pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **STERLING HOME LLC**
LEGAL ENTITY

To operate **STERLING HOME**
NAME OF FACILITY OR AGENCY

Located at **1318 ARCH STREET, MCKEESPORT, PA 15132**
(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 **42** (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 **June 4, 2025** until **December 4, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452694**

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: JUNE 4, 2025

[redacted], Owner
Sterling Home LLC
[redacted]
[redacted]

RE: Sterling Home
1318 Arch Street
McKeesport, PA 15132
License/COC#: 452694

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on December 19, 2024, and March 10, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LISs) 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 45269) and issues you a FOURTH PROVISIONAL license to operate the above facility. A FOURTH 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) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (6) (relating to conditions for denial, nonrenewal or revocation). Your FOURTH PROVISIONAL license is enclosed and is valid from June 4, 2025 to December 4, 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.

Your facility's FOURTH PROVISIONAL license will expire on December 4, 2025. Pursuant to 55 Pa. Code § 20.54, a maximum of four consecutive provisional certificates of compliance may be issued to the legal entity for each specific facility or agency (1 Pa. Code. Part II).

If you disagree with the decision to issue a FOURTH 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
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: *STERLING HOME* **License #:** *45269* **License Expiration:** *03/06/2025*

Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *STERLING HOME LLC*
Address: [redacted]
Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *01/30/2023* **Issued By:** *L&I*
Type: *C-2 LP* **Date:** *08/22/2001* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *41* **Waking Staff:** *31*

Inspection Information

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

Reason: *Complaint, Provisional* **Exit Conference Date:** *12/19/2024*

Inspection Dates and Department Representative

12/19/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* **Residents Served:** *41*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *33* **Are 60 Years of Age or Older:** *30*
Diagnosed with Mental Illness: *27* **Diagnosed with Intellectual Disability:** *2*
Have Mobility Need: *0* **Have Physical Disability:** *1*

Inspections / Reviews

12/19/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/09/2025*

01/13/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/01/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *01/20/2025*

01/23/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/01/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *01/30/2025*

05/06/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *02/01/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

At approximately 12:02 p.m., the public and conspicuously posted emergency operations plan in the home's lobby contained a resident list dated 6/28/21 with the full names and dates of birth for all of the home's twenty-one residents at the time of printing that also included the names and dates of birth for current residents of the personal care home to include:

- *Resident #1*
- *Resident #2*
- *Resident #3*
- *Resident #4*
- *Resident #5*
- *Resident #6*
- *Resident #7*
- *Resident #8*

REPEAT VIOLATION 2/15/24 et. al.

Plan of Correction ***Directed (- 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to remove the list from the book that was placed on the welcome table in error.

To enhance the currently compliant operations, on or before 01/10/2025 the Administrator will hold a training for all staff on 2600.17 regulations and need to safeguard the privacy and protected health information of all residents. Moving forward the Administrator will do daily checks in all common areas to ensure confidentiality of all residents' information. The Administrator will be responsible for ongoing compliance

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). 1/23/25

Directed Completion Date: *01/24/2025*

Implemented (- 04/16/2025)

18 - Compliance With Laws

2. Requirements

2600.

18 - Compliance With Laws *(continued)*

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

Description of Violation

In accordance with the Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance."
• However, on 12/19/24 at approximately 11:53 a.m. the carbon monoxide detector located outside of the home's laundry room was approximately six feet from the gas operated EVCON furnace and approximately ten feet from the gas operated State Proline commercial grade hot water heater.
• However, on 12/19/24 at approximately 12:05 p.m. the carbon monoxide detector located outside of the home's A-Hall electrical room next to the pantry was approximately six feet from the gas operated Rheem Classic 90 Plus furnace and approximately four feet from the gas operated Ruud Achiever hot water heater.
• However, on 12/19/24 at approximately 1:50 p.m. the carbon monoxide detector located outside of the home's A-Hall electrical room next to resident room #20 was approximately six feet from the gas operated Rheem Classic 90 Plus furnace.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to relocate all carbon monoxide detectors so that they are in compliance with 2600.18.

To enhance the currently compliant operations, on or before 01/20/2025 a new procedure will be in place that will require the Administrator, or designee will conduct monthly checks to ensure that the detectors are maintained in an appropriate location that meets the requirements of 2600.18 and all carbon monoxide detectors are placed within federal, state and local law ordinances and regulations. The Administrator or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of monitoring/checks. █ 1/23/25

Directed Completion Date: *01/24/2025*

Implemented (█ - 04/16/2025)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51 - Criminal Background Check *(continued)*

Description of Violation

Ancillary staff person A was hired on [redacted]. However, ancillary staff person A did not have a criminal background check in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (relating to protective services for older adults) until 10/2/23.

REPEAT VIOLATION 8/12/24

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken by the administrator to begin auditing all employee records. On or before 01/20/24 the Executive Director will complete the audit. Moving forward a new policy and procedure will be in place that requires the Administrator or designee to conduct background screening prior to the employees first day of employment. The Executive Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented ([redacted] - 04/16/2025)

57b - 1 Hour/Day

4. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 12/6/24 the home's census was 40 total residents to include none with mobility needs, requiring a total of 40 direct care staffing hours; however, on 12/6/24 only 37.5 direct care staffing hours were provided.

Plan of Correction ***Directed ([redacted] - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to review all staffing schedules and to secure and maintain an adequate number of Direct Care Staff at times that is in compliance with 2600.57.

On 12/21/24 the Regional Director provided an education the Administrator to ensure the Administrator understands the staffing requirements in accordance with 2600.57.b

Effective 12/20/2024 a new procedure will be in place in which weekly checks of the staffing schedule will be reviewed before posting the schedule to maintain ongoing compliance with ensuring direct care staff persons are available to provide at least 1 hour per day of personal care services to each mobile resident. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. The Executive Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of

57b - 1 Hour/Day (continued)

education in accordance with Regulation 2600.65(i). █ 1/23/25

Directed Completion Date: *01/24/2025*

Implemented (█ - 04/16/2025)

57d - Waking Hours

5. Requirements

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

Description of Violation

On 12/6/24 the home's census was 40 total residents to include none with mobility needs, requiring a total of 40 direct care staffing hours of which 30.75 must be waking hours; however, on 12/6/24, only 30 direct care staffing hours were provided during waking hours.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to when creating the schedule making sure there is always enough direct care staffing hours during waking hours.
On 12/21/24 the Regional Director provided an education the Administrator to ensure the Administrator understands the staffing requirements in accordance with 2600.57.d

Effective 12/20/2024 a new procedure will be in place in which weekly checks of the staffing schedule will be reviewed before posting the schedule to maintain ongoing compliance with ensuring direct care staff persons are available to provide at least 1 hour per day of personal care services to each mobile resident. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. The Executive Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Directed Completion Date: *01/24/2025*

Implemented (█ - 04/16/2025)

60a - Staff/Support Plan

6. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 12/6/24, direct care staff person B worked alone from 11:00 p.m. until 7:00 a.m. on 12/7/24 and was not qualified to pass prescribed pro re nata (PRN) medications if requested by the home's residents.

60a - Staff/Support Plan (continued)

On 12/13/24, direct care staff person B worked alone from 11:00 p.m. until 7:00 a.m. on 12/14/24 and was not qualified to pass prescribed pro re nata (PRN) medications if requested by the home's residents.

Plan of Correction ***Accept (- 01/13/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to ensure that there is a med tech on every shift so that if a resident may need any medication, it will be ready and available.

To enhance the currently compliant operations, as of 12/20/2024 the Administrator or designee will review schedule weekly before posting to ensure there is a qualified med tech on every shift, with a completion date of 01/10/25 Any deficiencies will be corrected immediately, and findings will be documented and reported to the Administrator for further review and continuous improvement. The Administrator or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented (- 04/16/2025)

63a - First Aid/CPR Training

7. 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

On 12/13/24 there were 41 residents present in the home, however, direct care staff person C and direct care staff person D were the only staff working in the home and were not trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 6:00 p.m. until 11:00 p.m.

On 12/14/24 there were 41 residents present in the home, however, direct care staff person C and direct care staff person E were the only staff working in the home and were not trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 7:00 a.m. until 10:00 a.m.

Plan of Correction ***Accept (- 01/13/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to ensure there is at least one staff person for every 50 residents who is trained in first aid and CPR present and in the home at all times.

As of 12/20/24 a new procedure will be in place that the Executive Director or designee must check the schedules weekly to ensure that at all times at least one staff person has CPR and 1st aide is present in the building at all times. The Executive Director or designee will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented (- 04/16/2025)

65i - Training Record

8. Requirements

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

Description of Violation

The training record for direct care staff person F did not include the source of the training or the content of the training for the required annual topics during the 2023 training year.

The training record for direct care staff person G did not include the source of the training or the content of the training for the required annual topics during the 2023 training year.

The record of training for direct care staff person D's initial orientation and first working week's training did not indicate the trainings, the length, the source, the contents, or the topics, and were just signed and dated copies of regulations 2600.65(a-g).

The record of training for ancillary staff person A's initial orientation and first working week's training did not indicate the trainings, the length, the source, the contents, or the topics, and were just signed and dated copies of regulations 2600.65(a-g).

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to initiate a new annual staff training plan and a new policy will be in effect on or before 01/31/25. Additionally, on or before 01/15/25 an audit will be conducted on all employee records and all employees not meeting the annual training requirements will be scheduled to train and complete all required training topics on or before 02/15/25.
The administrator made a new annual training plan. All corrective action will be completed by 2-15-25.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall review Regulation 2600.65(i). █ 1/23/25

Within three days of receipt of the accepted plan of correction: The administrator shall develop and implement a system to document all staff training in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall reconcile all staff training records. If the staff training records cannot be reconciled in accordance with Regulation 2600.65(i) the administrator shall reeducate the staff persons on the training topics not documented in accordance with Regulation 2600.65(i).

Within five days of receipt of the accepted plan of correction: The administrator shall educate the staff responsible to implement the new policy and procedures. Documentation of education will be kept in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall conduct monthly monitoring of all staff education documentation to ensure compliance with Regulation 2600.65(i). Documentation of monitoring

65i - Training Record (continued)

will be kept. █ 1/23/25

Directed Completion Date: *01/28/2025*

Not Implemented (█ - 04/16/2025)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

At approximately 10:31 a.m. there was a pervasive odor of urine coming from the back right corner of the rear television room off the D-Hall that leads to the deck and smoking area.

At approximately 10:45 a.m., the ceiling fan in the D-Hall full bathroom next to resident room #5 was heavily matted with white and grey fibrous lint that coated the spaces between the fan slats.

At approximately 10:45 a.m., the flooring throughout the D-Hall full bathroom was dirty to include dark substances that appeared to be mud or other brown debris and various bits of paper, dust and dirt.

At approximately 11:30 a.m., the ceiling fan in the C-Hall half-bathroom next to resident room #11 was heavily matted with white and grey fibrous lint that coated the spaces between the fan slats.

At approximately 11:38 a.m. there was a build-up of cobwebs above resident █ in resident room #13 belonging to resident █ and resident █.

At approximately 11:38 a.m. there was a heavy build-up of dust and lint on the return air vent in resident room #13 belonging to resident █ and resident █

At approximately 1:11 p.m. there was a build-up of cobwebs all over the ceilings and walls of resident room #7 belonging to resident █ and resident █.

At approximately 1:59 p.m. in the shared half-bathroom of resident room #21 belonging to resident █ and resident █ there was what appeared to be a reddish-orange mold as well as fungus and what appeared to be a mushroom cap growing where the wall meets the floor to the right of the toilet. Additionally, there was what appeared to be feces on the floor, toilet seat, and in the sink of the shared half-bathroom.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by housekeeping to promptly clean the fans in C and D halls, cobwebs in rooms 7 and 9 as well as the urine odor in the rear living room area and cleaning of the floors and all the other soiled areas. Additionally, on 12/20/24 the Administrator scheduled maintenance to clean the air vents and room #21 bathroom needing fixed.

85a - Sanitary Conditions (continued)

On 12/21/24 the Executive Director conducted a room to room walk through to determine other areas that need to be cleaned or addressed in accordance with 2600.85a.

On or before 01/15/25 the Executive will ensure that any deficiencies in all resident rooms are addressed.

On or before 02/10/25 the Executive will implement a new housekeeping schedule and educate the housekeeping staff to ensure all resident rooms and common spaces are being cleaned adequately and in compliance with 2600.85a. The Executive Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator or designee shall correct the heavy build-up of dust and lint on the return air vent in resident room #13 belonging to resident and resident ,the reddish-orange mold as well as fungus and mushroom cap growing where the wall meets the floor to the right of the toilet seat, and in the sink of the shared half-bathroom of resident room #21 belonging to resident and resident 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.85(a) and the home's policy and procedures to maintain compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator or a designee shall audit the home weekly to ensure sanitary conditions are maintained. Documentation of audits shall be kept. 1/23/25

Directed Completion Date: *01/28/2025*

Not Implemented (- 04/16/2025)

87 - Lighting

10. 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

At approximately 11:19 a.m., the light fixture outside of the emergency exit door and pathway leading to the rear of the home and the dumpster area was missing and there was no other source of exterior lighting on the emergency evacuation route.

Plan of Correction ***Directed (- 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 to schedule a repair of the exterior light. The light will be repaired on or before 01/10/25.

On or before 01/01/25 a new procedure will be in place that the Administrator will be expected to facilitate walk throughs the facility weekly to ensure lights are in working order and in compliance with 2600.87.

87 - Lighting (continued)

The Executive Director or Designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall educate all staff on the requirements of Regulation 2600.87 and the home's policy and procedures to maintain compliance with the regulation. Documentation of education will be kept in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of weekly audits are kept. █ 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

88a - Surfaces

11. Requirements

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

Description of Violation

At approximately 10:45 a.m. the plaster on the right side-corner of the shower stall in D-Hall full bathroom was deteriorated in two areas, the first area measured approximately one-foot high by two-inches wide and exposed the metal corner bead below. The second area was also approximately one-foot by two-inches but was on the inner wall of the shower stall and exposed the metal corner bead below.

At approximately 10:45 a.m., the shower-pan in the D-Hall full bathroom next to resident room #5 was cracked in a circular shape around where the floor drain and flange connect to the shower-pan which created an opening for water to leak beneath the shower-pan on to the sub-floor below and created a hazard for resident's skin and their feet while using the shower.

At approximately 11:24 a.m. there were two capped electrical wires dangling from a hole in the top of the doorframe plaster for the emergency exit door that leads to the rear of the home and the dumpster area.

At approximately 1:59 p.m. in the shared half-bathroom of resident room #21 belonging to resident █ and resident █ there was damage to the drywall to the left of the toilet in two areas, the first was a hole created by the door knob and measured approximately five-inches wide by one-and-one-half-inch high, the second area was depressed drywall in the shape of a fist near the grab bar that measured approximately four-inches wide by three-inches high.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to schedule all repairs to completed on or before 01/17/25.

The Administrator will ensure that all of these issues are fixed and within compliance in the appropriate time frame, with a completion date of 01/17/2025.

88a - Surfaces (continued)

Effective 12/20/2024 the Administrator will perform weekly facility walkthroughs to maintain ongoing compliance with ensuring floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

On or before 01/25/25 the Executive Director will facilitate a staff education to inform all staff they must report any all issues to the Executive Director immediately so compliance can be maintained.
The Executive Director or designee will be responsible for ongoing compliance.
D-Hall bathroom is set to be fixed starting on 1-23-25 with an anticipated completion date of 1-30-25. Maintenance took care of room #21.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of weekly audits are kept. █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of education will be kept in accordance with Regulation 2600.65(i). █ 1/23/25

Directed Completion Date: *01/28/2025*

Not Implemented (█ - 04/16/2025)

95 - Furniture and Equipment

12. Requirements

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

Description of Violation

At approximately 10:39 a.m. the handrails on the right-side wall in D-Hall leading to the rear television room were loose and partially disconnected to include the approximate seven-foot rail to the left of resident room #6 and the two-foot rail between resident room #5 and the full bathroom immediately to the right.

At approximately 11:05 a.m. in resident room #5 belonging to resident █ and resident █ there was damaged light fixture that still had a light bulb and the light shade harp attached that was hanging loosely behind a standing cabinet in the resident room and was still attached to the wall by the electrical housing wiring. Additionally, the wire that entered the electrical housing at the base was cut off and left with an approximately two-inch long "pigtail" hanging out of the wall.

At approximately 1:59 p.m. the wax ring or other plumbing of the toilet in the shared half-bathroom of resident room #21 belonging to resident █ and resident █ had failed, and water was leaking on to the bathroom floor and pooling against the tile seam where the floor meets the wall along the left side of the bathroom.

At approximately 2:23 p.m. the toilet bowl tank in the B-Hall bathroom across from the home's dining room was missing the lid and all the internal plumbing was left exposed. Additionally, the entire toilet was loose, was not

95 - Furniture and Equipment (continued)

securely bolted to the bathroom floor, and was held in place by a wooden shim.

REPEAT VIOLATION 2/15/24 et. al.

Plan of Correction ***Directed (- 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 the administrator to schedule repairs. These include handrails and foot rails being loose, the light fixture behind the dresser in room #5 room #21's bathroom as well as tank in the bathroom in B-hallway with a scheduled completion date of 1-10-25.

As of 12/20/24 the Executive Director will be required to facilitate weekly walk throughs of the building to ensure ongoing compliance.
On or before 01/25/25 the Executive Director will facilitate a staff education to inform all staff they must report any all issues to the Executive Director immediately so compliance can be maintained.

The Executive Director or designee will be responsible for ongoing compliance.

Maintenance Man completed each task in this violation.
On or before

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of weekly audits are kept. 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of education will be kept in accordance with Regulation 2600.65(i). 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (- 04/16/2025)

100a - Exterior - Free of Hazards

13. Requirements

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

Description of Violation

At approximately 11:20 a.m. to the right of the latched gate from the emergency exit route to the home's dumpster area, there were multiple pieces of uncovered trash scattered around the rear yard of the home to include five stacked used medicine cups, used sweet and low packets, various plastic container lids, and two shattered glass bottles of what appeared to be alcohol that created a hazard.

Plan of Correction ***Directed (- 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to clean up the area surrounding the dumpster.

100a - Exterior - Free of Hazards (continued)

As of 12/20/24 a new procedure will be in place that requires the Executive Director to make weekly building rounds to ensure all physical site areas are clean, safe and in good repair which includes the exterior grounds. The Executive Director will be required to address any areas of concerns immediately either be scheduling applicable clean up or repairs.

On or before 02/10/25 the Executive will facilitate a training will all staff that includes proper disposal of trash, reporting of grounds repairs and hazards.

The Executive Director will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of weekly audits are kept. █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of education will be kept in accordance with Regulation 2600.65(i). █ 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

At approximately 1:11 p.m. the bedsheets for resident #12 in resident room █ were soiled with what appeared to be dirt and other debris, and the resident could not recall the last time clean sheets were provided.

REPEAT VIOLATION 8/12/24

Plan of Correction ***Directed (█ - 01/23/2025)***

Following the inspection on 12/19/24 the Executive Director ensured that resident #12's soiled linens were removed and replaced with clean linens.

Effective 12/20/24 the Executive Director will perform weekly checks to maintain ongoing compliance. On or before 02/10/25 the Executive Director will facilitate a training with all housekeepers and Direct Care staff to ensure ongoing compliance.

Moving forward, the Executive Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

101j3 - Bed/Linens/Pillows/Blankets (continued)

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of weekly audits are kept. █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of education will be kept in accordance with Regulation 2600.65(i). █ 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

102c - Tub/Shower - 10 users

15. Requirements

2600.
102.c. There shall be at least one bathtub or shower for every ten or fewer users, including residents, staff persons and household members.

Description of Violation

The home is licensed for a capacity of 42 residents, and on 12/19/24 reported a census of 41 residents. However, on 12/19/24 there were only four tub/showers to serve all the residents of the personal care home and the home's staff indicated the shower stall in the B-Hall bathroom that was missing the cold-water control knob was not in use, leaving only three usable tub/showers for the home's 41 residents to bathe in. Interviews with direct care staff indicated another bathroom with a tub/shower stall in the C-Hall was currently being used for a storage space and not as a functional bathroom.

Plan of Correction ***Directed (█ - 01/23/2025)***

Immediately following the inspection on 12/0/24, the Executive Director scheduled repairs to ensure to that there are at least 5 working showers in order to ensure there is one working shower for every 10 residents. The estimated completion date for this is on or before 01/10/25.

On 12/26/24 The Regional Director retrained on the Executive Director on the expectations of 2600.102c and overall responsibilities as it relates to PA 2600 compliance.

A new policy and procedure will be in place on or before 02/25/25 to ensure that all site issues relating to repairs are addressed promptly by the Executive Director.

Moving forward, the Executive Director and Maintenance Director will be responsible for ongoing compliance.
The D-Hall bathroom is set to start being fixed on 1-23-25 with and anticipated completion date of 1-30-25. My census currently is 38 residents as opposed to 41 at inspection so we will have all working bathrooms when my census reaches full capacity again.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator or designee shall audit the home weekly home to ensure compliance with regulation 2600.102(c). Documentation of audits shall be kept. █ 1/23/25.

Within one day of receipt of the accepted plan of correction: The administrator shall ensure documentation of

102c - Tub/Shower - 10 users (continued)

education is kept in accordance with Regulation 2600.65(i). ▇ 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (▇ - 04/16/2025)

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

16. 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

At approximately 10:45 a.m. the grab rail to the right of the sink in the D-Hall full bathroom located next to resident room #5 was not firmly attached to the wall. Additionally, the grab bar in the toilet stall of the same bathroom on the right side of the stall was not firmly secured to the wall.

Plan of Correction ***Directed (▇ - 01/23/2025)***

On 12/20/24 immediately following the inspection the Executive Director scheduled repairs for the grab rail and bar.

On 12/26/24 The Regional Director retrained on the Executive Director on the expectations of 2600.102d and overall responsibilities as it relates to PA 2600 compliance.
A new policy and procedure will be in place on or before 02/15/25 to ensure that all site issues relating to repairs are addressed promptly by the Executive Director.
The administrator will be in charge of weekly monitoring to ensure compliance.

The Executive Director and Maintenance Director will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). ▇ 1/23/25

Within one day of receipt of the accepted plan of correction: The administrator shall ensure documentation of audits are Kept. ▇ 1/23/25.

Directed Completion Date: *01/24/2025*

Implemented (▇ - 04/16/2025)

102e - Privacy - Doors/Partitions

17. Requirements

2600.
102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

At approximately 1:59 p.m. the bathroom door would not fully close to allow privacy for either resident in the shared half-bathroom of resident room #21 belonging to resident ▇ and resident ▇

102e - Privacy - Doors/Partitions *(continued)*

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator in response to the violation on 12-19-24 by the Pennsylvania Bureau of Human Services Licensing, to schedule repairs on Room #21's bathroom door.

The estimated completion date for the repair is 1-13-25.

Effective 12/20/2024 the Administrator will perform weekly physical site checks throughout the building and will be responsible to address any deficiencies in a timely manner.

The Executive Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECETD
Within five days of receipt of the accepted plan of correction: The administrator shall educate all staff persons regarding Regulation 2600.102(e) and the home's policy and procedures to ensure compliance. Documentation of education shall be kept in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of weekly audits are kept. █ 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

102f - Towel/Washcloth/Soap

18. Requirements

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

At approximately 10:45 a.m. there was a used but dried washcloth that was not labeled with any resident's name found sitting on the first shelf in the cabinet to the left of the shower stall in the D-Hall full bathroom next to resident room #5.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to have the housekeeping staff replace each individual resident's washcloth and to identify each resident's items.

On or before, 12/26/24 the Executive Director will complete a room audit to ensure that all residents have an individual towel, washcloth and soap. Upon completion of the audit the resident will address any areas that need to be corrected immediately.

On or before 02/10/25 that Executive Director will train all the applicable staff on 2600.102f to ensure ongoing compliance.

102f - Towel/Washcloth/Soap (continued)

The Executive Director and Designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Within one day of receipt of the accepted plan of correction: The administrator shall ensure documentation of audits are Kept. █ 1/23/25.

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

102i - Soap Dispenser

19. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At approximately 10:45 a.m. there was a bar of Irish Spring bath soap that was not labeled with the name of any resident that was found on the first shelf in the cabinet to the left of the shower stall of the D-Hall full bathroom next to resident room #5. Additionally, there was a used bar soap of an unknown brand found on the top left shelf of the shower stall that did not indicate any resident's name.

Plan of Correction ***Directed (█ - 01/23/2025)***

On 12/19/24 in response to the Department of Human Services inspection, the administrator removed the new and used bar soaps from the bathroom.

On 12/21/24 all residents' individual soap if applicable was labelled in the interim. On or before 01/10/25 the Administrator ordered dispenser items for each bathroom and will have them installed on or before 01/25/25 to ensure ongoing compliance.

On or before 02/10/25 All applicable staff will be educated on regulation 2600.102j and the applicable procedures to ensure ongoing compliance.

Effective 12/20/24 the Executive Director will conduct weekly building walkthrough in order to address any concerns.

The Executive Director and designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

102i - Soap Dispenser (continued)

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of audits are Kept. █ 1/23/25.

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

103g - Storing Food

20. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 2:18 p.m. there was a full size two-and-one-half inch deep hotel pan that was approximately one half full of bite size smoked sausages coated in what appeared to be barbecue sauce that was found partially wrapped with aluminum foil in the kitchen's two-door upright cooler.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the kitchen staff to immediately dispose of the pan of sausages from the refrigerator in the kitchen and staff was educated hat everything must be dated and fully covered in all refrigerators in accordance with 2600.103.g.

On or before 01/10/2025 the Administrator will put in place a daily procedure for the kitchen staff to check all food storage to ensure that there will be no food stored in any of the facility refrigerators uncovered and not dated properly. The Kitchen staff will be educated on the new procedure on or before 01/10/25.

The Executive Chef and Kitchen Manager will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator shall ensure documentation of audits are Kept. █ 1/23/25.

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

141a 1-10 Medical Evaluation Information

21. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #11's initial medical evaluation, dated [redacted], indicated "See medication addendum," however, there were no medications listed and there was no medication list or addendum attached to the form.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to attach the med list to this specific DME and then make sure moving forward once the DME is completed, if necessary, have the proper documents available.

To enhance the currently compliant operations, on or before 01/13/25 the Director of Wellness will audit all DME's and ensure all medications are listed and if not attach a medication list. On 12/22/25 the Executive Director trained the Director of Wellness and the designee on the requirements of 141.a.

The Executive Director and Wellness Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented ([redacted] - 04/16/2025)

144c1 - Smoking Area Guidelines

22. 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

At approximately 10:08 a.m., there were hundreds of cigarette butts scattered around the home's designated smoking area and in between the slats of the wooden decking. Additionally, the trash can in the home's smoking area was completely overfilled and forced the flip lid open with an empty can of Pepsi protruding through the opening with to two cigarette pack boxes and a cigarillo wrapper.

Plan of Correction ***Directed ([redacted] - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Administrator to have the designated smoking area cleaned up by staff.

144c1 - Smoking Area Guidelines (continued)

Effective 12/20/25 a procedure will be in place for the Executive Director to complete daily walk throughs of common areas to ensure safety, cleanliness and compliance in regard to 2600.144c.

On or before 1/13/25 a daily procedure will be in place for designated staff to check and clean up the designated smoke area.

The Executive Director or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall educate all staff persons regarding Regulation 2600.144(c)(1) and the home's policy and procedures. Documentation of education will be kept in accordance with Regulation 2600.65(i).

Within five days of receipt of the accepted plan of correction: The administrator shall educate all residents of the home's policy and procedures and home rules regarding smoking. █ 1/23/25

Within one day of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Directed Completion Date: *01/28/2025*

Not Implemented (█ - 04/16/2025)

183d - Prescription Current

23. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #11's MAPAP 325mg (Acetaminophen) tablets were found on the medication cart on 12/19/24 at approximately 3:19 p.m., however, the medication was stopped on 12/10/24.

Resident #11's Acetaminophen 500mg caplets were on the medication cart at approximately 3:12 p.m. on 12/19/24, however medication was ordered as needed for 7 days beginning 12/10/24.

Resident #15's MiraLAX powder was found on the medication cart on 12/19/24 at approximately 2:51 p.m., however, that medication did not appear on the December 2024 medication administration record and staff interviews with the home's medication technicians indicated the medication had been stopped on an unknown date.

Plan of Correction ***Directed (█ - 01/23/2025)***

In response to the violation on 12/19/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 12/20/2024 by the Med Tech to remove the items off the cart.

183d - Prescription Current (continued)

On 12/20/2024 the Director of Nursing audited medication cart to remove all items that should be on the cart and contacted the pharmacy to schedule a more n depth medication cart audit.

The Director of Nursing will complete a medication training with all med techs on or before 02/10/25 to ongoing compliance with 2600.183.

The Executive Director, Director of Wellness or designee will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall conduct a weekly medication cart audit in conjunction with resident MARs to ensure compliance with Regulation 2600.183(d). Documentation of audits shall be kept. █ 1/23/25

Directed Completion Date: *01/28/2025*

Not Implemented (█ - 04/16/2025)

187a - Medication Record

24. Requirements

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 #11 was prescribed Hydrocortisone 1% USP Cream, apply 1 application externally twice a day as needed for itching for 10 days beginning 12/6/24. However, resident #11's Hydrocortisone 1% USP cream was not included in the December 2024 medication administration record (MAR) to document the medication if requested by the resident.

187a - Medication Record (continued)

Resident #13 was prescribed Trazodone tablet 50mg, take one, tablet by mouth at bedtime. However, that medication was discontinued on 12/12/24 but still appeared as a current order on resident #13's December 2024 MAR.

Resident #13 is prescribed Insulin Lispo 100 Unit/mL, inject per sliding scale 3 times daily with meals: 0-150=0U; 151-200=4U; 201-250=6U; 251-300=8U; 301-350=12U; 351-400=14U; 401-450=18U; 451-500=20U; >500=22U & if unwell send." However, resident #13's December 2024 MAR does not contain spaces for units administered or site of injection, and there has been no tracking of insulin administration other than readings taken for the month of 12/2024.

REPEAT VIOLATION 2/15/24 et. al.

Plan of Correction ***Directed (█ - 01/23/2025)***

On 12/20/24, the Director of Wellness began an internal audit of the medication record system to be completed on or before 12/26/24.

Upon completion of the Audit the Director of Nursing will identify all deficiencies and will conduct a training with all Medtechs on or before 01/15/25 on how to properly document on the Medication Record in order to ensure ongoing compliance.

This will be added to the annual Quality Plan Meeting to review ongoing procedures and training to ensure ongoing compliance.
Orders are attached and pharmacy put a spot to record resident #13 units administered immediately.

The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall conduct a weekly medication cart audit in conjunction with resident MARs to ensure compliance with Regulation 2600.187(a). Documentation of audits shall be kept. █ 1/23/25

Directed Completion Date: *01/28/2025*

Not Implemented (█ - 04/16/2025)

187b - Date/Time of Medication Admin.

25. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #11 was prescribed Acetaminophen 500mg caplets, take two tablet (1000mg) by mouth every 6 hours as needed for 7 days." The order was written on 12/10/24 and the blister pack of medication still contained two doses of

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

Acetaminophen. However, resident #11's December 2024 medication administration record (MAR) did not document the administration of the pro re nata doses of Acetaminophen 500mg caplets, those areas were left blank.

Resident #15 was prescribed numerous medications to include:

- *Atorvastatin 10mg tablet, take by mouth one tablet at bedtime*
- *Carvedilol 25mg tablet, take by mouth one tablet twice a day*
- *Hydrocortisone 2.5% cream, apply to both feet twice a day*
- *Lantus Solostar 100Unit/mL, inject 12 units subcutaneously at bedtime*
- *Losartan 50mg tablet, take 1 tablet by mouth 2 times daily*
- *Risperidone 2mg tablet, take by mouth 1 tablet at bedtime*
- *Trazodone 50mg tablet, take by mouth one tablet at bedtime*
- *Ventolin HFA 90mcg 200A, inhale 2 puffs by mouth 2 times daily (8AM & 8PM)*

However, on 12/14/24, the medications were administered but not documented on the December 2024 MAR by direct care staff person H at the time of administration and those areas of the MAR were left blank.

Resident #9 was prescribed numerous medications to include:

- *Atorvastatin 80mg tablet, take one tablet by mouth once daily at bedtime*
- *Carbamazepine 200mg tablet, take 1 tablet by mouth every 8 hours*
- *Olanzapine 2.5mg tablet, take 1 tablet by mouth once daily at bedtime*
- *Perphenazine 8mg tablet, take by mouth 1 tablet daily at bedtime*
- *Polyethylene glycol powder, mix 17 grams in 8 ounces of water and take by mouth 2 times daily*
- *Senna Lax tab 8.6mg, take two tablets by mouth at bedtime*
- *Trazodone 100mg tablet, take 1 tablet by mouth once daily at bedtime*

However, on 12/14/24, the Carbamazepine 200mg tablet was administered at approximately 3:00 p.m. and all other medications were administered at approximately 8:00 p.m., but were not documented on the December 2024 MAR by direct care staff person H at the time of administration and those areas of the MAR were left blank.

Resident #13 was prescribed numerous medications to include:

- *Atorvastatin 40mg tablet, take one tablet by mouth once daily at 5 p.m.*
- *Insulin Lispo 100 Unit/mL, inject per sliding scale 3 times daily with meals: 0-150=0U; 151-200=4U; 201-250=6U; 251-300=8U; 301-350=12U; 351-400=14U; 401-450=18U; 451-500=20U; >500=22U & if unwell send.*
- *Lantus Solostar 100UN/mL, inject 50 units subcutaneously at bedtime*
- *Metoprolol 50mg tablet, take by mouth 1 tablet twice daily*
- *Sertaline 50mg tablet, take by mouth 1 tablet at bedtime*
- *Trazodone 50mg tablet, take by mouth1 tablet at bedtime*

However, on 12/14/24, the Insulin Lispro per sliding scale was administered at approximately 12:00 p.m. by direct care staff person C and was not documented on the December 2024 MAR at the time of administration and was left blank. Resident #13's Atorvastatin was administered at approximately 5:00 p.m. and the remaining medications were administered at approximately 8:00 p.m. but were not documented on the December 2024 MAR by direct care staff person H at the time of administration and those areas of the MAR were left blank.

REPEAT VIOLATION 2/15/24 et. al.

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

Plan of Correction ***Directed (█ - 01/23/2025)***

On 12/20/24, the Director of Wellness began an internal audit of the medication record system and proper documentation of medication administration to be completed on or before 12/26/24.

Upon completion of the Audit the Director of Nursing will identify all deficiencies and will conduct a training with all Medtechs on or before 01/15/25 on how to properly document on the Medication Record and to ensure that documentation is done at time of administration in order to ensure ongoing compliance.

This will be added to the annual Quality Plan Meeting to review ongoing procedures and training to ensure ongoing compliance.

The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Proposed Overall Completion Date: 01/21/2025

DIRECTED
Within five days of receipt of the accepted plan of correction: The administrator shall keep documentation of education in accordance with Regulation 2600.65(i). █ 1/23/25

Within five days of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall conduct a weekly MAR audit to ensure compliance with Regulation 2600.187(b). Documentation of audits shall be kept. █ 1/23/25

Directed Completion Date: *01/28/2025*

Implemented (█ - 04/16/2025)

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

Facility Information

Name: *STERLING HOME* **License #**: *45269* **License Expiration**: *03/06/2025*

Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *STERLING HOME LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/30/2023* **Issued By**: *L&I*
Type: *C-2 LP* **Date**: *08/22/2001* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *40* **Waking Staff**: *30*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date**: *03/10/2025*

Inspection Dates and Department Representative

03/10/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* **Residents Served**: *40*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *29* **Are 60 Years of Age or Older**: *34*
Diagnosed with Mental Illness: *40* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

03/10/2025 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/24/2025*

03/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/08/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/31/2025*

04/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/08/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/08/2025*

05/06/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/08/2025*

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

65i - Training Record

1. Requirements

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

Description of Violation

The record of training for direct care staff person A's initial orientation was dated [redacted] and did not indicate the date, source, content, or length of course.

The home provided the Department with training documents with staff training on 1/15/25 to include 7 staff for a total of 10 hours and 15 minutes of training. However, interviews indicate that only 2 hours and 15 minutes of training were completed on 1/15/25.

Plan of Correction ***Directed ([redacted] - 04/01/2025)***

Effective immediately, the facility has enrolled all staff into an online training platform called Relias to complete all trainings online through this program as well as the trainings we will do here within the facility. This training platform will provide date, source, content and length of course in accordance with 2600.65i. All trainings will be completed no later than 3-31-25. The facility will continue to host in person trainings as well and those trainings maybe manually tracked in a Binder that is overseen by the Administrator in her office and that indicates the date, source, content, or length of course in accordance with 2600.65i. The Administrator will ensure that all staff complete any outstanding required training and will continue to offer ongoing trainings that are in line with 2600.65i.

Staff person A as well as all staff completed all required trainings on Relias and are up to date. All staff trainings have been reviewed by the Executive Director and moving forward and new hires will complete all trainings on Relias before they are physically put on the schedule and on the floor.

Proposed Overall Completion Date: 03/31/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator shall review all of the staff training and documentation through the quality management review process to ensure compliance with Regulation 2600.65(i) [redacted] 41/25

Directed Completion Date: *04/02/2025*

Not Implemented ([redacted] - 04/16/2025)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

At approximately 10:17 a.m., in the shared bathroom of resident room #21 belonging to resident [redacted] and resident [redacted] there was what appeared to be feces smeared on the toilet seat, two small pieces of what appeared to be feces resting on the back ledge of the toilet bowl, and what appeared to be feces smeared on the wall near the grab bar to the left of the toilet. Additionally, there was what appeared to be fecal matter on the light switch and wall plate cover.

85a - Sanitary Conditions (continued)

At approximately 10:37 a.m., there was what appeared to be blood and/or feces smeared over the light switch and surrounding wall around the light switch and wall plate cover in the B-Hall full bathroom across from the home's dining area.

At approximately 10:44 a.m., the Advantco cooler in the home's kitchen had unidentifiable bits of food debris, dust and what appeared to be rust on the entire top ledge of the lower stainless steel vent cover.

At approximately 11:04 a.m. there was a brown substance of unknown origin in an area measuring approximately one-inch-by-one-inch that appeared to be feces smeared on the wall across from the toilet and to the right below the handrail of the C-Hall half bathroom.

Plan of Correction ***Directed (- 04/01/2025)***

In response to the violation 2600.85.a Resident and bathroom was immediately cleaned ,B-Hall full bathroom was immediately cleaned ,the C-hall half bathroom was immediately cleaned as well the Advantco cooler by the cleaning staff following the inspection on 3-10-25. Also, the cleaning staff scheduling hours are going to be changed to allow for more adequate coverage in the early morning hours. Additionally, a checklist will be put in place for each time the bathroom is cleaned, and the housekeepers will need to check the public bathrooms every two hours during the day. This new procedure and new schedule and assignments will be reviewed with the housekeeping department by the administrator and will be implemented by 03/28/25. The Administrator will check the checklist and respective bathrooms twice per day to ensure cleanliness. All other Direct Care Staff will be expected to assist with cleaning the resident's room during AM and PM Care and all staff will be informed of the requirement to report any unsanitary conditions immediately to the Administrator. The Administrator will review these expectations with all staff by 03/28/25. As of 03/28/25 the Administrator will now check the kitchen daily to ensure the staff is has a good daily cleaning routine to ensure ongoing compliance.

Proposed Overall Completion Date: 03/31/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator shall ensure the blood and/or feces smeared over the light switch and surrounding wall around the light switch and wall plate cover in the B-Hall full bathroom across from the home's dining area is cleaned and sanitized. 4/1/25

Directed Completion Date: *04/02/2025*

Not Implemented (- 04/16/2025)

85b - Infestation

3. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

There was an active bedbug infestation in the shared resident bedroom #19 belonging to resident and resident bed bug carcasses were observed on the ceiling and walls as well as captured in spider webs in the corners of the bedroom behind the bedroom door. Additionally, there was a multitude of bed bug carcasses scattered all over the bedroom floor both behind bedside tables and on other surfaces of the room.

85b - Infestation *(continued)*

Plan of Correction ***Directed (- 04/01/2025)***

In response to violation 2600.85.b Room 19 has since been treated by Pestco and cleaned thoroughly by staff daily. The administrator contacted Pestco and will follow any recommendations by Pestco to help rectify the issue more efficiently.

Room #19 will be audited by the Executive Director every Monday to monitor the progress of treatments. Documentation will be kept in the Executive Director's POC Audit binder. Audits will begin on 4-1-25 and continue until the problem is resolved.

Proposed Overall Completion Date: 03/31/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator or designated staff person shall audit the home daily to ensure compliance with Regulation 2600.85(b). Documentation of audits shall be kept. 4/1/25

Directed Completion Date: *04/02/2025*

Not Implemented (- 04/16/2025)

85e - Trash Outside Home

4. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 9:10 a.m. the left side of the home's dumpster was left open with approximately six full garbage bags within, and there were multiple pieces of garbage on the ground behind the dumpster to include to-go packaging for food and an empty gallon of Clorox Bleach.

Plan of Correction ***Accept (- 03/26/2025)***

In response to violation 2600.85.e the administrator immediately on 3-10-25 contacted the waste company. The company feels a second dumpster will not work because of the placement of our dumpster therefore we will be getting picked up 3x a week on Mondays, Wednesdays and Fridays so that our lids will remain shut. Administrator will also posted a sign-off sheet that whoever has to take the trash out, they are to date, sign and check that the lids remain closed. Administrator will monitor this daily.

Licensee's Proposed Overall Completion Date: *03/28/2025*

Not Implemented (- 04/16/2025)

88a - Surfaces

5. Requirements

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

Description of Violation

At approximately 10:39 a.m. the ceiling plaster surrounding the sprinkler unit to the left of resident room #1 was blistered and damaged by what appeared to be a water leak. The ceiling plaster was cracked, bubbled, blistered, and

88a - Surfaces (continued)

peeling away and hanging from the ceiling and the light fixture on the ceiling in an area that measured approximately two-feet-by-three feet.

Plan of Correction ***Directed (- 04/01/2025)***

On March 11th Maintenance Director was immediately called and fixed the area. There are no active issues. Executive Director will add this o her weekly checklist.

Executive Director immediately added this to her checklist of physical site following inspection. All Staff were educated on this regulation on 3-26-25 by the Executive Director

Proposed Overall Completion Date: 03/31/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator or designated staff person shall audit the home weekly to ensure compliance with Regulation 2600.88(a). Documentation of audits shall be kept. 4/1/25

Directed Completion Date: *04/02/2025*

Not Implemented (- 04/16/2025)

141b1 - Annual Medical Evaluation

6. Requirements

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

Description of Violation

Resident #3's most recent medical evaluation, dated did not indicate the resident's height, that area of the form was left blank. Additionally, the sections of the medical evaluation for medications and body positioning/movement were also left blank.

REPEAT VIOLATION 5/17/24, 2/15/24 et. al.

Plan of Correction ***Accept (- 04/01/2025)***

Resident #3's medical evaluation was fixed immediately. Two step procedure will be put into place. Moving forward all DME'S will be reviewed by Executive Director as well as supervisor before it goes into the residents charts and there will be a sign-off sheet. Medical Evaluations will be audited for the next 6 weeks moving forward.

All current resident medical evaluations were audited on 3-27-25 by the administrator. Documentation of audits will be kept in the POC audit binder and will be ready and available.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Not Implemented (- 04/16/2025)

144c1 - Smoking Area Guidelines

7. 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:

144c1 - Smoking Area Guidelines *(continued)*

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

At approximately 9:02 a.m. there were approximately two dozen cigarette butts scattered on the wooden decking by the door to the home's smoking area. Additionally, throughout the day residents were observed smoking on the concrete patio outside of the A-Hall television room which was marked with signage as a non-smoking area and there were hundreds of cigarette butts scattered in the area behind the concrete where residents were seated.

Plan of Correction ***Accept (- 04/01/2025)***

As of March 10th,2025 followiing the inspection the facility has decided to make this area off of the Television room at the end of A hall a designated smoking area as well as the patio being that this is a place that the residents like to go and smoke. The front of the facility will be designated for our residents that are non smokers and would like to be outside.This new rule will be in effective 30 days from March 10th. The home's smoking policy will be updated as well. Executive Director will check daily that the cleaning staff is cleaning up any and all cigarette butts that are on the ground and not in the designated cigarette receptacles.
All staff were educated on the new smoking policy on 3-26-25 by the administrator. All residents were educated on 3-27-25 on the updated policy and procedure that will be in place beginning April 10th 2025.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Not Implemented (- 04/16/2025)

183b - Meds and Syringes Locked

8. 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 approximately 9:04 a.m. there was unlocked, unattended, and accessible medications sitting on the floor by the rear exit door to the dumpster area to include a Divalproex Sodium 500mg tablet and a Metformin 500mg tablet.

At approximately 1:10pm, there were two tablets of Senna 8.6mg that belonged to resident #5 and were found unlocked, unattended, and accessible on table in the shared resident bedroom belonging to resident #5 and resident #6.

REPEAT VIOLATION 2/15/24 et. al.

Plan of Correction ***Directed (- 04/01/2025)***

In regard to the violation 2600.183.b all medication technicians will be re-educated on how to properly administer medication by 4-7-25 by the administrator. Staff medication technician will be educated on proper medication administration by the DON or Executive Director by 4-7-25. The Executive Director will check daily for ongoing compliance.

An audit will be done weekly starting April 1st by Administrator to ensure all meds are in a container that is locked at all times. Audits will be kept in POC Binder in Administrators Office ready and available.

183b - Meds and Syringes Locked (continued)

Completion of POC will be done by 4-7-25

Proposed Overall Completion Date: 04/07/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator or designated staff person shall place all medications cited in the violation in an area or container that is locked. █ 4/1/25

Directed Completion Date: *04/07/2025*

Not Implemented (█ - 04/16/2025)

183d - Prescription Current

9. 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

On 3/10/25 at approximately 2:02 p.m. there was a bottle of Docusate Sodium 100mg tablets that was found on the home's medication cart and belonged to resident #7. However, resident #7's Docusate Sodium was discontinued on admission to the personal care home on █

Plan of Correction ***Accept (█ - 04/01/2025)***

In regard to the violation 2600.183.d all medication technicians will be re-educated on how to properly dispose of medication and make sure that it is signed off properly by two medication technicians as well by the DON or Executive Director by 4-7-25. Staff will be reeducated on proper disposal by the DON or Executive Director as well. An audit will be done weekly starting April 1st by Administrator or DON to ensure all proper medications are discontinued when ordered.
Completion of POC will be done by 4-7-25.

Licensee's Proposed Overall Completion Date: *04/07/2025*

Not Implemented (█ - 04/16/2025)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #8's Lantus Solostar 100U/mL indicated "inject 6 units subcutaneously at bed time." However, resident #8 is prescribed Lantus Solostar 100U/mL inject 8 units at bed time beginning 3/4/25.

REPEAT VIOLATION 2/15/24 et. al.

Plan of Correction ***Accept (█ - 04/01/2025)***

On March 10th 2025, DON called pharmacy and got the corrected label to reflect the providers orders. Medical

184a - Resident's Meds Labeled (continued)

technicians will also be re-educated to ensure that what they are given matches what is in the computer by 4-7-25. Starting April 1st, the Administrator will do a weekly audit to make sure all labels match current orders that are given to the residents.

Completion of POC will be done 4-7-25

Proposed Overall Completion Date: 04/07/2025

Licensee's Proposed Overall Completion Date: *04/07/2025*

Not Implemented (- 04/16/2025)

185a - Implement Storage Procedures

11. 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

On 3/10/25 direct care staff person B administered Escitalopram 10mg to resident #7 and indicated this medication card was not empty. However, the Escitalopram 10mg tablets could not be found at the time of the medication audit on the cart or in the home and the home was unable to account for the missing supply of medication for resident #7.

Plan of Correction ***Directed (- 04/01/2025)***

Resident #7 received scheduled dose of escitalopram 10 mg on March 10th 2025. Med Tech supervisor contacted the pharmacy immediately to refill prescription to ensure we had available for the next dose. Medication was ordered and received. All med techs will receive training on homes ordering procedures by 4-15-25.
Med Cart audit will be done monthly not only by Lead med tech but also by Health Direct pharmacy.
Lead Med Tech Cart Audit will be completed by 4-15-25

Proposed Overall Completion Date: 04/15/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall conduct a weekly audit of all prescribed medications to ensure all prescribed medications are available in the home for administration. Documentation of audits shall be kept. 4/1/25

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator shall ensure all steps in the plan of correction are initiated by 4/7/25. 4/1/25

Directed Completion Date: *04/07/2025*

Implemented (- 04/16/2025)

187a - Medication Record

12. Requirements

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

Description of Violation

Resident #9 is prescribed Sucralfate 1GM tablet, take before meals and at the hour of sleep. However, the March 2025 medication administration record for resident #9 indicated Sucralfate 1GM tablet, take one tablet by mouth 2 times a day.

Resident #10 is prescribed Clozapine 100mg, take one tablet by mouth every morning and two tablets at bedtime. However, resident #10's March 2025 medication administration record had two entries, one that indicated "Clozapine 100mg, take one tablet by mouth at bedtime" and "Clozapine 200mg, take one tablet by mouth at bedtime."

REPEAT VIOLATION 2/15/24 et. al.

Plan of Correction ***Directed (- 04/01/2025)***

On March 10th 2025, contacted the pharmacy to get the prescriptions to reflect the prescribers orders. Effective immediately, any changes needed made the prescriber was contacted. Medical technicians will also be re-educated to ensure that what they are given matches what is in the computer by 4-7-25.
An audit will be done weekly starting April 1st by Administrator to ensure residents are receiving the medication the proper medication the physician prescribed and that all labels match.

Proposed Overall Completion Date: 04/07/2025

DIRECTED
Within 1 day of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall audit all resident MARS weekly to ensure compliance with Regulation 2600.187(a). Documentation of audits shall be kept. 4/1/25

Directed Completion Date: *04/07/2025*

Not Implemented (- 04/16/2025)