Sent via e-mail kaymarie33@aol.com
Sent via e-mail brittanymdungey@gmail.com
Sent via e-mail danbenjamin876@gmail.com
December 6, 2024

Ms. KayMarie Briddell
President
KayMarie Briddell
9157 Houndsbay Drive
Montgomery, Alabama 36117

RE: Vine Street Manor
230 North 65th Street
Philadelphia, Pennsylvania 19139
License #: 14234

Dear Ms. Briddell:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on September 10, 2024 and December 6, 2024 of the above facility, we have determined that your submitted plan of correction for the July 18, 2024 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Christina Eberhart

Christina Eberhart
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *VINE STREET MANOR* **License #**: *14234* **License Expiration**: *11/14/2024*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name:

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address:

Certificate(s) of Occupancy

Type: *Other* **Date**: *09/07/2018* **Issued By**: *Phila. L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *62* **Waking Staff**: *47*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *07/18/2024*

Inspection Dates and Department Representative

07/18/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *58*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *42* **Are 60 Years of Age or Older**: *38*

Diagnosed with Mental Illness: *58* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

07/18/2024 - Partial

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *08/23/2024*

08/29/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/04/2024*
Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *09/03/2024*

09/10/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/04/2024*
Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/04/2024*

12/06/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/04/2024*
Reviewer: [redacted] **Follow Up Type:** *Exception*

57c - 2 Hours/Day

1. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On ██████ there were 60 residents in the home, including three residents with mobility needs, requiring a total minimum of 63 hours of direct care service. On this date, only 60 hours of direct care staffing was provided.

Plan of Correction ***Do Not Accept (██ - 08/29/2024)***

There were sufficient hours of staffing provided on 7/3/2024. Please see schedule attached. The discrepancy between provided hours and inspectors' understanding is due to the reluctance to provide accurate accounting of his work hours by staff member D. Staff member D was so in fear of the possibility DHS may blame ██ for the demise of a resident ██ declined to confirm ██ had covered the shift of another staff member. Staff member D has been brought in to meet with management and received counseling. ██ now understands that the state inspectors' mission is to work hand in hand with providers like us to provide the best possible care for the resident and there is no reason to mislead them in the future.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (██ - 09/10/2024)***

Staff member D received verbal counseling and training on the importance of accurately reporting hours worked. This was aimed at reducing any fear or reluctance to communicate staffing coverage. A staff memo was relayed on 9/3/24 to reiterate the importance of clear communication and accurate reporting of hours worked. All staff were reminded of their responsibility to ensure compliance with state regulations regarding direct care staffing.
To ensure continued compliance with the staffing requirements outlined in regulation 2600.57.c, we will implement the following measures:
The home's administrator and consultant will conduct monthly staffing audits starting on 10/01/24. Audits will review staffing schedules and direct care hours provided against the needs of residents. Findings will be documented and reviewed with management to ensure accountability.
The administrator will be responsible for bi-weekly spot checks of staff reporting. Random checks will be conducted on staff clock-in and clock-out records against master schedule.
The administrator and consultant will conduct monthly staff training sessions starting on or before 10/01/24. Ongoing training will be provided to all staff on operational procedures, including how to report hours accurately and the significance of compliance with state regulations.
A feedback system has been established (GROUPME APP) for staff to voice concerns about reporting without fear of repercussions. This will foster an environment of transparency and facilitate timely resolution of any issues. The home's consultant will review staff concerns as they come in.
By implementing these steps, we strive to ensure that all residents receive the required personal care services and that our staff adhere to the highest standards of accuracy and accountability in their reporting. All measures will take place for three months unless an extension is found necessary.

57c 2 Hours/Day *(continued)*

Licensee's Proposed Overall Completion Date: *09/03/2024*

Evidence of Completion ***Implemented (- 12/06/2024)***

See attached.

57d Waking Hours

2. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On , a total of 63 hours of direct care was required. However, only 46 of the required hours, or 73 percent, were provided during waking hours.

Plan of Correction ***Do Not Accept (- 08/29/2024)***

This corresponding violation was unavoidable once the inspectors were under the incorrect assumption present in violation #1 therefore the same POC applies: There were sufficient hours of staffing provided on 7/3/2024. Please see schedule attached. The discrepancy between provided hours and inspectors' understanding is due to the reluctance to provide accurate accounting of his work hours by staff member D. Staff member D was so in fear of the possibility DHS may blame for the demise of a resident declined to confirm had covered the shift of another staff member. Staff member D has been brought in to meet with management and received counseling. He now understands that the state inspectors' mission is to work hand in hand with providers like us to provide the best possible care for the resident and there is no reason to mislead them in the future.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (- 09/10/2024)***

A thorough review of the staffing schedule was conducted to confirm the distribution of direct care hours provided during waking hours. Staff member D was counseled about the importance of reporting hours accurately, and the administration clarified that any concerns regarding accountability should be addressed openly.
To ensure ongoing compliance with the requirement that at least 75% of personal care service hours be available during waking hours, the following measures will be instituted:
The home's administrator will conduct monthly audits of service hours starting on 10/01/24. A comprehensive audit will be conducted each month to assess the number of personal care service hours provided during waking hours versus total required hours. This report will include an analysis of any discrepancies and corrective actions taken.
The administrator will be responsible for daily staff scheduling reviews starting 9/5/24. The administrator on duty will review daily schedules to ensure compliance with the required percentage of waking hours coverage. Any adjustments needed will be made in real time to maintain compliance standards.
The home's consultant will conduct quarterly training sessions on compliance standards starting 10/01/24. Training sessions will be held quarterly for all staff to educate them on compliance with care regulations, specifically

57d Waking Hours (continued)

including the importance of ensuring adequate staffing during waking hours.
By implementing these immediate and ongoing measures, we are committed to ensuring that the needs of residents with mobility needs are met effectively and that compliance with regulations is maintained. All measures will take place for three months unless an extension is found necessary.

Licensee's Proposed Overall Completion Date: *09/03/2024*

Evidence of Completion ***Implemented - 12/06/2024)***

See attached.
See attached training plan for 10/7.

62 Contact List

3. Requirements

2600.
62. List of Staff Persons The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person A, a housekeeper hired , was not included on the staff list that the home provided on

Plan of Correction ***Accept (- 08/29/2024)***

The staff list was updated to include the missing housekeeper's information when it was discovered. The administrator will immediately add new staff persons to the staff list as hired and post a new list weekly to ensure accuracy and compliance.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Evidence of Completion ***Implemented (CE - 12/06/2024)***

See attached.

65e - 12 Hours Annual Training

4. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person B received only two hours of annual training in training year 2023.

Direct care staff person C received no hours of annual training in 2023.

Plan of Correction ***Do Not Accept (- 08/29/2024)***

Both staff persons received the requisite number of training hours during the calendar year however, the administrator was asked for their general staff file which does not contain all training records. The administrator was made aware of the missing hours during the exit interview. Time did not permit the administrator to fully and properly hand over the training file with all documents to the inspectors. Please see the attached documents to confirm.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please indicate the immediate action that was taken to correct the violation.

65e 12 Hours Annual Training (continued)

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (- 09/10/2024)***

Direct care staff persons B and C had previously successfully completed the requisite 12 hours of annual training. Documentation confirming this training has been gathered and is ready for review. An immediate audit of all training records was conducted on 8/22/24 to compile a comprehensive training file for each staff member. All discrepancies noted during the exit interview have been addressed, ensuring that all training hours are accurately recorded and documented. Direct communication using the GROUPME app was established on 8/22/2024 with all direct care staff to inform them of the training requirements and the importance of timely completion of their training. Staff were given a clear deadline for their training and monitoring.
Starting 10/01/24 the home's consultant and administrator will conduct quarterly training audits of training records. The consultant and administrator will verify each staff member's training hours against the training plan and ensure that all staff are on track to complete their required training by the end of the year.
Starting 9/06/24 the home's consultant will perform monthly spot checks of training documents. The consultant will conduct random checks of training documentation to ensure accuracy and completeness. Any issues will be addressed immediately with the appropriate staff members.
Beginning on 9/10/24 the home's administrator will conduct monthly staff meeting reviews. Training expectations and compliance will be a regular agenda item during staff meetings to reinforce the importance of completing training requirements and providing clear updates on compliance status.
By implementing these actions, we aim to maintain ongoing compliance with training regulations. All measures will take place for three months unless an extension is found necessary.

Licensee's Proposed Overall Completion Date: *09/03/2024*

Evidence of Completion ***Not Implemented - 12/06/2024)***

See attached.

65f Training Topics

5. Requirements

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

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

Description of Violation

Direct care staff persons B and C did not receive training in the following areas during training year 2023:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool,

65f - Training Topics (continued)

medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Direct care staff person D did not receive training in safe management techniques during training year 2023.

Plan of Correction ***Do Not Accept (- 08/29/2024)***

The annual 12 hours, as stated in the licensing instrument, does not have to be approved by DHS, however the facility and the administrator have always understood that the state approved medication administration training that staff member C received would cover the lower tier "self-administration" compliance requirement. Since staff member B does not perform medication duties he was trained by the same med trainer in general medication self-administration. Please see documents attached.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Medication self-administration is not covered during the medication administration course.

Please indicate the immediate action that was taken to correct the violation.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (/10/2024)***

On August 18, 2023, direct care staff persons B and C participated in medication self-administration training, fulfilling the required training topics for compliance noted during the inspection on July 18, 2024. Staff person D also received all required training. This training has been documented and confirmed.
Beginning on 10/01/24 the home's consultant and administrator will conduct monthly evaluations of training records.The consultant and administrator will regularly review training documentation to ensure that all staff have completed required training in medication self-administration and other relevant topics. This will help maintain oversight and address any future discrepancies promptly. This process will continue three months unless an extension is found to be necessary.
Starting December 2024 the home's administrator and consultant will conduct annual reviews of training policies and procedures. The Administrator will assess the effectiveness of the current training programs and compliance with required topics to ensure all staff remains adequately trained.
These streamlined actions focus on maintaining compliance while ensuring that staff are equipped with necessary training without overburdening the facility.

Licensee's Proposed Overall Completion Date: *09/03/2024*

65f - Training Topics *(continued)*

Evidence of Completion ***Not Implemented (- 12/06/2024)***

See attached.

65g - Annual Training Content

6. 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

Staff persons B and C did not receive training in the following areas during training year 2023:

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

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

3. Resident rights.

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

5. Falls and accident prevention.

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

Plan of Correction ***Do Not Accept (- 08/29/2024)***

Training consultant erroneously assumed that the 1-hour OSHA certified training which included a competency test to receive a certificate would not only be in compliance with the DHS guidelines but supersede it. The administrator has since brought in an appropriate in person training program that was completed on 8/9/2024.

Licensee's Proposed Overall Completion Date: *08/23/2024*

Update: *08/29/2024*

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (- 09/10/2024)***

Starting 10/01/24 the home's consultant and administrator will conduct monthly reviews of training completion and needs. The consultant and administrator will evaluate training records every month for three months to ensure all staff are current with required topics. Any necessary follow-up training will be scheduled based on this review. Starting 10/01/24 the home's consultant and administrator will conduct quarterly spot checks of training records and staff feedback sessions. The consultant and administrator will conduct random checks of training documentation and gather feedback from staff regarding the training sessions to continuously improve the effectiveness and accessibility of training programs. These measures are designed to ensure ongoing compliance with training requirements while remaining manageable for the facility. This will help prevent future violations and foster a culture of safety and awareness among all staff members.

Licensee's Proposed Overall Completion Date: *09/03/2024*

65g - Annual Training Content *(continued)*

Evidence of Completion ***Not Implemented (█ - 12/06/2024)***

See attached.

65i - Training Record

7. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training, including staff persons B and D, does not include the staff persons' names, actual dates, and the lengths of each course.

Plan of Correction ***Do Not Accept (█ - 08/29/2024)***

The annual staff training plan was completed on a DHS supplied form and was accepted as in compliance with DHS regulations previously. The administrator will switch to a custom form to comply with PA 2600 going forward.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (█ - 09/10/2024)***

The administrator has transitioned to a custom training record form that includes all necessary information, such as staff persons' names, actual training dates, content of the courses, length of each course, and copies of any certificates received. This new form was implemented effective immediately to ensure compliance with PA 2600 standards.
Beginning on 10/01/24 the home's consultant and administrator will conduct monthly evaluations of training records. The consultant and administrator will regularly review training documentation for three months to ensure that all staff have completed required training in medication self-administration and other relevant topics. This will help maintain oversight and address any future discrepancies promptly.
Starting December 2024 the home's administrator and consultant will conduct annual reviews of training policies and procedures. The Administrator will assess the effectiveness of the current training programs and compliance with required topics to ensure all staff remains adequately trained. These streamlined actions focus on maintaining compliance while ensuring that staff are equipped with necessary training without overburdening the facility.

Licensee's Proposed Overall Completion Date: *09/03/2024*

65i Training Record *(continued)*

Evidence of Completion ***Not Implemented (█ - 12/06/2024)***

See attached.

85a - Sanitary Conditions

8. Requirements

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

Description of Violation

On 7/18/2024, there was a urine odor noticeable in the home, particularly in the first floor common area by the front entrance at 9:00am, and in room B 8 at 11:00 am.

Plan of Correction ***Do Not Accept (█ - 08/29/2024)***

Room B 8 does not contain any incontinent residents, and staff observed no odor or staines or bodily fluids upon inspection. The occupants of the room prefer to have their air conditioning off and this might have caused the room to smell "less fresh" than other areas that had the air conditioning running. The common area is fully cleaned by 7am each day and staff was again unable to discern any foul smell in that area. Staff has been directed to deodorize common areas and rooms throughout the day to prevent any perception of foul smells.

Licensee's Proposed Overall Completion Date: *08/23/2024*

Update: *08/29/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (█ - 09/10/2024)***

After the inspection on July 18, 2024, staff conducted a thorough cleaning of the first-floor common area and room B-8. Staff were instructed to increase the frequency of cleaning and deodorizing efforts in these areas to ensure a fresh and sanitary environment. Additionally, a review of the air conditioning settings in room B-8 was conducted to encourage better airflow and ventilation.
Starting 9/1/24 the home's staff supervisor will be responsible for daily sanitation inspections for all common areas and resident rooms. The Staff Supervisor will implement daily checks to ensure that sanitation procedures are followed consistently, and any issues addressed promptly. This process will last one month unless and extension is found to be necessary.
Starting 9/1/24 the home's administrator will be responsible for weekly building surveys of cleanliness and odor control in the facility. The Facility Administrator will conduct weekly reviews to assess the overall cleanliness and odor control within the home. Any identified concerns or areas needing improvement will be followed up immediately. This process will continue one month unless an extension is found to be necessary.
Starting 10/01/24 the home's administrator and consultant will conduct quarterly training sessions on sanitation and odor control best practices. Staff will receive training on effective cleaning techniques and strategies to maintain sanitary conditions. This training will reinforce the importance of maintaining a clean and odor-free environment for residents.
These actions will help ensure that sanitary conditions are consistently maintained and monitored to prevent future violations regarding odors and cleanliness in the facility.

85a Sanitary Conditions (continued)

Licensee's Proposed Overall Completion Date: *09/02/2024*

Evidence of Completion ***Not Implemented (█ - 12/06/2024)***

See attached.

Please see attached training plan for 10/7.

88a Surfaces

9. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 7/18/2024 at 9:00 am, the edge of the first tile step inside the home's front door has a crack of roughly eighteen inches in length. The tile has worn away at the edge, presenting a crooked slope which creates a tripping hazard for those entering and exiting the vestibule.

On 7/18/2024, there was a strip of paint, approximately a foot long, missing from the wall above the bed in room B-8. There were water stains on the wallpaper next to the staircase between the first and second floors.

Plan of Correction ***Do Not Accept █ - 08/29/2024)***

Work has begun on these maintenance issues and shall be completed by Monday August 26th at the latest. Staff member Clinton Linton has been placed in charge of walking the building during his shift and reporting all maintenance needs to the administrator. Needs will be reported via GroupMe App as apposed to verbally or handwritten until addressed to maintain compliance.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please include detailed information regarding start dates and frequencies for the building walkthrough.

Plan of Correction ***Accept (█ - 09/10/2024)***

Starting 8/29/24 a direct care staff member was made responsible for daily walkthroughs of the facility. DCS member will conduct inspections during his shifts of all areas, focusing on identifying maintenance needs, cleanliness, and safety hazards. Any issues found will be documented and reported through the GroupMe App to ensure timely responses and resolutions.
Starting 10/01/24 the home's consultant and administrator will perform monthly comprehensive facility inspections. The consultant and administrator will conduct a thorough inspection of the facility each month to assess the condition of floors, walls, ceilings, and other surfaces for cleanliness and safety. Any significant findings will be documented, and plans for remediation will be established.
These measures are designed to ensure ongoing compliance with requirements for maintaining a clean and safe environment for residents and staff, while also effectively addressing any future maintenance issues in a timely manner.

Licensee's Proposed Overall Completion Date: *09/02/2024*

Evidence of Completion ***Not Implemented █ - 12/06/2024)***

See attached.

95 - Furniture and Equipment

10. Requirements

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

Description of Violation

On 7/18/2024, the latch on the door leading outside to the rear smoking area had been completed removed.

Plan of Correction ***Do Not Accept [redacted] - 08/29/2024)***

Work has begun on these maintenance issues and shall be completed by Monday August 26th at the latest. Staff member [redacted] has been placed in charge of walking the building during his shift and reporting all maintenance needs to the administrator, All needs will be reported via GroupMe app as opposed to verbally or handwritten until addressed to maintain compliance.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please include detailed information regarding start dates and frequencies for the building walkthrough.

Plan of Correction ***Accept ([redacted] - 09/10/2024)***

Starting 8/29/24 a direct care staff member was placed in charge of daily walkthroughs of the facility. DCS member will conduct inspections during his shifts of all areas, focusing on identifying maintenance needs, cleanliness, and safety hazards. Any issues found will be documented and reported through the GroupMe App to ensure timely responses and resolutions.
Starting 10/01/24 the home's consultant and administrator will conduct monthly comprehensive facility inspections. The consultant and administrator will conduct a thorough inspection of the facility each month to assess the condition of floors, walls, ceilings, and other surfaces for cleanliness and safety. Any significant findings will be documented, and plans for remediation will be established.
These measures are designed to ensure ongoing compliance with requirements for maintaining a clean and safe environment for residents and staff, while also effectively addressing any future maintenance issues in a timely manner.

Licensee's Proposed Overall Completion Date: *09/02/2024*

Evidence of Completion ***Not Implemented ([redacted] - 12/06/2024)***

See attached.

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's most recent assessment was completed on [redacted]. It stated the resident required no supervision in the home, and that resident #1 had no problem with judgement or orientation to time, place, and person. Resident #1 exhibited wandering behaviors and went missing from the home overnight at least once in June 2024. The resident's assessment was never updated to reflect this status. On [redacted], resident #1 was noticed missing from the home.

225c Additional Assessment (continued)

Police found the resident deceased on [redacted]

Plan of Correction ***Do Not Accept (*** [redacted] ***- 08/29/2024)***

Inspectors relied on verbal accounts regarding the whereabouts of resident 1 on an undetermined day from various residents (unidentified to the PCH) who may have difficulty with perception of reality and are definitely not privy to the specific comings and goings of other residents. Resident 1 (as a new resident of the home) did leave the facility prior to the latest incident however resident 1 returned to the facility within the acceptable time period and presented no signs of harm, confusion or need of change in support. Resident 1 correctly stated at the time that resident 1 was free to visit family and friends and staff believe the constituted an awareness of surroundings, time, place and personal rights.

Licensee's Proposed Overall Completion Date: *08/22/2024*

Update: *08/29/2024*

Please indicate the immediate action that was taken to correct the violation.

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction ***Accept (*** [redacted] ***- 09/10/2024)***

Beginning on 9/6/24 the home's administrator and supervisor will conduct monthly audits of resident assessments and conditions. The administrator and supervisor will conduct monthly reviews of all resident assessments to ensure that they are current and reflect any significant changes in resident behavior or condition. This includes immediate updates as needed and will take place for three months unless an extension is found to be necessary.
Starting 10/01/24 the home's consultant will conduct quarterly training sessions regarding assessment updates and documentation. Staff will receive training on the importance of timely assessments and protocols for documenting changes in residents' conditions. This training will emphasize the criteria for when an assessment update is necessary.
Effective immediately the home's administrator will ensure that any incidents involving residents, particularly those who wander or exhibit concerning behaviors, are documented and reviewed in monthly staff meetings. This will help identify patterns and where additional support may be needed.
These action steps are aimed at enhancing the monitoring of resident assessments and ensuring that any significant behavioral changes are addressed promptly and documented accurately to maintain the safety and well-being of all residents.

Licensee's Proposed Overall Completion Date: *09/02/2024*

Evidence of Completion ***Not Implemented (*** [redacted] ***- 12/06/2024)***

See attached.