.
Crush or split the medication as ordered by the prescriber.
5.
Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6.
Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7.
Complete documentation in accordance with § 2600.187 (relating to medication records).
The administrator will maintain medication staff training for this regulation.

Directed Completion Date: *01/28/2025*

Not Implemented ██ - 02/05/2025)

183a - Original Containers and Injections

9. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 11/27/24 it was discovered that the home had removed medications from their original bottles/blister packs and placed them in pill organizer boxes. Medications for the following residents were found in pill organizer boxes: Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and resident #8.

183a - Original Containers and Injections *(continued)*

Plan of Correction *Directed - 01/13/2025)*

Directed Plan of Correction:

The home will administer medications in a manner consistent with these regulations. The administrator will provide medication technician staff with the resident's medications in the original bottles, bubble packs, or how the pharmacy packaged the medications. The home's administrator will train the medication staff on Medication administration includes the following activities, based on the needs of the resident: Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container. The administrator will maintain medication staff training for this regulation.

Directed Completion Date: *01/28/2025*

Not Implemented - 02/05/2025)

183b - Meds and Syringes Locked

10. 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

On 11/27/24 during a site visit, the door to the medication room where the unlocked medication cart is stored was found to be unlocked. Medications stored in the medication cart therefore were accessible to unauthorized persons.

Plan of Correction *Directed - 01/13/2025)*

Directed Plan of Correction:

All medications will be locked and inaccessible to residents and unqualified personnel. The administrator and qualified staff members will make sure that all medications are locked. The administrator will assign qualified staff on all three shifts to complete checks on the medication room that the door is locked. The administrator will complete weekly checks throughout the home and external area of the home to ensure compliance of this regulation. The administrator will keep the documented staff check list, if the Department request it.

Directed Completion Date: *01/28/2025*

Not Implemented - 02/05/2025)

183e - Storing Medications

11. Requirements

183e - Storing Medications *(continued)*

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

Description of Violation

During the site visit on 11/27/24 medications belonging to resident #2 were observed on the floor of the administrator’s office. Several bottles of pills were stored directly on the floor; other medications for resident #2 were observed in a bag and in a box, both on the floor of the office.

Plan of Correction ***Directed - 01/13/2025)***

Directed Plan of Correction:

The home will administer medications in a manner consistent with these regulations. The administrator will provide medication technician staff with the resident's medications in the original bottles, bubble packs, or how the pharmacy packaged the medications. The home's administrator will train the medication staff on Medication administration includes the following activities, based on the needs of the resident: 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. The administrator will maintain medication staff training for this regulation.

Directed Completion Date: *01/28/2025*

Not Implemented - 02/05/2025)

184a - Resident's Meds Labeled

12. 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

Medications belonging to the following residents were found stored in pill organizer boxes with no pharmacy labels to identify the elements required by this regulation:
Residents #2, 3, 4, 5, 6, 7, and 8.

Plan of Correction ***Directed - 01/13/2025)***

Directed Plan of Correction:
The home will administer medications in a manner consistent with these regulations. The administrator will provide medication technician staff with the resident's medications in the original bottles, bubble

184a - Resident's Meds Labeled (continued)

packs, or how the pharmacy packaged the medications. The home's administrator will train the medication staff on Medication administration includes the following activities, based on the needs of the resident:

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.
The administrator will maintain medication staff training for this regulation.

Directed Completion Date: *01/28/2025*

Not Implemented █ - 02/05/2025)

187b - Date/Time of Medication Admin.

13. 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 the morning of 11/27/24 staff person A administered seven medications to resident #2. The seven medications stored in a pill organizer box were the only medications accessible to staff person A and no other medications for resident #2 were stored in the medication cart. Resident #2 has a total of 18 medications listed on the MAR for morning administration. All 18 medications were initialed as administered on 11/27/24. Staff person A could not identify which medications were actually administered to resident #2 on the morning of 11/27/24.

Plan of Correction ***Directed █ - 01/13/2025)***

Plan of Correction:
The administrator will conduct weekly audits of the resident's MARs for missing initials on the resident's MARs. The administrator will assign a medication staff member from each shift to audit the resident's MARs for missing initials daily. The administrator will train medication staff on documenting MARs after administrating resident's medications. The administrator will maintain medication staff training for this regulation.

Directed Completion Date: *01/28/2025*

Not Implemented █ - 02/05/2025)

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

187d - Follow Prescriber's Orders

14. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On the morning of 11/27/24 resident #2 was administered only 7 of the 18 medications prescribed to the resident for morning medication administration. Staff person A, who administered the medications, was unable to identify which medications were administered and which medications were not administered.

Plan of Correction ***Directed ███ - 01/13/2025)***

Directed Plan of Correction:

The administrator will conduct a weekly audit of all resident's medications and MARs. The administrator will train medication staff on how to follow prescriber's orders, dispensing resident's medications from the original pharmacy container and properly documenting MARs. The administrator will maintain medication staff training for this regulation.

Directed Completion Date: *01/28/2025*

Not Implemented (███ 02/05/2025)

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

Facility Information

Name: *ALWAYS ON CARE* **License #**: *23006* **License Expiration**: *06/03/2025*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name:

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/22/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *21* **Waking Staff**: *16*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *10/22/2024*

Inspection Dates and Department Representative

10/22/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *17* **Are 60 Years of Age or Older**: *14*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *2 - blind*

Inspections / Reviews

10/22/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/09/2024*

Inspections / Reviews *(continued)*

02/05/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *11/11/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

95 - Furniture and Equipment

1. Requirements

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

Description of Violation

On 10/22/24, at 9:00am, there was a chair in the main floor sitting room that was unstable, which is a potential fall risk for any resident that may sit in it.

Plan of Correction ***Directed - 11/21/2024)***

To correct the hazard, the administrator removed the chair from the main floor sitting room. To prevent this from happening again the administrator will conduct quarterly periodic checks of all furniture in the building. The administrator is who will monitor its ongoing compliance.

Proposed Overall Completion Date: 11/11/2024

Directed: The administrator will conduct monthly checks on all furniture in the building to ensure that they are in good repair, clean, and free of hazards from 11/2024 through 2/2025. Any furniture item that is not in good repair, clean, or free of hazard will be immediately removed and either discarded, cleaned, or repaired before being returned to the home. These checks will be documented with the date the check was completed, results of the checks, and actions taken if needed. Verification of completed audit for November will be provided by 12/1/2024.

Directed Completion Date: *12/01/2024*

141b1 - Annual Medical Evaluation

2. Requirements

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

Description of Violation

Resident #1's most recent documentation of medical evaluation is dated 9/23.

Plan of Correction ***Directed (- 11/21/2024)***

The DME was not in the binder at the time of the inspection. The administrator will ensure that the DME is in its proper place and readily made available by conducting yearly periodic checks of resident records. The administrator checked the residents records on 11/2/24 to confirm that everyone's DME's are in its proper place. The administrator will monitor its proper compliance.

Proposed Overall Completion Date: 11/11/2024

Directed: From 11/2024 through 2/2025, the administrator will complete monthly audits on all resident DME's to verify that they are located in the correct location and completed within the required time frames. Any DME that will need to be completed prior to the end of the next month will be completed by the end of the month. Documentation of these monthly audits will include the date of the monthly audit, results of the audit, and actions taken if needed. Verification of completed audit for November will be provided by 12/1/2024.

141b1 - Annual Medical Evaluation *(continued)*

Directed Completion Date: *12/01/2024*

162e - Menu Changes

3. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 10/22/24, the menu posted on the daily chalk board in the dining room indicated that shrimp and broccoli would be served for dinner. The posted weekly menu was not updated to reflect this change to the dinner menu.

Plan of Correction ***Directed [redacted] - 11/21/2024)***

x

Proposed Overall Completion Date: 11/11/2024

Directed: Effective immediately, the administrator/designee will update the posted menu of any changes or substitutions prior to the meal being served and changes will be in accordance with 2600.161. These menu changes will be kept in accordance with policy and be able to be reviewed by the Department upon request.

Directed Completion Date: *11/22/2024*

183e - Storing Medications

4. 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

Resident #1 is prescribed Novolog, Residents #2 and #3 are prescribed Lantus. The manufacturer's directions indicate it is to be used within 28 days of the pen being opened. The insulin pens were not dated when they were opened.

Plan of Correction ***Directed [redacted] - 11/21/2024)***

The Administrator is responsible for fixing the violation related to documenting the date opened of insulin pens on 10/22/24.

In order to prevent the violation from reoccurring, the administrator educated staff on 10/25/24 regarding the recording of the date on the pens.
The administrator will monitor its compliance.

Proposed Overall Completion Date: 11/11/2024

Directed: The administrator will immediately discard all identified medications that were not dated per

183e - Storing Medications (continued)

manufacturer's directions. The administrator or designee will complete weekly audits on all insulin to ensure that it is being stored per the manufacturer's directions beginning 11/29/2024 and continued until 2/28/2025. These audits will include at a minimum the person doing the check, date of the check, a list of all diabetic residents' medications that were checked, and result of check and any action taken if needed. Verification of completed audit for November 11/29/2024 will be provided by 12/1/2024.

Directed Completion Date: *12/01/2024*

185a - Implement Storage Procedures

5. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The home did not properly maintain the Medication Administration Record (MAR) of the indicated residents due to staff failing to transcribe or incorrectly transcribing of the blood glucose test results on the individual glucometer. Resident #2 – At 6pm on [redacted]/24, the glucometer did not have a reading and the Medical Administration Record, MAR, was incorrectly transcribed as 175 and at 12pm, on 10/13/24, the glucometer did not have a reading, and the MAR was incorrectly transcribed as 201.

Resident #4 - At 8pm on [redacted]/24 there was not a reading in the glucometer but the log was incorrectly transcribed as 242. On 10/12/24, 2 blood glucose readings were present in the glucometer, 146 at 8am and 242 at 8pm. Neither of these readings were correctly transcribed to the MAR.

Repeat Violation 9/7/23

Plan of Correction ***Directed [redacted] - 11/21/2024)***

The Administrator is responsible for fixing the violation related to the transcription of glucometer readings on 10/22/24.

In order to prevent the violation from reoccurring, the administrator will audit the readings for correctness by creating a daily audit sheet for glucometers until 11/30/24.
These readings will be audited weekly, then decrease to monthly audits after two months to make sure the documents are accurate. The administrator will monitor its ongoing compliance. Staff were trained on the importance of medication recordings on 10/25/24.

Proposed Overall Completion Date: 11/11/2024

Directed: The administrator/designee will audit blood glucose readings and the corresponding documentation of the readings daily until 12/13/2024. Any errors will be addressed with the staff member that made the error. Staff members that make an error will be re-educated within 3 days of the error being identified. After 12/13/2024, the audits will be completed weekly until 2/14/2025. The audits will document the date that they were completed, records that were reviewed, and any errors identified, and actions taken as a result of the error. Verification of completed daily audit for November will be provided by 12/1/2024.

185a - Implement Storage Procedures *(continued)*

Directed Completion Date: *12/01/2024*

187b - Date/Time of Medication Admin.

6. 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

Residents # 2 and #4 are prescribed medication for administration at 8:00am and 8:00pm daily. On 10/12/24 at 8:00pm and on 10/13/24 at 8:00am the medications were not documented when administered. Resident's confirmed medications were administered.

Plan of Correction ***Directed [redacted] - 11/21/2024)***

The administrator corrected the medications missed for residents #2 and #4 in the electronic MAR system. The administrator will ensure that any missed meds are correct for all residents in the EMAR.

The administrator corrected the resident's records on 11/4/24 to confirm that the missed recordings of the med pass are updated. The administrator will monitor the MAR records weekly for all residents to confirm they are being updated correctly by med tech's. The administrator will monitor its proper compliance.

Proposed Overall Completion Date: 11/11/2024

Directed: By 11/28/2024, all staff that pass medications will be educated on documenting the administration of the medications at the time of administration. The administrator or designee will complete weekly audits of the MAR's to ensure that they are being documented. These audits will begin 11/29/2024 and last until 2/28/2025. Audits will document at a minimum the person doing the audit, date, and findings. Verification of completed audit for 11/29/2024 and verification of education provided to staff will be provided by 12/1/2024.

Directed Completion Date: *12/01/2024*

227g -Support Plan Signatures

8. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The Resident Assessment Support Plan for Resident #2, dated [redacted]24, was not signed by the resident. There was not a notation that the resident did not want to participate or was unable to sign.

Plan of Correction ***Directed [redacted] - 11/21/2024)***

The correct support plan was not in the binder at the time of the inspection. The administrator will ensure that the support plan is signed or notated that the resident did not want to participate or was unable to sign for all residents.

The administrator checked the residents records on 11/2/24 to confirm that everyone's support plans are in its proper place. The administrator will monitor its proper compliance.

Proposed Overall Completion Date: 11/11/2024

227g -Support Plan Signatures (continued)

Directed: The administrator will audit all RASP's monthly from 11/2024 through 2/2025 and verify that all required signatures are present or appropriate box indicating the reason is completed. The audit will include at a minimum the date of the audit, resident RASP's audited, and findings. Verification of completed audit for November will be provided by 12/1/2024.

Directed Completion Date: *12/01/2024*

252 - Record Content

9. Requirements

2600.
252. Content of Resident Records - Each resident’s record must include the following information:
 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #1 and resident #2’s picture contained in their record and Medication Administration Record are more than 2 years old. Resident #1’s picture is dated [redacted]/22 and Resident #2’s picture is dated [redacted]/20.

Plan of Correction ***Directed [redacted] - 11/21/2024)***

The administrator corrected the picture for resident #2, however, resident #1 is currently in the hospital and is unable to take a picture. The administrator will ensure that the photos are correct for all residents.

The administrator checked the resident's records on 11/4/24 to confirm that everyone's photos are updated. The administrator will monitor its proper compliance.

Proposed Overall Completion Date: 11/11/2024

Directed: The administrator will audit all Resident records monthly from 11/2024 through 2/2025 and verify that all required information is in the record. The audit will include at a minimum the date of the audit, resident records audited, and findings. Verification of completed audit for November will be provided by 12/1/2024.

Directed Completion Date: *12/01/2024*

Department of Human Services

Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ALWAYS ON CARE* **License #**: *23006* **License Expiration**: *06/03/2025*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name:

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date**: *09/17/2024*

Inspection Dates and Department Representative

09/17/2024 -

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *18*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *3* **Have Physical Disability**: *2*

Inspections / Reviews

09/17/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/11/2024*

Inspections / Reviews *(continued)*

10/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/04/2024*

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

10/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/04/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/04/2024*

02/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/04/2024*

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

Resident #1 reported to Department Representative that on 9/14/24 during breakfast [redacted] became angry when Resident #2 drank more coffee than the other residents and took bread to feed the squirrels. Resident #1 admitted to hitting Resident #2 in the back with [redacted] fist. Staff heard the argument but did not witness the physical altercation. This incident was not reported to the Department of Aging.

Plan of Correction ***Accept [redacted] - 10/29/2024)***

On 9/20/24, staff and the PCH administrator reeducated the residents on the importance of dignity and respect to others based on the Knowing Your Rights PCH Booklet. . Resident #1 and #2 had private conversations with the administrator and staff regarding their behavior. Some of Resident #1 medications have been changed by their Psychiatrist and has also been referred to a consultation for group therapy sessions on 10/21/24. Some medications have been changed by doctors at the hospital for Resident #2 to combat suicidal ideations and negative behaviors.

An incident report was sent to the department. It is attached. it was also reported to the Department of Aging through the Elder Abuse Hotline.
The personal care home administrator is who is responsible for monitoring the regulation and they retrained staff on 9/23/24 on the reporting of abuse within 24 hours, Resident Rights, The Older Adult Protective Services Act, and the Care of Residents with Dementia, Mental Illness, & Other Cognitive Impairments. The resources used for the training are attached.
The administrator reeducated the staff that there is a chain of command to report abuse which included contacting the administrator regarding the abuse to make sure all details are collected, documented, and report disseminated to the proper agencies.
The personal care home administrator will monitor its ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/29/2024*

Not Implemented [redacted] - 01/16/2025)

16c - Written Incident Report

2. 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

Resident #1 reported to Department Representative that on 9/14/24 during breakfast [redacted] became angry when Resident #2 drank more coffee than the other residents and took bread to feed the squirrels. Resident #1 admitted to hitting Resident #2 in the back with [redacted] fist. Staff heard the argument but did not witness the physical altercation. This incident was not reported to this Department.

16c - Written Incident Report *(continued)*

Plan of Correction ***Accept [redacted] - 10/29/2024)***

On 9/20/24, staff and the PCH administrator reeducated the residents on the importance of dignity and respect to others based on the Knowing Your Rights PCH Booklet. Resident #1 and #2 had private conversations with the administrator and staff regarding their behavior. Some of Resident #1 medications have been changed by their Psychiatrist and has also been referred to a consultation for group therapy sessions on 10/21/24. Some medications have been changed by doctors at the hospital for Resident #2 to combat suicidal ideations and negative behaviors. The personal care home administrator is who is responsible for monitoring the regulation and they retrained staff on 9/23/24 on the reporting of abuse within 24 hours, Resident Rights, The Older Adult Protective Services Act, and the Care of Residents with Dementia, Mental Illness, & Other Cognitive Impairments. The resources used for the training are attached.
The administrator reeducated the staff that there is a chain of command to report abuse which included contacting the administrator regarding the abuse to make sure all details are collected, documented, and report disseminated to the proper agencies.
The personal care home administrator will monitor its ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/29/2024*

Not Implemented [redacted] - 01/16/2025)

123d - Mobility Needs

4. Requirements

2600.
123.d. If the home serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

Description of Violation

Resident #3 is immobile and resides on the second floor of the home, which does not have a fire safe area specified in writing within the past year by a fire safety expert.

Plan of Correction ***Accept [redacted] 10/29/2024)***

The person who is responsible for fixing this problem is the personal care home administrator. What they did to fix it is confirmed that Resident #3 is able to be mobile during a fire drill without the use of a wheelchair. A fire drill was conducted on 9/15 and the resident was able to follow the prompts accordingly without the wheelchair. In addition, Resident #3 confirmed that he is able to be mobile without a wheelchair in case of emergency through a written statement that is attached. The administrator will monitor this compliance.

Licensee's Proposed Overall Completion Date: *10/29/2024*

Not Implemented [redacted] - 01/16/2025)

132d - Evacuation

5. 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.

132d - Evacuation *(continued)*

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the fire drill conducted on 8/30/24 at 11:30pm. Repeat Violation 9-7-2023

Plan of Correction ***Directed ███ 10/29/2024)***

Attached is the letter of the fire drill conducted by the Hazleton City Fire Department. In addition, another fire drill was conducted on 9/20/24 at 11:30am with a time of 2 minutes and 19 seconds. The person in charge of keeping this regulation in compliance is the personal care home administrator. The administrator and the staff will consistently look for ways to keep this regulation from occurring again by retraining the residents on the evacuation plan, and what to do if the primary escape route is blocked. In addition, consistently reevaluating residents to see who would be benefit from having a room on the 1st floor instead of the second floor.

Proposed Overall Completion Date: 10/29/2024

Directed Plan of Correction:

The home has an evacuation time of 2 minutes and 30 seconds. The administrator will have staff trained in fire safety and evacuating the residents from the home within 2 minutes and 30 seconds by 11-30-2024. The overnight drill conducted on 8-30-2024, had an evacuation time of 6 minutes and 11 seconds. The home can obtain a fire safety letter from a fire safety expert giving the home additional time to evacuate based on the construction of the home. The home will conduct a sleeping hour drill by 11-30-24. During the sleeping hours drill, all residents must be evacuated with in 2 minutes and 30 seconds. The home's administrator/owner will be responsible to have the staff trained in fire safety and conducting an overnight fire drill.

Directed Completion Date: *11/29/2024*

Not Implemented ███ - 01/16/2025)

183d - Prescription Current

6. 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

Resident #4's Albuterol HFA 90mcg PRN inhaler was discontinued but was still in the medication cart at time of inspection.

Plan of Correction ***Accept ███ - 10/29/2024)***

On 9/17 Resident #4's Albuterol HFA 90mcg PRN inhaler was disposed of to comply with regulations. Between 9/17-9/21, the administrator completed a medication audit for discontinued medications. The administrator retrained the techs on 9/23. To prevent the home from allowing this violation to occur again, the administrator will conduct a monthly audit of discontinued meds during the month to make sure they are disposed of properly. The person who will monitor this regulation is the care home administrator.

183d - Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: *10/29/2024*

Not Implemented [redacted] 01/16/2025)

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

Facility Information

Name: *ALWAYS ON CARE* **License #**: *23006* **License Expiration**: *06/03/2024*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *ALWAYS ON CARE LLC*

[redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/22/2010* **Issued By**: *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *24* **Waking Staff**: *18*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *07/10/2024*

Inspection Dates and Department Representative

07/09/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *18*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *2* **Have Physical Disability**: *2*

Inspections / Reviews

07/09/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/02/2024*

Inspections / Reviews *(continued)*

08/07/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *08/31/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *08/12/2024*

08/13/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *08/31/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *08/31/2024*

02/05/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *08/31/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

16c - Written Incident Report

1. Requirements

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

Description of Violation

On the following dates and times, Resident #1 did not receive [redacted] medications due to being out of the facility.
On 7/3/24, Resident #1 did not receive [redacted] 12pm insulin and blood sugar reading;
And on 7/5 at 8pm, Resident #1 did not receive [redacted] blood sugar reading, Hydralazine, and sliding scale Insulin Aspart.

These missed medications were not reported to the Department.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

The Administrator reviewed the medication administration process with the staff on 7/11/2024. The administrator and staff will make accommodations for residents out of the facility at the time of medication administration to receive their prescribed medication. In addition, the staff of the home will attend training that reinforces topics related to Medication Administration. The person who is in charge of reporting medication errors, whether during the week or on weekends, is the administrator. In the future, the home will immediately report missed medications in the home to the Regional Office within 24 hours of the event.
The administrator will complete the incident report on 8/5/24 and send to the department.
The training is on 8/27/24. The administrator will review the incidents required to be reported by 2600.16a with all staff. All future incidents will be reported as required.

Licensee's Proposed Overall Completion Date: *08/27/2024*

Not Implemented ([redacted] - 11/21/2024)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

At time of inspection, there was no carbon monoxide detector installed to measure emissions from the natural gas-powered stove in the home's kitchen.

There was no influenza poster posted in facility.

Plan of Correction ***Accept [redacted] - 08/07/2024)***

On 7/9/24 the Administrator installed a carbon monoxide detector in the kitchen. In addition, Administrator met with staff members to review safety use of the stove in the home's kitchen.
On 7/13/2024, the Administrator procured and posted an influenza poster in the facility at the front entrance of the facility, side entrance, and on a bulletin board.
The person who is in charge of maintaining compliance with laws is the Administrator.

18 - Compliance With Laws (continued)

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented - 12/05/2024)

25c2 - Fee Schedule

4. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Per resident interviews, the home charges monthly for additional services such as wireless internet. Resident #3's resident-home contract dated did not contain a fee schedule.

Plan of Correction ***Accept (- 08/13/2024)***

The Administrator reviewed Resident #3's resident-home contract dated 24. The administrator then revised Resident #3's contract to include an updated fee schedule on /24 and reviewed the contract with the resident. Furthermore, the Administrator will update future contracts to reflect current fee schedules.
The administrator will audit all of residents contracts by /24.
The person who is in charge of maintaining its compliance is the Administrator.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented - 12/05/2024)

25c6 - Refunds

5. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
6. The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

Description of Violation

Resident #3's resident-home contract dated /24 does not include verbiage regarding refunds made in accordance with the Elder Care Payment Restitution Act

Plan of Correction ***Accept 08/13/2024)***

The Administrator reviewed Resident #3's resident-home contract dated /24. The administrator reviewed then revised Resident #3's contract to include information under which conditions refunds will be made in accordance with Elder Care Payment Restitution Act. This updated contact will be reviewed with the resident on the week of 8/4/24.
By 8/20/24 all resident contracts will be reviewed by the administrator.
The person who is in charge of maintaining its compliance is the Administrator.

Licensee's Proposed Overall Completion Date: *08/20/2024*

Implemented - 12/05/2024)

26b - Quality Management Plan Content

6. Requirements

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

Description of Violation

The home's quality management review dated 4//26/24 did not address:
1. *The reportable incident and condition reporting procedures.*
2. *Complaint procedures.*
3. *Staff person training.*
4. *Licensing violations and plans of correction, if applicable.*
5. *Resident or family councils, or both, if applicable.*

Plan of Correction ***Accept (/07/2024)***

The administrator reviewed the home's quality management plan dated /24. The administrator has updated the plan to address the following in a meeting the week of 8/4/24:
The reportable incident and condition reporting procedures
Complaint procedures
Staff person training
Licensing violations and plans od correction, if applicable
Resident or family councils, or both, if applicable
The person who is in charge of maintaining its compliance is the Administrator.

Licensee's Proposed Overall Completion Date: *08/10/2024*

Implemented - 12/05/2024)

51 - Criminal Background Check

8. 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

The criminal background check for direct care Staff Person A was not completed until 7/9/24.

Plan of Correction ***Accept - 08/13/2024)***

The Administrator completed a comprehensive criminal history check on Staff Person A on /24 and received the investigation results on 24. The results were reviewed and filed in the administrative office.
A Criminal Background check will be pulled within 30 days of being a new employee at Always on Care.
The audit was completed for all staff on 7/15/24.
The person who is in charge of maintaining its compliance is the Administrator.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented - 12/05/2024)

65f - Training Topics

9. Requirements

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

Description of Violation

Direct care staff person B did not receive training in "Medication self-administration training" and "Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan" during training year 2023.

Plan of Correction ***Accept ███ - 08/13/2024)***

The administrator reviewed all training topics for staff members. Direct care staff person B reviewed and completed 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 on 7/29/24 for the training year 2024.
The administrator is responsible for the ongoing assessment and up-to-date training records for all staff members. The administrator will conduct an audit of al training staff by 8/19/24.

Licensee's Proposed Overall Completion Date: *08/19/2024*

Implemented ███ - 12/05/2024)

65g - Annual Training Content

10. 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:

Description of Violation

Direct care staff person B 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.

Plan of Correction ***Accept ███ - 08/13/2024)***

The administrator will enroll direct care staff person B in a fire safety training course by the week of 8/11/24 by a fire safety expert.
The administrator will continue ongoing evaluation and review of the annual training content to include fire safety.
The administrator will conduct an audit of all training for fire safety for by 8/31/24, pending the schedule of the fire safety expert.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented ███ - 12/05/2024)

82a - Poisonous Materials

11. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

In the home's laundry room, blue liquid detergent was pre-poured into small plastic containers. The containers did not contain original labels for the detergent.

Plan of Correction ***Accept ███ - 08/13/2024)***

The administrator has reviewed poisonous materials with staff members on 7/23/24. All laundry detergent will

82a - Poisonous Materials (continued)

remain in its original labeled container until its use to wash a load of laundry. Furthermore, all hazardous/poisonous material with remain in a locked area.
The blue liquid in the small plastic container was discarded on 7/10/24. The administrator conducted an audit of all cleaning supplies in that room on 7/12/24 and informed staff of the new procedures. The administrator will periodically review the cleaning supplies and adherence to the procedures, weekly.
The administrator will periodically review this information with the staff members to ensure proper use and storage of such materials.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented - 12/05/2024)

100a - Exterior - Free of Hazards

12. Requirements

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

Description of Violation

The concrete landing outside of the emergency exit door leading to the home's basement near the laundry area was cracked and broken, causing a possible fall hazard.

Plan of Correction ***Accept - 08/13/2024)***

The concrete landing outside of the emergency exit door will be fixed on the week of /24 to maintain an even leveled area free of fall hazards.
The administrator has assessed the area in question and is taking the necessary precautions to ensure the safety and well-being of all residents and staff members alike.
The concrete landing will be fixed by a contractor by 8/24/24 or earlier if they are able to fit into their schedule. The administer conducted an audit of the home's grounds on 7/15/24.

Licensee's Proposed Overall Completion Date: *08/24/2024*

Implemented (- 12/05/2024)

103e - Left Overs

13. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There were storage containers in the home's kitchen with potato chips, pretzels, and pretzel sticks in them that were not labeled or dated.

Repeat violation - 9/7/23

Plan of Correction ***Accept - 08/13/2024)***

All staff members have been verbally reminded that any leftovers or opened food packages must be labeled and dated in storage containers prior to being placed in the cabinets and/or refrigerator and freezer. The staff will

103e - Left Overs (continued)

check the cabinets, refrigerator, and freezer by the end of their shift to make sure all items are labeled appropriately.
The administrator placed a sign on the refrigerator reminding staff to label and date all opened containers.
The person who is in charge of maintaining its compliance is the Administrator.
The administrator will conduct weekly audits to make sure its in compliance.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented - 12/05/2024)

121a - Unobstructed Egress

14. Requirements

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

Description of Violation

The emergency exit door in the home's basement near the laundry area was closed with a magnetic lock that made the door difficult to open and prevented immediate egress.

Repeat violation - 9/7/23

Plan of Correction ***Accept 08/13/2024)***

On 8/2/24 the administrator assessed the current magnetic lock on the door and fixed it completely to ensure the integrity of the door is intact and that immediate egress is possible.
The person who is in charge of maintaining its compliance is the Administrator.
The magnetic lock has been removed.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented - 12/05/2024)

124 - Notice to Fire Department

15. Requirements

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

Description of Violation

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

Plan of Correction ***Accept (- 08/13/2024)***

The administrator has found the original email to the local fire department with information pertaining to the address of the facility, location of the bedrooms, and any assistance needed to evacuate in case of an emergency.
The administrator will keep it in their records and maintain its compliance.
The administrator will maintain its compliance by storing the letter in the fire safety file of the home.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented - 12/05/2024)

131f - Fire Extinguisher Inspection

16. 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 extinguishers located throughout the home have not been inspected by a fire safety expert since June 2023.

Plan of Correction ***Accept [redacted] - 08/07/2024)***

The administrator has contacted a certified fire safety expert company to inspect all extinguishers throughout the building. The inspection was completed on 07/31/2024.
The administrator will continue to ensure ongoing inspection of the extinguishers throughout the building annually.

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented [redacted] 12/05/2024)

132a - Monthly Fire Drill

17. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Per multiple resident interviews, the home is not conducting monthly fire drills.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

The administrator met with staff to review the process of conducting a fire drill. The administrator will ensure that monthly fire drills are conducted. Staff will ensure that all residents know the process and the importance of the fire drills to include the safety meeting point outside of the facility. Documentation of fire drills to include location of "fire," exit utilized, and the amount of time taken to assess drill.
The administrator will maintain compliance by having a set schedule of fire drills for the year and informing employees of the aid that's needed.
The administrator will keep it in their records and maintain its compliance.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented [redacted] - 12/05/2024)

132e - Fire Drill Sleeping Hours

18. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home has not conducted a fire drill during sleeping hours within the past 6 months.

Repeat violation - 9/7/23

Plan of Correction ***Accept [redacted] - 08/13/2024)***

The administrator met with staff and residents to review the importance and process of fire drills especially during

132e - Fire Drill Sleeping Hours (continued)

sleeping hours. The administrator is responsible for the problem, implementation, and its compliance. There will be at least one unannounced fire drill at least every 6 months and record the drill in the fire drill record.
The home will conduct an overnight drill on 8/16/24.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Not Implemented ██ - 12/05/2024)

133.2 - Exit Signs Direction

19. Requirements

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

The Exit sign near the Administrator's office is broken and hanging down, making the arrow point toward an area of the home that does not have an emergency Exit and preventing the arrow from pointing to the emergency Exit near the Administrator's office.

Plan of Correction ***Accept ██ - 08/07/2024)***

The exit sign near the administrator's office has been repaired to reflect the correct direction of the emergency exit. The administrator will continuously be responsible for the upkeep and maintenance of the sign. The sign was repaired on 8/2/24.

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented ██ - 12/05/2024)

144c1 - Smoking Area Guidelines

20. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

There were in excess of 5 cigarette butts on the ground of the home's designated smoking area.

Repeat violation - 9/7/23

Plan of Correction ***Accept ██ - 08/07/2024)***

Per the Personal Care Home resident contract, smoking is permitted only in designated areas and new residents who smoke are escorted to those designated smoking areas outside. Staff and residents are reminded of the designated smoking area. Furthermore, staff members will routinely go outside and redirect smokers to the appropriate areas. Also, additional cigarette receptacles were purchased and placed in the designated smoking area to decrease the amount of cigarette butts placed on the ground. All cigarette butts were disposed of on the ground by the

144c1 - Smoking Area Guidelines (continued)

administrator on 7/31/24.
The person who is in charge of maintaining its compliance is the Administrator and Staff

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented [redacted] - 12/05/2024)

162b - Missed Meals

21. Requirements

2600.
162.b. When a resident misses a meal, food adequate to meet daily nutritional requirements shall be available and offered to the resident.

Description of Violation

On 7/10/24, Resident #4 missed breakfast, stating that [redacted] was denied breakfast due to getting to the dining room after 8:00am. Resident #4 was not offered food adequate to meet daily nutritional requirements.

Plan of Correction ***Accept [redacted] 08/07/2024)***

Administrator has implemented meal alternatives when a resident has missed a meal. The administrator has met with the staff to review the meal substitutions to be offered at meal times. These meal substitutions will meet nutritional requirements and will be made available at any time a resident has missed a regularity scheduled meal time.
The person who is in charge of maintaining its compliance is the Administrator, and Staff.

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented [redacted] - 12/05/2024)

181c - Self-administration Assessment

22. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #5 self-administers medications to include a Copaxone shot; however, Resident #5 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications, as documented on the resident's most recent assessment and support plan and medical evaluation.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Resident #5 expresses desire to self-administer Copaxone shot. Pursuant of code 2600.277(e), the administrator has contacted and set up an appointment with the Resident's primary care physician to assess the Resident. Furthermore, the appointment is set for [redacted]/24 where documentation will be provided from the PCP's office outlining Resident #5 ability or inability to self-administer this specific medication. Upon the results of the assessment, if Resident #5 is deemed appropriate to self-administer, frequent education and medication reminders will be provided along with supervision of medication as needed. Proper storage and handling of medication with be provided by staff before

181c - Self-administration Assessment (continued)

and after administration. This assessment will then be updated to be included in the resident's most recent assessment, support plan, and medical evaluation.
We will monitor the plan is followed by comparing those who self administer to their RASP and DM.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented (█ - 12/05/2024)

187d - Follow Prescriber's Orders

25. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On the following dates and times, Resident #1 did not receive his/her medications due to being out of the facility:

On 7/3/24, Resident #1 did not receive █ 12pm insulin and blood sugar reading;
And on 7/5 at 8pm, Resident #1 did not receive █ blood sugar reading, Hydralazine, and sliding scale Insulin Aspart.

Repeat violation - 9/7/23

Plan of Correction ***Accept (█ - 08/13/2024)***

When a resident is out of the facility at any given point, the Administrator and staff will make every effort to make sure that the resident receives the prescribed medication as indicated by their provider. If a resident is unable to receive scheduled medication at the prescribed time, an incident report shall be generated and submitted to the department. The resident's provider will also be contacted about missed dosage and Administrator will receive instruction from provider to carry out for resident. Documentation will be available of each incident.
We will monitor that the plan is followed by having notes of the resident in events as these and following the instructions on procedures.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented (█ - 12/05/2024)

188b - Medication Error Reporting

26. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

On the following dates and times, Resident #1 did not receive █ medications due to being out of the facility:
On 7/3/24, Resident #1 did not receive █ 12pm insulin and blood sugar reading;
And on 7/5 at 8pm, Resident #1 did not receive █ blood sugar reading, Hydralazine, and sliding scale Insulin Aspart.

This medication error was not reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting *(continued)*

Plan of Correction ***Accept [redacted] - 08/07/2024)***

When a resident is out of the facility at any given point, the Administrator and staff will make every effort to make sure that the resident receives the prescribed medication as indicated by their provider. If a resident is unable to receive scheduled medication at the prescribed time, an incident report shall be generated and submitted to the department. The resident will be informed of the medication error and the resident will be monitored by the staff to ensure no adverse reactions occur. The resident's provider will also be contacted about missed dosage and Administrator will receive instruction from provider to carry out for resident. Documentation will be available of each incident.
The person who is in charge of maintaining its compliance is the Administrator

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented [redacted] - 12/05/2024)

225a - Assessment 15 Days

28. 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

On Resident #3's initial assessment and support plan (RASP), dated [redacted]24, the Behavioral or Cognitive Needs section is incomplete. Also, page 2 and half of page 3 of the RASP outlining the resident's Personal Care Needs are incomplete.

Repeat violation - 9/7/23

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Resident #3's initial assessment and support plan dated [redacted]24, the behavioral or cognitive needs section has been updated and completed to reflect the resident's current status and needs. Completion of this Resident's assessment occurred on 8/1/24.
The person who is in charge of maintaining its compliance is the Administrator
The home will conduct an audit on all residents assessments by 8/30/24.
the administrator will monitor that the plan is followed.

Licensee's Proposed Overall Completion Date: *08/30/2024*

Implemented [redacted] - 01/16/2025)