pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MANATAWNY AL OPERATING COMPANY LLC**
LEGAL ENTITY

To operate **THE RESIDENCES AT MANATAWNY VILLAGE**
NAME OF FACILITY OR AGENCY

Located at **30 OLD SCHUYKILL ROAD, POTTSTOWN, PA 19465**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **124** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 24**

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 6, 2025** until **December 6, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **148512**

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 6, 2025

[redacted]
Sole Member
Manatawny AL Operating Company, LLC
[redacted]

RE: The Residences at Manatawny Village
30 Old Schuylkill Road
Pottstown, Pennsylvania 19465
License #: 148512

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection November 6, 2024 and January 7 and 8, 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), 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) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from June 6, 2025 to December 6, 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.

[redacted]

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)
65a	III	59	$3	$177	15 calendar days from mailing date of this letter
88a	II	59	$5	$295	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 SECOND 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.

Mr. Mordechai Weisz

If you decide to appeal your SECOND 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
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[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: *THE RESIDENCES AT MANATAWNY VILLAGE* **License #**: *14851* **License Expiration**: *12/18/2024*

Address: *30 OLD SCHUYKILL ROAD, POTTSTOWN, PA 19465*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MANATAWNY AL OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *08/15/1989* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *83* **Waking Staff**: *62*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *11/06/2024*

Inspection Dates and Department Representative

11/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Horizons* **Capacity**: *24* **Residents Served**: *20*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *26* **Have Physical Disability**: *1*

Inspections / Reviews

11/06/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/30/2024*

Inspections / Reviews *(continued)*

12/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/05/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/26/2024*

12/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/05/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/03/2025*

05/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/05/2025*

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

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat Violation: 1/03/2024

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

Staff member A was immediately given another orientation by the administrator that included.
2600.
65.a.
1.
Evacuation procedures.
2.
Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3.
The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4.
Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5.
The location and use of fire extinguishers.
6.
Smoke detectors and fire alarms.
7.
Telephone use and notification of emergency services.

Starting immediately the home has revised its training to include the following:
evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or

65a - FS Orientation 1st Day (continued)

within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.
Personal Care will provide its own training for personal care staff
Starting 12/1/2024administrator will sign off on all the new hire trainings to ensure the first day of orientation 1st day is completed and we remain in compliance this will indefinitely.
Starting 1/10/2025 the administrator will complete monthly employee chart audits on 6 random employee charts to stay in compliance. This audit will remain for 6 months.

Licensee's Proposed Overall Completion Date: *01/03/2025*

Not Implemented ([redacted] - 02/04/2025)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [redacted] 40th scheduled work hour on [redacted]. However, this staff person did not complete training in the following topics: mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), emergency medical plan, reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

Staff person A was immediately given another orientation by the PC administrator that required regulations for 2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
Starting immediately the home has revised its training to include the following:
mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), emergency medical plan, reporting of reportable incidents and conditions.
Personal Care will provide its own training for personal care staff
Starting 12/1/2024 the administrator will sign off on all the new hire trainings to ensure all topics are completed

65b - Rights/Abuse 40 Hours (continued)

within 40scheduled working hours, and we remain in compliance this will indefinitely.
Starting 1/10/2025 the administrator will complete monthly employee chart audits on 6 random employee charts to stay in compliance. These audits will remain for 6 months.

Proposed Overall Completion Date: 01/02/2025

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented ([redacted] - 02/04/2025)

65d - Initial Direct Care Training

3. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.
   xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services on [redacted] However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

On 11/11/2024 staff person A was given the revisewd orientaion training by the administrator that included :
1.
Training that includes a demonstration of job duties, followed by supervised practice.
2.
Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3.

65d - Initial Direct Care Training (continued)

Initial direct care staff person training to include the following:
i.
Safe management techniques.
ii. ADLs and IADLs
iii. Personal hygiene.
iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Starting 12/1/2024 the administrator will sign off on all the new hire trainings to ensure all topics are completed within 40scheduled working hours, and we remain in compliance this will indefinitely.

Starting 1/10/2025 the administrator will complete monthly employee chart audits on 6 random employee charts to stay in compliance. This audit will remain for 6 months.

Proposed Overall Completion Date: 01/02/2025

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented ([redacted] - 02/04/2025)

65e - 12 Hours Annual Training

4. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person B received 0 hours of annual training in training year 2023.

Plan of Correction ***Accept ([redacted] - 12/16/2024)***

Starting 12/15/2025 the administrator will aduit employee 12 training hours monthly to ensure all staff persons

65e - 12 Hours Annual Training (continued)

are in complience with Dementia and annual trainings.
The Administrator will keep all staff trainings records in [redacted] office to ensure all trainings are avaible.
The Administrator is working on updating employee trainings and ensuring all current employees are in complience for 2024, this will be completed by 12/31/2024.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented ([redacted] - 02/04/2025)

[redacted]

124 - Notice to Fire Department

7. Requirements

2600.

124 - Notice to Fire Department *(continued)*

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

Description of Violation

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

Plan of Correction ***Accept (- 12/16/2024)***

As of 12/3/2024 the administrator is in the process of reviewing and updating the written notification to the local fire departmented to be send by 12/3/2024, due to the new fire cheif and changes within the fire department.
Starting immediately after the adminstrator will complete an audit sheet that will include any new immobile residents or deceased resident to be send per resdients needs along with a floor plan of our PC unit.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented (- 02/04/2025)

183d - Prescription Current

8. 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 11/6/2024, Januvia 25 mg tablet prescribed for resident 1, was on the medication cart; however, the medication was discontinued on 11/4/2024.

Plan of Correction ***Accept (- 12/16/2024)***

On 11/6/2024 the medication was immediately removed from the medication cart.
On 10/17/2024 the CSD assigned med weekly med cart audits to overnight LPN, however the medications not included on the residents medication record were found in the cart.
On 11/13/2024 the CSD assigned monthly med cart audits to all med techs and nurses to ensure any medicatons that is not on the resdients medication record is not in the cart.
These audits will continue until further notice.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented (- 02/04/2025)

183e - Storing Medications

9. 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

On 11/6/2024, resident 2's Xtampza Er Cap 13.5 mg blister package had a perforation in the package.

183e - Storing Medications (continued)

On 11/6/2024, resident 3's Dipehan/Atrop tab 2.5 mg spot 6 of the blister package had perforations in the package.

On 11/6/2024, Resident 4's Dipehan/Atrop tab 2.5 mg spots 16, 24, and 26 of the blister package had perforations in the package.

On 11/6/2024, there were 6 loose pills on cart AB.

On 11/6/2024, there were 4 loose pills on cart BD.

Plan of Correction ***Accept (- 12/16/2024)***

On 11/6/2024 all medications with perforation in the package were destroyed by nurse and med tech.
On 10/17/2024 the CSD assigned med weekly med cart audits to overnight LPN, however some medications had perforations that was not noticed and loose pills still found in the cart.
On 11/13/2024 the CSD assigned monthly med cart audits to all med techs and nurses to ensure all blister packs are checked for perforations and loose pills.
Starting 11/8/2024 all nurses or med techs who are giving medications will check the cart for loose pills as the go and at the end of their shift.
These audits will continue until further notice.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented (- 02/04/2025)

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:
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

On 11/6/2024, resident 5's medication label on the control substance sheet for Oxycodone IR 5 mg tablet states to be given every 4 hours as needed for pain. The medication was labeled incorrectly on the blister package and stated to give every 8 hours as needed for severe pain.

Plan of Correction ***Accept (- 12/16/2024)***

On 11/7/2024 the medication lable was corrected.

184a - Resident's Meds Labeled (continued)

On 11/7/ 2024 all med techs and nurses were in serviced on matching lables to the medication record and medications.
On 10/17/2024 the CSD assigned med weekly med cart audits to overnight LPN, however unmatched lables was missed.
On 11/13/2024 the CSD assigned monthly med cart audits to all med techs and nurses to ensure that all lables on the medications match what is on the medication record.
These audits will continue until further notice.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented ([redacted] - 02/04/2025)

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 11/6/20204, at 4:01 pm, resident 1's glucometer was not calibrated the glucometer read 11/5/2024 at 3:26 am.

On 10/21/2024, resident 1's glucometer had a reading of 152 but documented on the Medication administration record as 151.

On 10/24/2024, resident 1's glucometer had a reading of 204 but was documented on the Medication administration record as 202.

Resident 6 is prescribed Acetaminophen 325 mg as needed. On 11/6/2024, Acetaminophen 325 mg medication was not available in the home.

Resident 7 is prescribed Lubricate Eye drops .4 - .3 % as needed. On 11/6/2024, Lubricate Eye drops .4 - .3 % medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 12/16/2024)***

On 11/6/2024 the glucose machine was fixed by the med techs to the correct date and time.
Starting 12/1/2024 the med techs will check all glucose machine will be checked monthly to ensure the correct date and time is noted.
Starting 11/7/2024 the med techs will check the glucose machine for accuarcy before documenting the reading.
On 10/17/2024 the CSD assigned med weekly med cart audits to overnight LPN, however some medications were still not avaiable.

On 11/13/2024 the CSD assigned monthly med cart audits to all med techs and nurses to ensure all medicatons are avaible to residents.

185a - Implement Storage Procedures (continued)

These audits will continue until further notice.

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented (- 02/04/2025)

[redacted]

WITHDRAWN 5/21/25

[redacted]

187a - Medication Record

13. 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 1 is prescribed True Plus Chew Glucose Tablets 4 tablets once daily as needed for low blood sugar, however, it is not included on resident 2's medication administration record.

187a - Medication Record (continued)

Resident 6 is prescribed Omeprazole 20 mg take 1 tablet twice a day was located in the medication cart but was not on the Medication administration record.

Plan of Correction ***Accept (- 12/23/2024)***

On 11/6/2024 both medications were removed from the medication cart.
On 10/17/2024 the CSD assigned med weekly med cart audits to overnight LPN, however the medications not included on the residents medication record were found in the cart.
On 11/13/2024 the CSD assigned monthly med cart audits to all med techs and nurses to ensure any medicatons that is not on the resdients medication record is not in the cart.
These audits will continue until further notice.

Proposed Overall Completion Date: 01/02/2025

Licensee's Proposed Overall Completion Date: *01/02/2025*

Not Implemented (- 02/04/2025)

191 - Resident Right to Refuse

14. Requirements

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

Description of Violation

Resident 4, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 6, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 7, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 8, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 9, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 12/23/2024)***

On 11/12/2024 the home revised its contract to include the right to question and refuse any medication if the resident believes there may be a medication error, so documentation of the education is kept.
By 12/6/2024 Resident 4,6,7,8 and 9 will be educated by the CSD on the resident to question or refuse any medication if the resident believes there may be a medication error.
By 12/31/2024 all residents' charts will be checked to ensure all residents were educated.
The right to refuse will also be discussed in December's residents' council meeting.

191 - Resident Right to Refuse (continued)

Proposed Overall Completion Date: 01/02/2025

Licensee's Proposed Overall Completion Date: *01/02/2025*

Implemented (- 02/04/2025)

231c - Preadmission Screening

15. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, resident 6's written cognitive preadmission screening was not completed.

Plan of Correction ***Accept (- 12/23/2024)***

On 11/8/2024 the administrator did review and complete the cognitive preadmission screening for the POC.
Beginning 12/8/2024 -12/13/2024 the CDS will review all prescreens for every resident residing in the Secure Dementia Unit to ensure that the written cognitive screen was completed, and the home is in compliance with 2600.231.c
Beginning immediately all new admission and residents who will transfer over to the Secure Dementia Unit will be checked by the CSD and a nurse prior to admission and both the CSD and nurse or administrator will also initial on the form.

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

Implemented (- 02/04/2025)

236 - Staff Training

16. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had only 2 hours of training in dementia care during the 2023 to 2023 training year.

Plan of Correction ***Accept (- 12/23/2024)***

Beginning 12/2024 the home will provide two monthly dementia training indefinitely to ensure the staff will stay in compliance with the 6 hours of dementia training in addition to 12-hour annual training.
By 12/30/2024 all staff dementia training hours will be audited by the administrator for complience.
Starting 1/1/2025 the administrator will aduit employee dementia training hours monthly.

Proposed Overall Completion Date: 01/02/2025

Licensee's Proposed Overall Completion Date: *01/02/2025*

236 - Staff Training *(continued)*

Implemented ([redacted] - 02/04/2025)

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

Facility Information

Name: *THE RESIDENCES AT MANATAWNY VILLAGE* **License #:** *14851* **License Expiration:** *12/18/2024*

Address: *30 OLD SCHUYKILL ROAD, POTTSTOWN, PA 19465*

County: *CHESTER* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MANATAWNY AL OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-1* **Date:** *08/15/1989* **Issued By:** *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *79* **Waking Staff:** *59*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *01/08/2025*

Inspection Dates and Department Representative

01/07/2025 - On-Site: [redacted]

01/08/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served:** *59*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Horizons* **Capacity:** *24* **Residents Served:** *20*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *11* **Are 60 Years of Age or Older:** *59*

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

Have Mobility Need: *20* **Have Physical Disability:** *1*

Inspections / Reviews

01/07/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/14/2025*

02/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/14/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/13/2025*

05/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/14/2025*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 1/7/2025, the home's current violation report, dated 4/24/2024, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/7/2025, The Executive Director was able to post a copy of the homes current license as well as the license inspection summary in a conspicuous and public place in the personal care home.
The license and current LIS are both posted on the bulletin board on the second floor, to the left of the elevators.
The administrator will complete a weekly audit to ensure that the Current License and the current LIS continue to be posted. These audits will end 3/8/25.

Licensee's Proposed Overall Completion Date: *03/08/2025*

Not Implemented (- 05/01/2025)

[redacted]

WITHDRAWN 5/21/25

[redacted]

[redacted]

17 - Record Confidentiality

3. 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

On 1/7/2025, at 9:54 AM, phlebotomy order log was unlocked, unattended, and accessible on a desk in front of the A wing.

On 1/8/2025, at 9:00 AM, a packet of the home License Inspection Summary reports was posted on a public bulletin board with the privacy coding attached.

At 12:04 PM a narcotic logbook was unlocked, unattended, and accessible on the B/C medication cart.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

On 1/7/2025, the phlebotomy order log was immediately locked in the Nurses Station Room. The Nursing staff will conduct daily audits starting 2/11/2025 to ensure that it remains locked away and inaccessible. These audits will begin 2/11/2025 and will continue for the next month ending 3/11/2025.
On 1/7/2025 The License Inspection Summary that was posted on the public bulletin board with the privacy has been replaced without the privacy coding attached.
Starting 2/10/2025 the administrator will begin weekly audits to ensure that the Privacy coding remains unattached to the posted LIS.
On 1/7/2025 the Narcotic logbook for hallways B & C was immediately locked away in the med cart.
Starting 2/11/2025 all nursing staff will conduct daily audits to ensure that the narcotic logbooks are locked, and inaccessible at all times.
On 2/11/25 all staff have been in-serviced on the importance of Record Confidentiality.

Licensee's Proposed Overall Completion Date: *03/11/2025*

Implemented ([redacted] - 05/01/2025)

62 - Contact List

4. Requirements

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

Description of Violation

The home maintains a list of staff persons that does not include substitute and newly hired staff.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/8/2025 the administrator received an updated contact list including all current staff as well as newly hired staff and substitute personnel and volunteers.

The administrator will review the contact list weekly with HR to ensure it remains updated with substitute and newly hired staff. These audits will go from 2/11/25-3/11/25 to ensure continued compliance with this regulatory requirement.

Licensee's Proposed Overall Completion Date: *03/11/2025*

Implemented (- 05/01/2025)

65a - FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was , did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat Violation: 1/3/2024

Plan of Correction ***Accept (- 02/26/2025)***

On 2/11/2025, staff member A, whose first day of work was has receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation,

65a - FS Orientation 1st Day (continued)

transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.
An audit is being conducted starting 2/12/2025 for all staff files to ensure that they have had proper orientation prior to or during orientation. Any staff that hasn't, will receive the proper orientation with all required topics which will have "POC audited and the date of 1/7/2025-1/8/2025) at the top of their orientation paperwork.
The administrator will audit all new hires and will ensure that the proper orientation is being given. This audit will continue for the next month, concluding 3/12/2025.

Licensee's Proposed Overall Completion Date: *03/11/2025*

Not Implemented ([redacted] - 04/30/2025)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [redacted] 40th scheduled work hour on approximately [redacted] However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

In response to violation on 1/7/25, a one-time audit was performed to ensure all PC staff has completed training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, reporting of reportable incidents and conditions on 2/13/2025.
On 2/13/2025 Staff member A has completed the proper training in the 4 topics that were missed. At the top of the orientation form, it states, "POC Audited with the date of Inspection which was 1/7/2025".
To enhance the currently compliant operations, the administrator will review all new hires weekly to ensure Orientation is completed within 40th scheduled work hour with a completion date of 3/13/2025

Licensee's Proposed Overall Completion Date: *03/13/2025*

Not Implemented ([redacted] - 04/30/2025)

65b - Rights/Abuse 40 Hours *(continued)*

65d - Initial Direct Care Training

7. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

As of [redacted] Staff Member B no longer works at Manatawny Manor.
On 2/14/2025 an audit was completed for all current employees in order to identify any other staff members who have not received Initial Direct Care Training.
This administrator will create a tickler for all new hires to ensure that they received their Initial Direct Care Training before providing unsupervised ADL services.

Licensee's Proposed Overall Completion Date: *02/14/2025*

Not Implemented ([redacted] - 04/30/2025)

65i - Training Record

8. Requirements

2600.

65i - Training Record *(continued)*

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

Description of Violation

The home's record of direct care staff training that was completed on 11/7/24 does not include length and source of trainings.

Plan of Correction ***Accept (- 02/26/2025)***

Starting on the week of 2/17/25 The administrator will audit all trainings in 2024 to ensure that they include the length and source of trainings for each month of 2024.
The administrator will audit all records of trainings monthly to ensure that they are completed and filled out fully.

Licensee's Proposed Overall Completion Date: *02/14/2025*

Implemented (- 05/01/2025)

81b - Resident Personal Equipment

9. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident 2 has a bedside mobility device inserted in between the mattress. The device is not secured properly on both sides and easily moves on the right side 6 inches.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/7/2025 Maintenance was able to immediately remove the beside mobility device for resident #2. Maintenance did an immediate audit of all residents with bedside mobility devices and has since removed them all.
The administrator will conduct weekly audits to ensure that all devices remain removed from all bedsides.

Licensee's Proposed Overall Completion Date: *03/11/2025*

Implemented (- 05/01/2025)

82c - Locking Poisonous Materials

10. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 1/7/2025, Lantiseptic skin protectant for resident 3, with a manufacturer's label indicating "if ingested call poison control", was unlocked, unattended, and accessible to residents in the bedside table in the bedroom of resident 2 and resident 4.

Crest scope toothpaste, with a manufacturer's label indicating "if ingested call poison control", was unlocked, unattended, and accessible to residents in the bathroom of resident's 2 and 4.

82c - Locking Poisonous Materials (continued)

On 1/8/2025, fresh mint toothpaste, with a manufacturer's label indicating "if ingested call poison control", was unlocked, unattended, and accessible to residents in the bathroom of resident 5.

Not all the residents of the home, including residents of the Secure Dementia Care Unit (SDCU), have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/8/25 an immediate audit was completed, & all poisonous materials were immediately removed from all rooms.
Starting on 2/13/25 staff will conduct daily room audits to ensure all poisonous materials are inaccessible to residents at all times. These audits will continue daily and will conclude 3/13/2025.
On 2/13/2025 The Administrator will in-service all staff on Locking up all Poisonous Materials.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Implemented (- 05/01/2025)

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

On 1/3/2025, at 4:15 PM, resident 1's glucometer was used to take a reading for resident 6. Resident 6 has a reading documented in [redacted] medication administration record of 235 on 1/3/2025 at 17:00, however this reading was not observed in resident 6's glucometer. The reading was observed in resident 1's glucometer.

On 1/7/2025, there were approximately 20 dead bugs in the light fixture in the B stair well.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/8/2025 immediate action was taken, and all residents were ordered new Glucometers. All Glucometers are labeled.
The Nursing Coordinator In-serviced all Nursing staff on the Importance of Sanitary Conditions.
Maintenance took immediate action and had since removed all bugs from the light fixture in stairwell B.
Maintenance will conduct weekly audits beginning the week of 2/10/2025 to ensure that sanitary conditions are maintained. These audits will begin weekly starting 2/10/2025 and will conclude the week of 3/10/2025.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Implemented (- 05/01/2025)

87 - Lighting

12. Requirements

2600.

87 - Lighting *(continued)*

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

On 1/7/2025, the lights in stairwells B and D were dim and almost out.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

On 1/7/2025 the Maintenance director replaced the lights in Stairwells B and D.
The Maintenance director or assignee will perform weekly lighting audits until the weekl of 3/10/2025 in order to maintain on-going compliance with lighting requirements.
Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Implemented ([redacted] - 05/01/2025)

88a - Surfaces

13. Requirements

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

Description of Violation

On 1/7/2025, the ceiling vent in the resident laundry room was water stained and showed signs of mold, the ceiling vent in front of the human resources office showed signs of water damage was descending through the ceiling tile, ceiling tiles in the A stairwell showed signs of water damage, ceiling tiles in front of the electrical room showed signs of water damage, and there was a large gash on the corner of the wall in memory care.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

As of 2/14/25, Maintenance has replaced the ceiling tiles in stairwell A and in front of the electrical room.
On 1/7/25, Housekeeping was able to immediately clean the Vents in the resident laundry room as well as in front of the Human Resources Office.
On 2/13/2025 the large gash on the corner of the wall in in the Horizons/Memory Care Unit has been 100% repaired.
Maintenance has been in-serviced on Surfaces on 2/14/2025 by the Administrator.
The Administrator/Maintenance will do weekly walk throughs of the building to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. These walk throughs will begin the week of 2/10/2025 and will conclude the week of 3/10/25.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Not Implemented ([redacted] - 04/30/2025)

95 - Furniture and Equipment

14. Requirements

95 - Furniture and Equipment *(continued)*

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

Description of Violation

The light switch cover in the bathroom of room 316 was broken and split down the middle.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/8/2025 Maintenance repaired the light switch cover in the bathroom of room 316.
On 2/13/2025 the administrator completed an audit of all resident bathrooms to identify any other residential bathrooms with this issue. All findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/14/2025*

Implemented (- 05/02/2025)

101j7 - Lighting/Operable Lamp

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 4 does not have access to a source of light that can be turned on/off at bedside.

Resident 7 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 02/26/2025)***

On 1/8/2025 a Lamp was placed at the bedsides of Resident #4 & resident #7. On 2/13/2025, The administrator did an audit of all residents to ensure that all residents have an operable lamp or other source of lighting that can be turned on at bedside.

Licensee's Proposed Overall Completion Date: *02/13/2025*

Not Implemented (- 04/30/2025)

[redacted]

WITHDRAWN [redacted] 5/21/25

[redacted]

WN [redacted] 5/21/25

[redacted]

121a - Unobstructed Egress

17. 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

On 1/7/2025, at approximately 9:32 AM, both exits in the SDCU unit had paper stop signs attached to the doors.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

On 1/7/2025 the Paper stop signs were immediately removed from the doors at both exits in the SDCU.
The administrator/maintenance will complete weekly walkthroughs of the SDCU to ensure that all Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. These weekly walkthroughs will be conducted until the week of 3/10/2025.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Implemented ([redacted] - 05/02/2025)

[redacted]

[redacted]

WITHDRAWN [redacted] 5/21/25

[redacted]

[redacted]

162c - Menus Posted

19. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 1/5/25-1/11/25 was posted in the memory care kitchen. However, the menu for the next week was not posted.

On 1/7/2025, the home had a 4-week menu outside of the dining area in personal care, however there is no indication of the current week being served. Staff persons, and resident interviewed were confused by the menu and could not determine what week was being served.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

On 1/7/2025 the dietary manager immediately posted the menu for the week of 1/12/25 in the memory care kitchen.
On 1/7/25 the dietary manager also fixed the 4-week menu in the dining area of personal care to include dates to ensure that residents and staff are able to determine which week is being served, as well as identify the day.
On 1/7/2025 the ED in-serviced the Dietary Director on the importance of Menus being posted weekly with dates to indicate which week is being served.
Startin 2/10/2025, the Administrator/dietary manager will complete weekly audits to ensure that the 2-week menus are posted with dates.
These audits will continue until 3/10/2035 to ensure continued compliance with this regulation.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Not Implemented ([redacted] - 04/30/2025)

183b - Meds and Syringes Locked

20. Requirements

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

Description of Violation

On 1/7/2025, at 9:40 am, Lantiseptic skin protectant for resident 3, was unlocked, unattended, and accessible in resident 2 and 4's bedroom.

At approximately 9:56 am, acetaminophen 500 mg tablets and fluticasone nasal spray was unlocked, unattended, and accessible in resident 6's bedroom.

183b - Meds and Syringes Locked (continued)

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

On 1/7/25 immediate action was taken and all meds in resident #6's bedroom were removed from the room and disposed of.
On 1/8/25 an immediate audit was completed, & all poisonous materials were immediately removed from all rooms including the skin protectant for resident 3.
Starting on 2/13/25 staff will conduct daily room audits to ensure all poisonous materials are inaccessible to residents at all times on the SDCU. These audits will be completed daily and will conclude 3/13/2025.
On 2/13/2025 The Administrator has in-serviced all staff on Locking up all Poisonous Materials.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Not Implemented ([redacted] - 05/02/2025)

183e - Storing Medications

21. 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

On 1/8/2025, there was a loose white round pill in the bottom drawer of cart A/B.

Resident 1's blister pack of potassium chloride capsules had punctured foil on pills 5 and 6.

There was a loose orange pill in the second drawer of medication cart B/C

Resident 8's blister pack of oxycodone 5 mg had punctured foil on pill 9.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

On 2/13/2025 all nursing staff have been in-serviced on storing medications.
Daily Medication Cart Audits will be conducted starting 2/13/2025 with a completion date of 3/13/2025.
All loose pills were properly disposed of on 1/8/2025.
The pills from the punctured blister packs have been disposed of as well.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Not Implemented ([redacted] - 04/30/2025)

184b - Labeling OTC/CAM

22. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 1/7/2025, a package of acetaminophen 500 mg tablets and fluticasone nasal spray belonging to resident 6 was in an open storage cart in the resident's shared bedroom and was not labeled with the resident's name.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

In response to findings, the Medications have been removed from Resident #6's room and was labeled with residents' name.
An immediate audit was conducted by the Unit manager and all resident rooms were checked for accessible and unlabeled meds.
The Unit Manager/assignee will conduct weekly audits of all residents who self-medicate to ensure that all medications are locked up and labeled with their names at all times. These audits will begin the week of 2/10/25 and will conclude the week of 3/10/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Not Implemented ([redacted] - 05/02/2025)

185a - Implement Storage Procedures

23. Requirements

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

Description of Violation

Resident 6's January 2025 blood glucose readings were incorrectly documented as follows:
On 1/7/2025, at approximately 17:00, the MAR was documented as 182 however the glucometer had a reading of 166.
On 1/5/2025, at approximately 20:30, the MAR was documented as 204 however the glucometer had a reading of 205.

On 11/12/24, resident 9's narcotic log for liquid morphine sulfate was documented that .25 ml was administered leaving a balance of 11.75 ml. On 1/2/2025, it was documented that the resident was administered .25 ml leaving a balance of 8.25 ml. There is no documentation of any doses administered or destroyed between 11/12/24 and 1/2/2025. On 1/2/2025, a late entry was written in with a date of 1/1/2025 listing 3.5 ml or 14 doses "wasted". The home did not document any errors during narcotic counts or investigate the missing medication.

Plan of Correction ***Accept ([redacted] - 02/26/2025)***

As of 2/13/2025 The administrator in-serviced all nursing staff on Storage Procedures and proper documentation on 2/10/2025.
As of 02/14/2025 all medication errors have been reported.
Starting 2/10/25, The Unit Manager began in-servicing all Nursing Staff on Glucometer checks & Proper documentation as well as written incident reports/med errors
Starting 2/10/25 the nursing staff will complete daily audits by the end of their shift. These audits are to ensure

185a - Implement Storage Procedures (continued)

that Resident #1's readings are being taken using the correct glucometer and will ensure that it matches with the MAR.

These audits will continue daily until 3/10/2025. Any deficiencies will be reported and documented for internal review.

Licensee's Proposed Overall Completion Date: *03/10/2025*

Not Implemented (- 05/01/2025)

[redacted]

[redacted]

[redacted]

227d - Support Plan Medical/Dental

26. 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

The assessment for resident 10, dated [redacted] did not have any questions in the "Behavioral and Cognitive Needs" section completed.

227d - Support Plan Medical/Dental (continued)

Repeat violation: 2/22/2024, 10/2/2023

Plan of Correction ***Accept (- 02/26/2025)***

Immediate action was taken and the Behavioral and Cognitive Needs section of resident #10's support plan was completed. The Unit manager explained the update to the resident, and she did sign and date.
Beginning the week of 2/14/25, the administrator will complete an audit of all RASPS, to ensure that all sections are completed in full. This audit will be completed by 3/14/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Not Implemented (- 05/02/2025)

234a - Admission Support Plan

27. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 11 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Resident 12 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept (- 02/26/2025)***

The administrator will create a tickler by 2/14/2025 to ensure all Support plans are completed within 3 days of admission for all new and future residents.
Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/14/2025*

Implemented (- 05/02/2025)