pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE GATHERING PLACE PERSONAL CARE LLC**
LEGAL ENTITY

To operate **THE GATHERING PLACE PERSONAL CARE**
NAME OF FACILITY OR AGENCY

Located at **390 MOUNTAIN ROAD, UNIONTOWN, PA 15401**
(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 **16** (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 9, 2025** until **October 9, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454172**

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 9, 2025

[redacted], Owner
The Gathering Place Personal Care LLC
[redacted]
[redacted]0

RE: The Gathering Place Personal Care
390 Mountain Road
Uniontown Pennsylvania 15401
License/COC #: 454172

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on December 16, 2024, and March 5, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from April 9, 2025 to October 9, 2025.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
63(a)	II	14	$5	$70	5 calendar days from mailing date of this letter
65(e)	III	14	$3	$42	15 calendar days from mailing date of this letter
65(f)	III	14	$3	$42	15 calendar days from mailing date of this letter
65(g)	III	14	$3	$42	15 calendar days from mailing date of this letter
185(a)	II	14	$5	$70	5 calendar days from mailing date of this letter

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

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

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

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

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

Sincerely,

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: *THE GATHERING PLACE PERSONAL CARE* **License #**: *45417* **License Expiration**: *03/03/2025*

Address: *390 MOUNTAIN ROAD, UNIONTOWN, PA 15401*

County: *FAYETTE* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *THE GATHERING PLACE PERSONAL CARE LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/06/1993* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *12/16/2024*

Inspection Dates and Department Representative

12/16/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served**: *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *14*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

12/16/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/15/2025*

Inspections / Reviews *(continued)*

01/15/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/10/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *01/21/2025*

01/22/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/10/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *02/10/2025*

03/11/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *02/10/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

18 - Compliance With Laws

1. Requirements

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors. However, the date of battery installation was not present on the battery-operated carbon monoxide detector, located in the hallway across from the linen closet.

Plan of Correction ***Accept (- 01/22/2025)***

On 12/16/24, during an inspection, it was discovered that a carbon monoxide battery was not dated. As soon as this was found, the administrator replaced the battery and dated it for that day. The carbon monoxide detector in the basement was checked on 12/16/24 to ensure that it was labeled correctly, which it was. In order to be compliant with PA Code 2600.18, and to prevent this moving forward, the Administrator or the designated employee will check that all carbon monoxide detectors are working properly. and the batteries are dated on the day of the unannounced fire drill. Batteries will be changed and dated the same day as the smoke detector batteries. A sign off sheet will be created and placed in the fire drill folder and signed off by the person conducting the fire drill. Carbon Monoxide detectors will be checked every 16th of every month and will be signed off with date and if batteries needed replaced and signed off by staff member conducting the check. Quality Management meetings will be held on the 1st and 16th of each month and will be discussed in every meeting and signed off that is was discussed. Documentation of the meeting topics and attendees will be documented and kept in accordance with PA Code 2600.18.

Proposed Overall Completion Date: 01/21/2025

Licensee's Proposed Overall Completion Date: *01/21/2025*

Implemented (- 03/11/2025)

63a - First Aid/CPR Training

3. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

There were undetermined lengths of time during numerous shifts on numerous days in which there was no staff person present in the home who is trained in first aid and certified in obstructed airway techniques and CPR, to include the following days:

- *On 12/14/24 from approximately 3:00pm through 11:00pm*
- *On 12/13/24 from approximately 3:00pm through 11:00pm*
- *On 12/10/24 from approximately 3:00pm through 11:00pm*
- *On 12/9/24 from approximately 3:00pm through 11:00pm*

63a - First Aid/CPR Training (continued)

REPEAT VIOLATION: 6/5/2024

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/2024, it was discovered that employees were on the schedule who "didn't have" CPR. The Administrator had all employees who needed CPR class attend an online class for renewal. They were unaware that actual in-person, hands on class was required for compliance. Upon this discovery, the Administrator reached out to the CPR class instructor to get a class scheduled for all employees needing this course. The class is tentatively set for 1/29/25. (DIRECTED: The administrator shall ensure the CPR instructor is an individual certified as a trainer by a hospital or other recognized health care organization in accordance with 2600.63b. 1/22/25). In order to be compliant with PA Code 2600.63a, only in-person, hands-on class will be scheduled for all employees and a calendar event will be created on the first of the month that all CPR cares are set to expire so that they don't expire. (DIRECTED: By 2/1/25: The administrator shall develop and implement a tracking system which includes the names of all current staff persons who are currently certified in CPR/first aid, as well as their CPR/first aid expiration dates. The tracking system shall be reviewed and updated quarterly to ensure compliance with 2600.63a. 1/22/25).

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator/designee shall review the direct care staffing schedule daily to ensure compliance with 2600.63a. 1/22/25).

The next QM meeting will be held on Feb 01,2025 All staff will attend and documentation of attendees will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 01/21/2025

Directed Completion Date: *02/01/2025*

Not Implemented (- 03/11/2025)

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

Staff person the home's administrator, did not receive any Department-approved trainings during the 2023 training year.

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/2024, it was discovered that the Administrator didn't have the required 24 hours of continuing education completed. At the time of the inspection, the Administrator explained that staffing issues and other business related issues was the reason that the CEUs were not completed. I realize that is not a good answer but it was an honest one. I just couldn't find the time to complete these requirements.

64c - Annual Training (continued)

It was a priority for the Administrator that 2024 would be completed in a timely fashion in order to be compliant with PA Code 2600.64c. The CEUs that were required for 2024 were completed by 11/5/2024. As of 11/5/2024, the Administrator completed 29.25 hours of continuing education, exceeding the required 24 hours. To prevent this from happening in the future, the same priority has been set for 2025 and the Administrator has already started the CEU classes. Although the plan for correction completion is scheduled for 1/31/25, it will be completed throughout the year as they are offered by providers.

Beginning 2/1/25, the Administrator will review training records monthly to ensure compliance with 2600.64c. Training will be scheduled in a timely fashion to ensure that everyone is trained and compliant.

The next QM meeting will be held on Feb 01,2025 All staff will attend and documentation of attendees will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Implemented (██ - 03/11/2025)

65e - 12 Hours Annual Training

5. 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 C, hired on ██ did not receive any trainings during the 2023 training year.

REPEAT VIOLATION: 4/16/2024

Plan of Correction ***Directed (██ - 01/22/2025)***

On 12/16/24, during an inspection it was discovered that staff person C did not receive the training required for compliance of 2600.65f. Staff Person C was the person who completed the training for the employees. ██ had not received any personal training because, as a trainer, ██ training the class can not count as ██ personal training. To ensure that trainer training is completed for 2025 for the one training the employees, outside training will be scheduled for both herself and the Administrator by a different provider.

Beginning on 2/1/25, the Administrator will review all training records monthly to ensure compliance with PA Code 2600.65e. Reminders will be scheduled in the calendar on the computer as well as the daily planner to be sure that compliance is maintained.
The 2025 staff training plan has been created and will cover 12+ hours of training for staff.

The next QM meeting will be held on Feb 01,2025. All staff will attend and documentation of attendees will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b.

65e - 12 Hours Annual Training (continued)

Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Not Implemented (- 03/11/2025)

65f - Training Topics

6. 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.

Description of Violation

Direct care staff person C, hired on did not receive training on the following topics during the 2023 training year:

- *Medication self-administration training*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Care for residents with dementia and cognitive impairments*
- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration*
- *Personal care service needs of the resident*
- *Safe management techniques*

REPEAT VIOLATION: 4/16/2024

Plan of Correction ***Directed (- 01/22/2025)***

On 12/16/24, during an inspection it was discovered that staff person C did not receive the training required for compliance of 2600.65f. Staff Person C was the person who completed the training for the employees. had not received any personal training because, as a trainer, training the class can not count as personal training. To ensure that trainer training is completed for 2025 for the one training the employees, outside training will be scheduled for both herself and the Administrator by a different provider.

DIRECTED: By 2/10/25: The administrator shall provide training to direct care staff person C on all topics specified in 2600.65f. Documentation of the training shall be kept in accordance with 2600.65i. 1/22/25

Beginning on 2/1/25, the Administrator will review all training records monthly to ensure compliance with PA

65f - Training Topics (continued)

Code 2600.65e. (DIRECTED: The monthly administrator reviews shall also include ensuring all direct care staff persons receive training on all topics specified in 2600.65f during each training year. ███ 1/22/25). Reminders will be scheduled in the calendar on the computer as well as the daily planner to be sure that compliance is maintained. The 2025 staff training plan has been created and will cover 12+ hours of training for staff.
The next QM meeting will be held on Feb 01,2025. All staff will attend and documentation of attendees will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ███ 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/10/2025*

Not Implemented (███ - 03/11/2025)

65g - Annual Training Content

7. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

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

Description of Violation

Direct care staff person C, hired on ███, did not receive training on the following topics during the 2023 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*
- *Resident rights*
- *The Older Adult Protective Services Act*
- *Falls and accident prevention*

REPEAT VIOLATION: 4/16/2024

Plan of Correction ***Directed (███ - 01/22/2025)***

On 12/16/24, during an inspection, it was discovered that staff person C did not receive the training required for compliance of 2600.65f. Staff Person C was the person who completed the training for the employees. ███ had not received any personal training because, as a trainer, ███ training the class can not count as ███ personal training. To ensure that trainer training is completed for 2025 for the one training the employees, outside training will be scheduled for both herself and the Administrator by a different provider.

DIRECTED: By 2/10/25: The administrator shall provide training to direct care staff person C on all topics specified

65g - Annual Training Content (continued)

in 2600.65g. Documentation of the training shall be kept in accordance with 2600.65i. ██ 1/22/25

Beginning on 2/1/25, the Administrator will review all training records monthly to ensure compliance with PA Code 2600.65e. (DIRECTED: The monthly administrator reviews shall also include ensuring all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. ██ 1/22/25). Reminders will be scheduled in the calendar on the computer as well as the daily planner to be sure that compliance is maintained.
The 2025 staff training plan has been created and will cover 12+ hours of training for staff.
The next QM meeting will be held on Feb 01,2025. All staff will attend and documentation of attendees will be kept. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/10/2025*

Not Implemented (██ - 03/11/2025)

91 - Telephone Numbers

8. 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

No emergency telephone numbers were posted on or near the telephone in the hallway between bedrooms #5 and #6.

REPEAT VIOLATION: 4/16/2024

Plan of Correction ***Directed (██ - 01/22/2025)***

During the inspection on 12/16/24, it was stated that there were no phone numbers posted in the hall by the phone between bedrooms 5 and 6. When speaking with the inspectors during the exit interview, the Administrator said that there were, in fact, phone numbers posted by the phone. The inspector walked back to the phone with the Administrator to see that they were there. Because they were covered with a Christmas doily, ██ didn't see it.

After the exit interview on 12/16/2024, the Administrator inspected the 4 phones that are in the house. All had the emergency phone numbers posted visibly by them. The one with the doily was immediately removed to expose the list of emergency phone numbers. In order to be complaint with PA Code 2600.91, there will be nothing covering the emergency phone numbers, including holiday decorations. To ensure that they are all visible, after decorations are placed, the Administrator or the designated employee will walk through the facility to ensure that all phone numbers are visible at all times. No decorations in the future will be placed by any phones. (DIRECTED: Beginning on 2/1/24: The administrator/designee shall inspect the home monthly to ensure the telephone numbers specified in 2600.91 are posted on or near each telephone with an outside line. ██ 1/22/25).

During the QM meeting on the 1st and 16th of each month, a walkthrough will be done to ensure that all phone

91 - Telephone Numbers (continued)

lists are visible. Documentation and staff attendance will be documented and maintained. (DIRECTED: The quality management review scheduled for 2/1/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Implemented (- 03/11/2025)

101j6 - Mirror

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

No mirror is present in bedroom #4.

Plan of Correction ***Directed (- 01/22/2025)***

During the inspection on 12/16/24, it was discovered that a mirror was not present in bedroom #4. A mirror was placed on the back of the closet door, but, for some reason, was not present at the time of the visit. After the exit interview on 12/16/2024, the owner went to the store and purchased a new mirror and installed it the same day. also purchased an extra one, in case one might get broken.

To ensure that we are in compliance with PA Code 2600.101j, during the next QM meeting scheduled for 2/1/25, the Administrator and designated employee will walk through the facility and will happen at least once per month beginning 2/1/2025. This will include a full room inspection to ensure that all required items are present and functional. Documentation will be kept of the QM meeting and maintained. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Implemented (- 03/11/2025)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

10. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

A slip-resistant surface was not present on the shower floor in the common shower room next to bedroom #8.

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/24, it was discovered that the flooring in the walk in shower did not have slip resistance on the tile. On 12/16/2024, after the exit interview, the owner went to the store to purchase strips that

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)

go on the floor of the shower to prevent residents or employees from slipping and installed them the same day, 12/16/2024.

To remain compliant with PA Code 2600.102d, the employees will be instructed to inform the owner, Administrator, or manager of any missing, slipping, or damaged strips and all grab bars are present and functional to ensure the safety of everyone. (DIRECTED: By 2/5/25: The administrator shall reeducate all staff persons on ensuring all toilet and bath areas have grab bars, hand rails or assist bars, and that bathtubs and showers have slip-resistant surfaces. The education shall also include reporting procedures for items that need repaired or replaced. Documentation of the staff education shall be kept in accordance with 2600.65i. ██ 1/22/25).

During the QM meeting that will be held on 2/1/25, during our monthly house walk through, an inspection to ensure the presence of all hand rails, grab bars, and assist bars will be done in all of the restrooms and showers. (DIRECTED: Beginning on 2/1/25: The administrator/designee shall inspect all toilet and bath areas monthly to ensure compliance with 2600.102d. ██ 1/22/25). Any that are missing or damaged will be replace immediately, Instruction will be given to all attendees about the strips and instructed to inform the Administrator or the designated employee if any need to be replaced. Documentation of the QM meeting will be maintained. (DIRECTED: The quality management review scheduled for 2/1/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/05/2025*

Not Implemented (██ - 03/11/2025)

121a - Unobstructed Egress

11. 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

At approximately 9:45am, the emergency exit door from the front sun porch was locked with a sliding latch lock and was blocked with a gray retractable safety gate.

REPEAT VIOLATION: 4/16/2024

Plan of Correction ***Directed (██ - 01/22/2025)***

During an inspection on 12/16/24, it was discovered that the screen door on the front sun porch had a lock and a retractable safety gate installed. These were installed before our purchase of the facility so we assumed it was not a violation. After learning that it was a violation of PA Code 2600.121a, the gate and the lock were removed from the door frame and the door. This gate and lock were removed by the owner on 12/16/2024, after the exit interview of the inspection. There are no longer gates or locks blocking any exit route from the facility.

To ensure compliance of 2600.121a, each staff person per shift will do a walk through of the facility to ensure that all exits, hallways ,stairs, passageways, and egress routes from rooms and building are unlocked and unobstructed. (DIRECTED: The walk-throughs conducted by a staff person on each shift shall begin on 1/23/25. ██ 1/22/25). ALL staff has been educated on in compliance of 2600.121a. This training was conducted on 1/23/25 (DIRECTED:

121a - Unobstructed Egress (continued)

Documentation of the staff education shall be kept in accordance with 2600.65i. █ 1/22/25).

the QM meeting will be held bi-monthly, beginning on 2/1/25. Documentation will be kept of the meeting and the attendees. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/22/25).

Proposed Overall Completion Date: 01/23/2025

Directed Completion Date: *02/01/2025*

Implemented (█ - 03/11/2025)

183b - Meds and Syringes Locked

12. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 9:55am, a medication cart was unlocked, unattended and accessible in the hallway next to bedroom #8, which contained numerous medications, to include the following:

- *A tube of Triamcinolone Acetonide-0.5% cream belonging to resident #1*
- *A bottle of Nystatin powder-100,000 units belonging to resident #2*
- *A 50g container of Silver Sulfadiazine Cream-1%, which contained no pharmacy label*

Plan of Correction ***Directed (█ - 01/22/2025)***

During an inspection on 12/16/24, it was discovered that our Treatment Cart was unlocked, unattended, and accessible to everyone positioned by Room #8. This cart is normally kept in the walk-in shower when not in use for wounds and treatments.

After the exit interview on 12/16/24, the owner purchased locks for the cart that were installed the same day, 12/16/24, so that only the employees would be able to open and access contents of the cart. This will ensure that no one will be able to access medications or supplies that could be harmful. There is only one other place in the home that has prescription medication and it is locked behind a sliding door when not passing or administering medications.

To ensure compliance of PA Code 2600.183b, a daily walk through will be done by the lead person on staff to check that the cart will remain locked at all times, even when in storage. (DIRECTED: The daily walkthroughs shall begin on 1/23/25 to ensure compliance with 2600.183b. █ 1/22/25). The keys will be kept on the set of keys that only the employees have access to.

All staff members will be reeducated on the regulation of ensuring all medication is locked and stored safely. This training will occur on 1/23/25 and will be done by the owner. Documentation will be maintained of the retraining.

The QM meeting is scheduled for 02/1/2025. During this meeting, the storing of medications will be reiterated with

183b - Meds and Syringes Locked (continued)

all staff. Documentation will be kept of the meeting. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 01/23/2025

Directed Completion Date: *02/01/2025*

Not Implemented (- 03/11/2025)

183d - Prescription Current

13. 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

At 9:55am, numerous discontinued medications were present in a medication cart in the hallway next to bedroom #8, to include the following:

- *A tube of Triamcinolone Acetonide-0.5% cream for resident #1, with a pharmacy label indicating to "Apply a thin layer to affected area twice a day for 14 days". The medication was dispensed from the pharmacy on 2/5/24.*
- *A tube of Nystatin Powder-100,000 units for resident #2, with a pharmacy label indicating to, "Apply a nickel sized amount topically behind right ear twice a day for 14 days". This medication was dispensed from the pharmacy on 11/22/23.*

At 9:55am, there was a tube of Hydrocortisone-1% cream present in the home for resident #5, who was discharged from the home on

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/24, it was discovered that there were medications stored in the Treatment Cart that were discontinued from use. Upon this discovery, the medication was immediately discarded by the home manager on 12/16/24. After the exit interview, the cart was fully inspected for any other medications that may have been missed and was discarded immediately.

To ensure compliance of PA Code 2600.183d, the Treatment Cart will be inspected upon the termination of a resident's stay to ensure that all medications are either transferred to home or facility with the resident. If the resident passed away, all medications will be discarded when the medication cart is cleared of their medication. (DIRECTED: The new process shall begin on 1/23/25. 1/22/25).

During the monthly medication audit that will begin on 2/1/25, the Treatment Cart will be inspected in addition to the medication cart to ensure there are no expired medications or medications belonging to residents who no longer reside with us. (DIRECTED: The monthly cart audits shall be conducted by the administrator/designee. 1/22/25).

183d - Prescription Current (continued)

All staff will be trained during the training session that will be held on 1/23/25 in regards to ensuring there are no expired, unlabeled, or belonging to residents who are no longer in the facility. This training will be done by the owner and documentation of the training will be kept in accordance with PA Code 2600.65i. (DIRECTED: The training shall also include the home's procedures for removing medications from the home immediately upon receipt of discontinued orders from the prescriber. ██ 1/22/25)

A QM meeting will be held bi-monthly beginning on 2/1/25 and this topic will be discussed. Documentation will be kept of this meeting. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 1/22/25).

Proposed Overall Completion Date: 01/23/2025

Directed Completion Date: *02/01/2025*

Not Implemented (██ - 03/11/2025)

183e - Storing Medications

14. 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

At 9:55am, numerous expired medications were present in a medication cart in the hallway next to bedroom #8, to include a tube of Nystatin Cream-100,000 units, with an illegible pharmacy label, which expired on 6/26/24.

Plan of Correction ***Directed (██ - 01/22/2025)***

During an inspection on 12/16/24, it was discovered that there were medications stored in the Treatment Cart that were discontinued from use. Upon this discovery, the medication was immediately discarded by the home manager on 12/16/24. After the exit interview, the cart was fully inspected for any other medications that may have been missed and was discarded immediately.
To ensure compliance of PA Code 2600.183d, the Treatment Cart will be inspected upon the termination of a resident's stay to ensure that all medications are either transferred to home or facility with the resident. If the resident passed away, all medications will be discarded when the medication cart is cleared of their medication. (DIRECTED: The new process shall begin on 1/23/25. ██ 1/22/25).

During the monthly medication audit that will begin on 2/1/25, the Treatment Cart will be inspected in addition to the medication cart to ensure there are no expired medications or medications belonging to residents who no longer reside with us. (DIRECTED: The monthly cart audits shall be conducted by the administrator/designee. ██ 1/22/25).
All staff will be trained during the training session that will be held on 1/23/25 in regards to ensuring there are no expired, unlabeled, or belonging to residents who are no longer in the facility. This training will be done by the owner and documentation of the training will be kept in accordance with PA Code 183e. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. ██ 1/22/25).

A QM meeting will be held bi-monthly beginning on 2/1/25 and this topic will be discussed. Documentation will be

183e - Storing Medications (continued)

kept of this meeting. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 1/22/25).

Proposed Overall Completion Date: 01/23/2025

Directed Completion Date: *02/01/2025*

Not Implemented (██ - 03/11/2025)

184a - Resident's Meds Labeled

15. 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

At 9:55am, no legible pharmacy labels were present on the following medications, which were present in the medication cart in the hallway next to bedroom #8:

- *A 50g container of Silver Sulfadiazine Cream-1%, which contained no pharmacy label*
- *A tube of Nystatin Cream-100,000 units, which contained an illegible pharmacy label*

REPEAT VIOLATION: 6/29/2023

184a - Resident's Meds Labeled (continued)

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/24, it was discovered that there were medications stored in the Treatment Cart that were not labeled by the pharmacy. Upon this discovery, the medication was immediately discarded by the home manager on 12/16/24. The medication belonged to a resident who moved to a different facility. They weren't part of normal medication regimen so they were missed when packing medications up. There is no need to get a new pharmacy label. The medications were discarded immediately by the Administrator. After the exit interview, the cart was fully inspected for any other medications that may have been missed and was discarded immediately.

To ensure compliance of PA Code 2600.184a, the Treatment Cart will be added to the medication audit that will be done monthly, beginning 2/1/25. Any medication that doesn't have a label will either have a new label issued from the pharmacy or the medication will be discarded if expired. (DIRECTED: The monthly cart audits shall be conducted by the administrator/designee and shall include a review of all current resident medications during each monthly review to ensure compliance with 2600.184a. 1/22/25).

During the monthly medication audit that will begin on 2/1/25, the Treatment Cart will be inspected in addition to the medication cart to ensure there are no expired medications or medications belonging to residents who no longer reside with us. (DIRECTED: The monthly cart audits shall be conducted by the administrator/designee and shall include a review of all current resident medications during each monthly review to ensure compliance with 2600.184a. 1/22/25).
All staff will be trained during the training session that will be held on 1/23/25 in regards to ensuring there are no expired, unlabeled, or belonging to residents who are no longer in the facility. This training will be done by the owner and documentation of the training will be kept in accordance with PA Code 183e. (DIRECTED: The training shall also include ensuring each resident's medication has a current pharmacy label in accordance with 25600.184a. Documentation of the staff education shall be kept in accordance with 2600.65i. 1/22/25).
A QM meeting will be held bi-monthly beginning on 2/1/25 and this topic will be discussed. Documentation will be kept of this meeting. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 01/23/2025

Directed Completion Date: *02/01/2025*

Not Implemented (- 03/11/2025)

185a - Implement Storage Procedures

16. 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

According to resident #3's glucometer, ██ lunchtime blood glucose reading on 12/13/24 at 11:47am was 262; however, this reading was not documented on resident #3's blood glucose log.

Resident #3 is prescribed blood glucose readings 3 times daily with Novolin insulin sliding scale coverage. On numerous occasions, resident #3's glucometer readings were incorrectly documented on resident #3's blood glucose log, to include the following dates and times:

Date and time	Glucometer reading	Blood glucose log reading
• 12/13/24 at dinner	280	260
• 12/10/24 at lunch	180	196
• 12/9/24 at breakfast	237	236

REPEAT VIOLATION: 6/29/2023

Plan of Correction ***Directed (██ - 01/22/2025)***

During an inspection on 12/16/24, it was discovered that blood glucose readings were written down wrong, conflicting with the glucometer reading. After the inspector left, the Administrator and the house manager audited the glucometer to correct any other readings that were off.

On 12/17/24, a meeting was held by the Administrator with all persons who check residents blood glucose and were educated on the importance of accuracy with glucose readings, as it could be detrimental to the resident if the wrong dose of insulin is given. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. ██ 1/22/25).
To ensure that readings are correct, the Administrator or the designated employee will audit the glucometers weekly, beginning on 1/26/25. If readings are off in the future, the employee who is responsible will be required to take Diabetic training using videos. Weekly audit of each glucometer will be held on weekly beginning on 1/25/25. This audit shall include a weekly review of r all residents prescribed blood sugar checks and shall include a review of all glucometers as well as the documentation to ensure accuracy.

QM meeting will be held on 2/1/25 and the findings of the audit will be discussed. Documentation will be kept of the meeting. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Not Implemented (██ - 03/11/2025)

187a - Medication Record

17. Requirements

187a - Medication Record *(continued)*

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

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

Description of Violation

Resident #1 is prescribed, "Ibuprofen 200mg tablet-Take 1 tablet by mouth twice a day as needed"; however, this medication is not present on resident #1's December 2024 medication administration record (MAR).

Resident #1 is prescribed, "Quetiapine 100mg tablet-Take 1 tablet by mouth twice a day'; however, resident #1's December 2024 MAR indicates, "Quetiapine 50mg tablet-Take 1 tablet by mouth twice a day".

Resident #3 is prescribed Novolin insulin-Inject subcutaneously 3 times daily with meals in accordance with the following sliding scale coverage: 200-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; >400, call MD. However, resident #3's December 2024 MAR does not include the number of units of insulin that were administered to resident #3 daily from 12/1/24 through the morning of 12/16/24.

REPEAT VIOLATION: 9/16/2024; 6/29/2023; 3/8/2023

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/2024, a review of the resident #1 medication record regarding Ibuprofen 200mg was not present on the medication record from the pharmacy. Upon this finding, the Administrator called the pharmacy to find out why it was removed from the MAR. The pharmacy stated that the medication order had expired. The medication was removed from the cart and discarded immediately.

Upon further review of Resident #1 medication record, another medication error was found. The medication was the Quetiapine 100mg tablet-take 1 tablet by mouth twice a day. This medication was the same as it was when came in. There was no order change found that showed the dosage was dropped to 50mg BID. The house physician was called for an official order for the discontinuation. A discussion was had with the house doctor as for Resident #1. determined that no longer needed the 50mg Seroquel and discontinued it that day. This order was sent to the Administrator. The Administrator removed the 50mg medication from the medication cart. The pharmacy was updated of the order and the new order was sent to them to update the MAR.

187a - Medication Record (continued)

During a medication review of Resident #3, who has an order for Novolin insulin-inject subcutaneously 3 times daily with meals in accordance with the sliding scale, was determined that the number of units given were not being logged at the time of the diabetic check. The employees were reading the sliding scale and following that. The pharmacy was notified and requested to have the units added to the MAR. (DIRECTED: By 1/25/25: The administrator shall check the MAR's for all residents currently prescribed sliding scale insulin coverage to ensure each resident MAR contains an area to document the number of units of insulin that are administered. 1/22/25). In order to ensure that this is logged at all times, all staff members were re-trained and informed to include the number of units of insulin that are being administered to Resident #3 three times daily per sliding scale. For example, if the morning reading is 210, according to the sliding scale, they are to get 4 units of insulin. The reading (210) will be documented in the blood glucose book, and next to the reading will be the number of units of insulin given as well as written on the MAR in the space provided. To ensure accuracy, the Administrator or the house manager will review the blood glucometers weekly beginning 1/26/2025 and compare to the log book and the MAR to ensure that all information is accurate. Cross referencing the current physician orders to f accuracy to the current MAR will be ensured. If there is a discrepancy, the physician will be contacted to get a new order and the MAR will be changed to match.

DIRECTED: By 2/5/25: The administrator shall reeducate all staff persons qualified to administer medications on the home's procedures for updating resident MAR's immediately upon receipt of new orders issued from the prescriber, to ensure each resident has an accurate and complete MAR in accordance with 2600.187a. Documentation of the education shall be kept in accordance with 2600.65i. 1/22/25

Beginning 2/1/2025, during the scheduled QM meeting, a review of all resident MAR's will be done weekly for the next 2 months and done at every QM meeting starting on 04/01/2025. (DIRECTED: The weekly MAR reviews shall be conducted by the administrator/designee to ensure each resident has an accurate and complete MAR in accordance with 2600.187a and in accordance with prescribers' orders. Documentation of the weekly MAR reviews shall be kept for 1 month. The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/05/2025*

Not Implemented (- 03/11/2025)

225a - Assessment 15 Days

18. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department’s assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4's assessment, dated , does not include numerous diagnoses indicated on resident #4's medical evaluation, dated to include Dementia, Acid Reflux, Agitation, Nausea/Vomiting and Edema.

REPEAT VIOLATION: 4/16/2024; 6/29/2023; 3/8/2023

225a - Assessment 15 Days (continued)

Plan of Correction ***Directed (█ - 01/22/2025)***

During an inspection on 12/16/24, it was discovered that Resident #4 had an incomplete assessment in regards to numerous diagnoses. The Administrator completed a new assessment on 12/19/24 to include all of the diagnoses for Resident #4. To become compliant with PA Code 2600.225a, the Administrator and designated employees have been retrained on how to do a proper written assessment and ensure that all diagnoses is documented within the first 15 days of admission.
Beginning 1/22/25, the designated person shall review all resident folders to ensure that all diagnoses are present and accurate. This review will be completed by 1/30/25. The Administrator will review the charts for a complete check to ensure nothing was missed. Any new residents will be entered and double checked by the Administrator and the designated employee within 10 days and signed off on by both people for accuracy.

DIRECTED: Beginning on 3/1/25: The administrator/designee shall review at least 6 different resident assessments per month to ensure each resident has an accurate and complete assessment present in their record. █ 1/22/25

QM meetings are held every 1st and 16th of every month. As of 02/01/25 the administrator and manager will go over the chart reviews that were completed by 1/30/25 and discuss any discrepancies to ensure that all assessments are complete and accurate. (DIRECTED: The quality management review scheduled for 2/1/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/22/25).

Proposed Overall Completion Date: 01/30/2025

Directed Completion Date: *02/01/2025*

Not Implemented (█ - 03/11/2025)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2 is currently receiving Hospice services; however, resident #2's most recent assessment, dated █, does not include the name and contact information for resident #2's Hospice provider.

Resident #2's most recent assessment, dated █, does not include numerous diagnoses indicated on resident #2's most recent medical evaluation, dated █ to include Mood Disorders, Agitation, Constipation and Dry Eyes.

Plan of Correction ***Directed (█ - 01/22/2025)***

2600.225.c During the inspection on 12/16/24, it was discovered that the RASP for Resident #2 didn't contain the Hospice agency name and contact information. The Administrator completed a new assessment for Resident #2 on 12/19/24 to include all necessary information.

It was also discovered that Resident #2 had an incomplete assessment in regards to numerous diagnoses. The Administrator completed a new assessment on 12/19/24 to include all of the diagnoses for Resident #2.

225c - Additional Assessment (continued)

To prevent this from happening in the future, The Administrator and the designated employees were all retrained on 12/19/24 regarding when and how often an assessment will be needed to be updated. This includes anyone who will be doing any type of care for the residents, including Hospice agencies, home health agencies, etc. During that training provided by the Administrator, have also been trained on how to document all of the diagnoses into the assessment plan.

DIRECTED: By 1/30/25: The administrator shall review all current resident records to ensure each resident has an accurate and complete assessment present. Beginning on 3/1/25, the administrator/designee shall review at least 6 different resident assessments per month to ensure each resident has an accurate and complete assessment present in their record. 1/22/25

QM meetings are held every 1st and 16th of every month. As of 02/01/25 the administrator and manager will go over the chart reviews that were completed by 1/30/25 and discuss any discrepancies to ensure that all assessments are complete and accurate. (DIRECTED: The quality management review scheduled for 2/1/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 01/31/2025

Directed Completion Date: *02/01/2025*

Not Implemented (- 03/11/2025)

226a - Mobility Assessment

20. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #4's assessment, dated indicates resident #4 requires some physical assistance with transferring in/out of bed/wheelchair and with ambulation; however, resident #4's assessment indicates the resident is mobile. Also, resident #4's support plan, dated , indicates resident #4 cannot go from sit to stand without assistance.

Plan of Correction ***Directed (- 01/22/2025)***

2600.226.a During an inspection on 12/16/24, it was discovered that Resident #4s assessment was not accurate with the current state of the resident. PA Code 226a states that the resident shall be assessed for mobility needs as part of the resident's assessment. This includes the pre-screening before admission. On 12/19/24, the Administrator completed a new assessment to update the mobility needs of the resident. Upon admission, when the assessment is filled out, it will be accurate and correct with all of the residents needs and mobility issues. To ensure that proper assessments are completed, the Administrator retrained all designated employees who fill out the assessments have been retrained on 12/19/24 on how to do assessment of mobility to ensure accuracy.

DIRECTED: By 1/30/25: The administrator shall review all current resident records to ensure each resident's assessment accurately reflects each resident's current mobility needs. 1/22/25

DIRECTED: By 2/1/25: The administrator shall develop and implement procedures to immediately update resident assessments as mobility needs change. Documentation of the procedures shall be kept. 1/22/25

226a - Mobility Assessment (continued)

QM meeting was held on 01/16/25 and staff person C trained the administrator and designated employees. The administrator and manager will do the residents assessment to ensure each resident has a complete and accurate assessment. During this meeting, residents mobility needs will be assessed. If there is a change, a new Resident Assessment will be done within 24 hours and will replace the existing one. (DIRECTED: The next quality management review scheduled for 2/1/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Not Implemented (- 03/11/2025)

227d - Support Plan Medical/Dental

21. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2 is currently receiving Hospice services; however, resident #2's most recent support plan, dated does not include the specific Hospice services or frequency of Hospice services resident #2 is receiving.

Resident #4's assessment, dated indicates resident #4 requires some physical assistance with transferring in/out of bed/wheelchair and requires some physical assistance with ambulation; however, resident #4's support plan, dated , indicates "N/A" for the description and plan to meet resident #4's mobility needs. Additionally, resident #4's assessment indicates resident #4 has minimal supervision needs and cannot self-administer medications; however, resident #4's support plan indicates "N/A" for the descriptions and plans to meet resident #4's supervision and medication needs.

REPEAT VIOLATION: 9/16/2024

Plan of Correction ***Directed (- 01/22/2025)***

During an inspection on 12/16/24, it was discovered that Resident #2 didn't have specific Hospice services or frequency of services listed on their assessment or support plan. On 12/19/24, the Administrator completed a new support plan to update the Hospice information, including the scope of practice and also the frequency of the visits. On 12/19/24, the Administrator also held a training session with the designated employees who will be performing and inputting the assessments into Tabula Pro. This was covered with how to perform a proper assessment.

227d - Support Plan Medical/Dental (continued)

It was also discovered that Resident #4 had N/A marked for the description and plant to meet residents mobility needs and the supervision and medication needs. On 12/19/24, the Administrator completed a new support plan to include all plans to meet the resident needs. The Administrator also retrained the designated employees on providing the correct assessment on supervision of medications and medication needs and explained that N/A is not an option unless it doesn't apply to that resident. To ensure that this isn't in anyone's assessment, this will be a line item added to the audit sheet for resident folders.

DIRECTED: By 1/30/25: The administrator shall review all current resident records to ensure each resident has an accurate and complete support plan present in their record. █ 1/22/25

DIRECTED: By 2/1/25: The administrator shall develop and implement procedures to immediately update resident support plans as resident care needs change. Documentation of the procedures shall be kept. █ 1/22/25

During the QM meetings, resident folders will be discussed by the Administrator and the designated employee to ensure that, if N/A is present, it actually applies to that resident. If it does not, the assessment will be redone to be accurate. This will occur with all new residents, as well as when there are changes to a current resident. (DIRECTED: The next quality management review scheduled for 2/1/25 shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. █ 1/22/25).

Proposed Overall Completion Date: 02/01/2025

Directed Completion Date: *02/01/2025*

Not Implemented (█ - 03/11/2025)