pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **RONALD E INSINGER**
LEGAL ENTITY

To operate **INSINGER'S PERSONAL CARE-SOUTH**
NAME OF FACILITY OR AGENCY

Located at **6 EAST CENTRAL AVENUE, SOUTH WILLIAMSPORT,, PA 17702**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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 **38**
(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 **April 18,** **2025** until **October 18,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **202091**

ISSUING OFFICER

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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

[redacted]
Owner/President
[redacted]

RE: Insinger's Personal Care-South
6 East Central Avenue
South Williamsport, Pennsylvania 17702
License#: 202091

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 18, 2024, and December 9, 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 202090) 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 April 18, 2025 to October 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.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *INSINGER'S PERSONAL CARE-SOUTH* **License #:** *20209* **License Expiration:** *06/03/2025*

Address: *6 EAST CENTRAL AVENUE, SOUTH WILLIAMSPORT,, PA 17702*

County: *LYCOMING* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *RONALD E INSINGER*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *03/06/2009* **Issued By:** *S. Williamsport Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *30* **Waking Staff:** *23*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *12/09/2024*

Inspection Dates and Department Representative

12/09/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served:** *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *22* **Are 60 Years of Age or Older:** *23*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability:** *7*

Have Mobility Need: *0* **Have Physical Disability:** *1*

Inspections / Reviews

12/09/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/28/2024*

Inspections / Reviews *(continued)*

01/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/23/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/30/2025*

03/26/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/23/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

[redacted]

WITHDRAWN [redacted] 4/10/25

[redacted]

103e - Left Overs

3. 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

On 12/9/24, at approximately 1:00pm, a bowl of tuna salad was located in the kitchen refrigerator. The salad was not dated when it was placed in the refrigerator.

Plan of Correction ***Directed ([redacted] - 01/15/2025)***

Tuna was thrown away at time of inspection. Administrator will make sure cooking staff knows to label and date all food. Administrator will post sign on fridges as a daily reminder and make sure staff is supplied with permanent markers and or paper as needed to properly label and date foods going forward

Proposed Overall Completion Date: 12/27/2024

Directed Completion Date: *12/27/2024*

Not Implemented ([redacted] - 01/31/2025)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

On 12/9/24, at approximately 12:50pm, located in the new freezer in the basement was 5 bags of tater tots and in the freezer next to the washers were bags of chicken tenders. Both items did not have a label with a date.

Plan of Correction ***Directed (- 01/15/2025)***

Bags of tator tots and chicken tenders were thrown out day of inspection. Administrator will properly train staff to label and date all foods as needed and administrator in the future will supply the staff with permanent markers and paper for labeling and dating food and post signs on fridges as a reminder to label and date food when needed

Proposed Overall Completion Date: 12/27/2024

Directed Plan of Correction:
The administrator will designate a person to check all food items stored in the home to ensure that no outdated or spoiled food or dented cans are used on a weekly basis.

Directed Completion Date: *01/30/2025*

Not Implemented (- 01/31/2025)

125a - Combustible Storage

5. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 12/9/24, at approximately 12:50pm, Department representative observed the dryer hose on the left side was not connected to the exit vent. Therefore, the lint was piling up all over the wall, on the silver dryer hoses, and on the floor behind the dryer. Additionally, where the hose end was placed there was a pile of lint that the dryer hose was sitting on and blowing hot air onto. The pile of lint was approximately 5 to 6 inches wide. Also, the dryer hose to the right side was connected to a vent, However, there was a ball of lint sitting in the vent that leads to the outside of the building.

Plan of Correction ***Accept (- 01/15/2025)***

Administrator is responsible for making sure lint is removed and dryers are hooked up and working properly. Administrator called the contractor at the time of inspection and asked him to come hook up the dryer hose and clean all lint build up. Dryer hose was repaired and lint was cleaned up. In the future the administrator will check weekly that the dryer hoses are hooked up properly and that lint is removed.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Not Implemented (- 01/31/2025)

141a - Medical Evaluation

6. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted to the home on As of 12/9/24, the resident did not have a completed medical

141a - Medical Evaluation (continued)

evaluation.

Plan of Correction ***Directed (- 01/15/2025)***

Resident 1 had an appointment on 9/30/24 but dr never filled out the forms. I Forms were faxed in Oct and faxed in Dec by DCS asking for dr office to fill them out. Called more than once and told they were working on it. Finally, was told they were not filled out because did not see own dr. Administrator made another appointment for December 27th that was the quickest appointment they had for own dr. Paperwork to follow appointment on 12/27/24. Administrator will leave new resident file folders on desk moving forward as a reminder that Med-Eval. paperwork needs filled out within 30 days after admission

Proposed Overall Completion Date: 12/27/2024

Directed Plan of Correction:
The administrator will ensure that all newly admitted residents have a medical evaluation within the time frames required by this regulation. The administrator will audit all new resident admission DME's. Resident #1's DME will be updated.

Directed Completion Date: *01/30/2025*

Not Implemented (- 01/31/2025)

144c1 - Smoking Area Guidelines

8. 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

Approximately 20 extinguished cigarette butts were noted on the wooden floor of the home's front porch.

Plan of Correction ***Accept (- 01/15/2025)***

See attached. Administrator is responsible for making sure that proper safeguards are being followed when it comes to fire safety. Administrator will assign staff 4 times a day to clean and check front porch for any signs of fire safety violations. Furthermore administrator will make sure there is proper fireproof receptacles for the cigarette butts.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Not Implemented (- 01/31/2025)

225a - Assessment 15 Days

9. 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.

225a - Assessment 15 Days *(continued)*

Description of Violation

Resident #1 was admitted to the home on [redacted] An assessment and support plan was not completed within 15 days of admission. As of 12/9/24, the resident did not have a completed assessment and support plan.

Plan of Correction ***Directed ([redacted] - 01/15/2025)***

See attached. Administrator did not fill out the RASP within 15 days. In the future Administrator will keep the new resident file books on desk as a reminder to complete the assessment/support plans (RASP) within the 15/30 day timeframe. Administrator will do their best to complete all RASPs in the future. RASP is now complete

Proposed Overall Completion Date: 12/27/2024

Directed Plan of Correction:
The identified resident(s) will have a detailed, comprehensive assessment that identifies all of the resident(s)'s personal care needs. The assessment(s) will be documented on the Department's required form. Forms will be filled out in their entirety, including signatures and date. The administrator will audit all new admitted residents RASPs.

Directed Completion Date: *01/30/2025*

Not Implemented ([redacted] - 01/31/2025)

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

Facility Information

Name: *INSINGER'S PERSONAL CARE-SOUTH* **License #:** *20209* **License Expiration:** *06/03/2025*

Address: *6 EAST CENTRAL AVENUE, SOUTH WILLIAMSPORT,, PA 17702*

County: *LYCOMING* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *RONALD E INSINGER*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *03/06/2009* **Issued By:** *S. Williamsport Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *30* **Waking Staff:** *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *09/18/2024*

Inspection Dates and Department Representative

09/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served:** *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *22* **Are 60 Years of Age or Older:** *22*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability:** *7*

Have Mobility Need: *0* **Have Physical Disability:** *1*

Inspections / Reviews

09/18/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/12/2024*

Inspections / Reviews *(continued)*

10/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/20/2024*

10/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/02/2024*

03/26/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/22/2024*

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

Based on staff interviews and review of the Medication Administration Records, it was determined that Resident #1 was out of the building all day on the following dates: [redacted] *As a result, Resident #1 did not receive their 7:00am and 4:00pm medications as prescribed. The medication error was not reported to the Department as required.*

Repeat Violation-8-29-23

Plan of Correction ***Directed (- 10/23/2024)***

How it happened : Resident # 1 left the facility with meds. for [redacted]
when returning the evening of [redacted] *had* [redacted] *meds. Staff placed them in the med cart.*
Talked to Resident # 1 about the importance of taking [redacted] *meds. contacted* [redacted] *physician on 9/23/24. In the future staff will check med evals to see if residents can self administer their meds. Administrator will contact Physician and licensing within 24 hours, The Administrator did receive letter from residents #1's physicians saying* [redacted] *can self administer* [redacted] *medication when out overnight with family/friends.*

Proposed Overall Completion Date: 10/16/2024

Directed Plan of Correction
The administrator will review the incidents required to be reported by 2600.16a and train all staff. All future incidents will be reported as required. The home's administrator will be responsible to report all incidents within 24 hours.

Directed Completion Date: *11/02/2024*

Not Implemented (- 01/24/2025)

18 - Compliance With Laws

2. Requirements

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

Description of Violation

The batteries in the carbon monoxide detectors near the gas stove in the home's kitchen and gas clothes dryer in the basement were last changed in August 2023.

Repeat Violation-8-29-23.

Plan of Correction ***Accept (- 10/23/2024)***

How it happened :when the home maintenance replaced batteries in the smoke detectors the administrator believed the carbon monoxide detector was also replaced, they needed different batteries.
The carbon monoxide detector was changed on 9/19/24.

18 - Compliance With Laws (continued)

The Administrator will be responsible for overseeing the work is done.

Proposed Overall Completion Date: 10/16/2024

Licensee's Proposed Overall Completion Date: *10/16/2024*

Implemented (- 01/15/2025)

25b - Contract Signatures

3. 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

The resident-home contract, dated , for resident #1 was not signed by the resident.

Plan of Correction ***Accept (- 10/23/2024)***

How it happened : When resident #1 moved in the contract was already done by Insinger's West, administrator was unaware a new contract needed to be done.
a contract was completed on 9/19/24. In the future the Administrator will recheck all contracts for completion on all residents.
The Administrator is responsible, and competed 9/19/24.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Implemented (- 01/15/2025)

64c - Annual Training

4. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Records for Staff Person ' indicate only 16.5 of the required 24 hours annual Administrator Training were completed for the year 2023.

Plan of Correction ***Accept (- 10/23/2024)***

How it happened : Administrator was a lot in the beginning of the year, and had a lot of time off .
Administrator registered for Dementia boot camp =4.5 CEU's and 2 on line trainings =4 CEU's in total 8.5 CEU's
In the future the new administrator will complete 24 hours of CEU's ( )
the Administrator is responsible, 24 Hours will be completed by 11/6/24 and the new Administrator will review the completed hours.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Not Implemented (- 01/15/2025)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Records for Direct Care staff person "B", hired 7/15/24, did not contain the Department-approved direct care training course certificate.

Plan of Correction ***Accept (- 10/15/2024)***

How it happened : The home hired Staff B a former employee of Insinger North, was hired to cook only, administrator didn't feel had any hand on with residents, and was only doing ancellary.
when asked staff B to take the competency test, Staff B decided to terminate employment, In the future administrator will have any Direct Care complete a competency test.

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

Implemented (- 01/15/2025)

87 - Lighting

7. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The stairwell leading from the 2nd floor to the emergency fire exit on the first floor was not properly lit due to the light being inoperable.

Plan of Correction ***Accept (- 10/23/2024)***

How it happened :The emergency fire exit light was motion sincere when opening the door the sincere went bad.
maintenance was contacted and it was replaced the day of inspection.
In the future Emergency exit lights will be checked with fire drills monthly.
and monitored by staff conducting the drill.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Implemented (- 01/15/2025)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 9/18/24 at approximately 2:00pm, the upright freezer located in the basement near the washer and dryer had a temperature of 20 degrees.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

How it happened : The administrator was not aware of the freezer not working properly all food was moved to the other2 freezers until the new freezer was delivered (ordered on 9/19/24
A replacement freezer came on 9/30/24 temperature will be checked weekly.
The Administrator will monitor ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Implemented ([redacted] - 01/15/2025)

103i - Outdated Food

10. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The upright freezer in the basement on the opposite side of the room from the washer and dryer, had two 5-pound bags of shredded cheddar cheese and a large bag of fish sticks that was not properly dated with an expiration date or a date the items were received.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

How it happened : the staff that normally puts away food order was on vacation, the Contance and date was put on a dry board stuck to the freezer.
In the future all food items will be labeled and dated.
The head cook staff [redacted] is responsible for monitoring freezers food items and seeing that food is dated, and was dated 9/18/24. and will be each week.

Licensee's Proposed Overall Completion Date: *10/16/2024*

Not Implemented ([redacted] - 01/15/2025)

104b - Dishes/Glassware/Utensils

11. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

A Social Services Professional reported to the Department that on 6/11/24, while visiting residents in the dining room, they observed Staff Person ' [redacted] serving grilled cheese sandwiches by placing them directly on the table instead of using plates. Reporter stated Staff Person ' [redacted] was present and observed what Staff Person ' [redacted] was doing but did not correct them.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

How it happened : at first Administrator did not notice the cook putting sandwiches directly on the table, when it got my attention the residents had them eaten them, I brought it to the cooks attention, to never do that again.
Both cooks was told to always use plates and bowls on 6/11/24.
Administrator did monitor staff [redacted] serving and will continue to do so.

Licensee's Proposed Overall Completion Date: *10/16/2024*

104b - Dishes/Glassware/Utensils *(continued)*

Implemented ([redacted] - 01/15/2025)

125a - Combustible Storage

12. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A piece of cardboard was noted on the ground behind the gas clothes dryer located in the home's basement.

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

How it Happened : The home food order just had come, staff when opening boxes must have dropped it not knowing, the card board was picked up the day of the inspection, on 9/18/24.
The basement is cleaned every Wednesday. Maintenance is responsible of keeping all flammable materials away from heat sources and monitor every Wednesday.

Proposed Overall Completion Date: 10/16/2024

Directed Plan of Correction
Staff will be instructed to keep combustible and flammable materials away from heat sources and hot water heaters at all times. Maintenance is responsible for ongoing compliance.

Directed Completion Date: *11/02/2024*

Not Implemented ([redacted] - 01/15/2025)

144c1 - Smoking Area Guidelines

13. 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

Resident # 7 was observed smoking on the landing directly outside of the exit door leading to the designated smoking area located on the right side of the building.
Several discarded cigarette buts were noted on the floor of the front porch and on the ground outside of the rear exit door near Room A.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

How it happened : Resident #7 had been told of our smoking area and policy, [redacted] has now a verbal warning, This was also gone over in a resident meeting.
The home checks for and cleans any butts and debris found outside on the ground or on the porch weekly. (Wednesdays)
Maintenance will be responsible to monitor grounds. and did so on 9/18/24.

144c1 - Smoking Area Guidelines *(continued)*

Licensee's Proposed Overall Completion Date: *10/16/2024*

Not Implemented (- 01/15/2025)

185a - Implement Storage Procedures

15. Requirements

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

Description of Violation

Resident #2's glucometer was not calibrated to the correct date and time.

Resident #2 is prescribed to have blood sugar checked 4 times a day. On 9/10/24 at 12:44, the residents blood sugar was checked, and the glucometer indicated the level was 173. However, this was not documented on the MAR.

Resident #5 is to receive blood sugar level (BSL) checks 3x daily. Review of Resident # 5's glucometer and medication administration record (MAR) indicated the following: on 9/9/24 @ 7am, the meter had a BSL reading of 110; 99 was documented on the MAR. On 9/12/24 @ 4:00pm, the meter had a BSL reading of 296; 246 was documented on the MAR.

Resident # 6's glucometer was not calibrated to the correct date and time.

Repeat Violation-8-29-23.

Plan of Correction ***Directed (- 10/23/2024)***

how it happened : Resident # 2 and # 6 glucometers were not calibrated due to staff hitting the wrong buttons. Resident # 2 blood sugar was done in bedroom and staff forgot to enter it. Resident # 5 does own blood sugars , and had not given staff incorrect numbers.
how to fix : Resident #2 and # 6 glucose monitors were calibrated the day of inspection by the med administrator staff on duty.
Resident # 2 reading on 9/10/24 at 12:44 of 173 was entered by the med administrator on duty
The correct number for Resident # 5 was entered in MAR for 9/9/24 at 7: 00 AM and 9/12/24 at 4 PM by the med administator staff n duty
Having med manager will have a staff meeting to go over proper techniques for taking blood sugars with different machines, entering proper numbers in the MAR . Also assign a med administrator staff to calibrate machines weekly (Fridays)

Proposed Overall Completion Date: 10/17/2024

Directed Plan of Correction
Medication administration staff will have a training conducted by 11-2-2024 by medication manager on documenting blood sugar readings in the resident's medication administration record. The medication manager will conduct weekly audits of documented blood sugar readings and calibrating resident's glucometers for the first 3 months.

185a - Implement Storage Procedures (continued)

Directed Completion Date: *11/02/2024*

Not Implemented (- 01/15/2025)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Based on staff interviews and review of the Medication Administration Records, it was determined that Resident #1 was out of the building all day on the following dates: . Therefore, Resident #1 did not receive the following medications as prescribed: Bupropion HCL 150mg; twice daily at 7:00am and 4:00pm; Calcium 600mg once daily at 7:00 am; Celecoxib 100mg. once daily at 7:00am; Daily Vit once daily at 7:00am; Divalproex 500mg. twice daily at 7:00am and 4:00pm; Levothyroxine 25mcg. Once daily at 7:00am; Omeprazole 20mg. once daily at 7:00am.; Sertraline 50mg. once daily at 7:00am.

Resident #2 had an order for furosemide 40mg tablet by mouth once a day in the morning. The order was discontinued on 9/9/24 at 10:00am. On 9/10/24, the resident was administered the medication, a day after it was discontinued.

Plan of Correction ***Accept (- 10/23/2024)***

How it happened : Resident #1 did not receive madication while out of our facility,
Resident # 2 med. was signed in error after being D/C'ed.
Physician and pharmacy was notified by med manager that resident #1 did not receive meds while out of facility. The physician then faxed a note that reads may take own meds the days is not at Insinger's. That staff was given 2 remediation med. passes by the med trainor, making sure new orders and discontinued orders are fallowed in the future. The administrator moving forward will follow the med eval to make sure a resident is capable of leaving the home and administering their own medications and contact the physician when needed for compliance with medications. Resident 1#'s medication was entered into the Quick MAR as a duplicate because of a recent refill and hospital stay. So essentially the old script was left in the system and the staff on duty signed for both orders but did not give medication twice. Med mananger went onto Quick MAR and discontined the old order. Going forward the 2nd shift med staff will be responsible for discontinuing old olders on Quick Mar when new medications arrive. 1st shift med staff will double check the Quick MAR while logging in first thing in the morning that there are no more actions left to complete.

Proposed Overall Completion Date: 10/17/2024

Directed Plan of Correction

Licensee's Proposed Overall Completion Date: *10/17/2024*

Implemented (- 01/15/2025)

188b - Medication Error Reporting

17. 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

Based on staff interviews and review of the Medication Administration Records, it was determined that Resident #1 was out of the building all day on the following dates: [redacted] *Therefore, Resident #1 did not receive the following medications as prescribed: Bupropion HCL 150mg; twice daily at 7:00am and 4:00pm; Calcium 600mg once daily at 7:00 am; Celecoxib 100mg. once daily at 7:00am; Daily Vit once daily at 7:00am; Divalproex 500mg. twice daily at 7:00am and 4:00pm; Levothyroxine 25mcg. Once daily at 7:00am; Omeprazole 20mg. once daily at 7:00am.; Sertraline 50mg. once daily at 7:00am. The medication error was not reported to the resident #1's physician or designated person.*

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

How it happened : Resident # 1 decided while out of the facility did not to take [redacted] listed medications that day.
Physicians office was notified on 9/19/24 by med manager and on 9/23/24 physician sent a faxed note saying resident #1 could take and self administer medications while not at the home.
Med trainer had meetings with staff week of 9/22/24 and emphasized the importance of staff to notify Physicians and designated person within 24 hours of any medication errors. Staff was told to contact med administrator as soon as the med error is noticed so that the med administrator could contact physicians and designated person with 24 hours.

Proposed Overall Completion Date: 10/17/2024

Directed Plan of Correction
In the future, the home will ensure that all medication errors are reported to the Department, the resident, the resident's designated person and the prescriber. The medication manger will complete weekly audits of this regulation for the next 3 months.

Directed Completion Date: *11/02/2024*

Not Implemented ([redacted] - 01/15/2025)

191 - Resident Right to Refuse

18. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #3's records did not document that the resident was counseled on the right to refuse and/or question medications.

Plan of Correction ***Directed ([redacted] - 10/23/2024)***

The Administrator did not notice Z was missing on resident rights, and then added it the day of inspection.
Administrator on 9/24/24 showed resident #3 the updated contract with Z added with resident rights.
The homes administrator will review all of the contract documents and souble check that Z (resident rights) are added onto the resident rights in the future.

191 - Resident Right to Refuse (continued)

Proposed Overall Completion Date: 10/17/2024

Directed Plan of Correction
The administrator will develop and implement a system to ensure that all residents receive a copy of the resident rights and complaint procedures at admission, and that these rights include the right to refuse medications. The procedures will include obtaining signed statements acknowledging receipt of these items. The home's administrator will audit all current resident records by 11-2-2024 to ensure all residents have the right to refuse medications.

Directed Completion Date: *11/02/2024*

Implemented ([redacted] - 01/15/2025)

224a - Preadmission Screen Form

19. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

How it happened : Resident #1 was a resident of Insinger West in the past, Administrator did not complete a pre-admission screening when the resident moved into the facility, the pre-admission screening was completed on 9/18/24 by administrator.
A pre-admission screening will be completed on all potential residents and active residents in the future by the administrator.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented ([redacted] - 01/15/2025)

227g -Support Plan Signatures

21. 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 #4, dated [redacted] and Resident #1, dated [redacted] were not signed by the residents. There was not a notation that the resident did not want to participate or was unable to sign.

Plan of Correction ***Accept ([redacted] - 10/23/2024)***

How it happened : Administrator had completed resident #1 and #4 RASP and the residents where out of the facility and administrator forgot about them not being signed. Both RASP's were signed on 9/20/24 by resident #1 and resident #4.
In the future Administrator will review and double check all RASP's for completion before filing. And administrator

227g -Support Plan Signatures (continued)

will also review RASPs every 6 months to make sure all information is filled out and completed.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Implemented (- 01/15/2025)