





# Pennsylvania Department of Human Services

Emailing Date: May 21, 2025

[REDACTED]  
Walden's View North Huntingdon OPCO LLC  
7990 US Route 30  
North Huntingdon, Pennsylvania 15642

RE: The Neighborhoods at Walden's View  
License #: 446810

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspection on January 10, 2025, January 14, 2024, January 15, 2025, January 16, 2025, and April 9, 2025, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

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

**Facility Information**

Name: *THE NEIGHBORHOODS AT WALDEN'S VIEW* License #: *44681* License Expiration: *06/30/2025*  
Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA 15642*  
County: *WESTMORELAND* Region: *WESTERN*

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: *WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC*  
Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA, 15642*  
Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *01/19/2015* Issued By: *Twp of North Huntingdon*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *76* Waking Staff: *57*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Provisional* Exit Conference Date: *04/09/2025*

**Inspection Dates and Department Representative**

04/09/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *40* Residents Served: *38*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *entire building* Capacity: *40* Residents Served: *38*

**Hospice**

Current Residents: *10*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *38*  
Diagnosed with Mental Illness: *4* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *38* Have Physical Disability: *0*

**Inspections / Reviews**

**04/09/2025 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/27/2025*

04/28/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/09/2025

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 05/05/2025

05/15/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 05/09/2025

Reviewer: [REDACTED] Follow-Up Type: Exception

## 85a - Sanitary Conditions

**1. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation***The bedroom, belonging to resident #1, had a strong odor of urine.**Dried fecal matter was smeared on the toilet and the floor of the bathroom and bedroom belonging to resident #2.**A used unlabeled comb was laying on a stand in the shower room, off the dining room in the Beach Hallway.***Plan of Correction****Accept** [REDACTED] **04/28/2025)***Immediately on 4/9/2025 the resident's room was deep cleaned by housekeeping and DCS assisted. On 4/10/2025 housekeeping placed the companies Ozonator machine in room #1 for 1 hour after it was also deep cleaned.**Admin/designee will do daily walk throughs starting 4/11/2025 to ensure that 85a-Sanitary conditions are being met. This will last 6 weeks, then 3xweek for 6weeks, then weekly thereafter and documentation will be kept. This will be reviewed during our quality management meeting quarterly to ensure compliance.**Walden's View respectfully submits this appeal to the Department of Human Services regarding violation 85a of unsanitary conditions. We understand the importance of maintaining a clean and safe environment for our residents and staff. We acknowledge that occasional incidents related to incontinence may occur in our Memory Care community. However, we have robust systems in place to address these incidents promptly and effectively. Our staff is trained to respond to these situations with dignity and respect for our residents.**To maintain a clean and hygienic environment, we have implemented the following programs and protocols:*

- 1. \*Dedicated Housekeeping Staff\*: 108 hours per week of dedicated housekeeping hours per week for just our 40 units of memory care to ensure thorough cleaning of our community.*
- 2. \*Deep Cleaning Schedule\*: Resident rooms are deep cleaned weekly using steam cleaning equipment, extractors, and ozonators as needed.*
- 3. \*Daily General Cleaning Schedule\*: A daily schedule is in place to maintain general cleanliness throughout the community.*
- 4. \*As-Needed Cleaning\*: Our staff is trained to respond promptly to any spills or accidents, ensuring timely and appropriate cleaning.*

*Documentation of above is available at request.**Given our robust cleaning programs and protocols, we respectfully request that this violation be removed from the report. We believe that it does not accurately reflect the regular conditions of our community. We are committed to providing a safe, clean, and compassionate environment for our residents and look forward to continuing to work with the Department of Human Services to ensure the highest quality of care.**Thank you for considering our appeal. We are confident that a review of our cleaning programs and protocols will demonstrate our commitment to maintaining a clean and safe environment for our residents***Licensee's Proposed Overall Completion Date: 06/04/2025****Implemented** [REDACTED] **- 05/15/2025)**

88a - Surfaces

2. 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

An approximate 6" x 8" section of plaster board was missing from the bottom of the wall divider in the shower room, off the dining room in the Beach Hallway.

An approximate 8" x 8" section of ceiling drywall/plaster was peeling and hanging over near the prep table past the main kitchen line.

Plan of Correction

Accept [redacted] - 04/28/2025)

Immediately on 4/10/2025 admin met with maintenance director to go over and educate on regulation 88a.

On 4/17/2025 the section of plaster board that was missing from the bottom of the wall divider in the shower room, off the dining room in the Beach Hallway, was repaired. Documentation (picture) has been kept.

On 4/10/2025 the section of ceiling drywall/plaster that was peeling and hanging over near the prep table past the main kitchen line, was repaired. Also, on 4/10/2025, Goods Plumbing came and repaired a broken PVC elbow that was the cause of the damage. Documentation will be kept.

Starting on 4/11/2025 a weekly walk through will be done by maintenance to ensure that the requirements for 88a-Surfaces are being met. Documentation will be kept. This will last for 6 weeks and quarterly there after. This will be reviewed during our quality management meeting quarterly to ensure compliance

Licensee's Proposed Overall Completion Date: 06/04/2025

Implemented [redacted] - 05/15/2025)

89a - Water Pressure

3. Requirements

2600.

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

The sink outside the shared toilet, in bedroom #302 in the Victorian hallway, did not have sufficient hot water pressure beyond a trickle.

Plan of Correction

Accept [redacted] - 04/28/2025)

On 4/10/2025 maintenance replaced the hot water blending valve on the sink in room 302. All sinks were then inspected to ensure sufficient hot water pressure. No other valves needed replaced at this time.

Starting on 4/11/2025 a weekly walk through will be done by maintenance to ensure that the requirements for 89a-water pressure are being met. Documentation will be kept. This will last for 6 weeks and quarterly thereafter. This will be reviewed during our quality management meeting quarterly to ensure compliance

Licensee's Proposed Overall Completion Date: 06/04/2025

Implemented [redacted] - 05/15/2025)

## 101r - Bedroom - shades/drapes/window covering

**4. Requirements**

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

**Description of Violation**

*There was no window covering on the window in bedroom #108.*

*The only window covering, in bedroom #205, was a vallance that did not cover the entire window and did not provide privacy.*

*The only window covering, in bedroom #302, was a robe that was hanging over the window.*

*The only window covering, in bedroom #405, was a vallance that did not cover the entire window and did not provide privacy.*

**Plan of Correction****Accept** [REDACTED] - 04/28/2025)

*Immediately on 4/10/2025 admin met with maintenance director to go over and educate on regulation 101r.*

*Immediately on 4/9/2025 all rooms were inspected for window covering by admin and maintenance. On 4/18/2025 an order was placed at Lowe's for 4 mini blinds for room's 108, 205, 302 and 405.*

*Starting on 4/11/2025 a daily walk through will be done by maintenance to ensure that the requirements for 101r-bedroom-shades/drapes/window coverings are being met. Documentation will be kept. This will last for 6 weeks and then will be done weekly for 6 weeks and quarterly thereafter. This will be reviewed during our quality management meeting quarterly to ensure compliance*

**Licensee's Proposed Overall Completion Date: 06/04/2025**

**Implemented** [REDACTED] - 05/15/2025)

## 105g - Lint Removal and Duct Cleaning

**5. Requirements**

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

**Description of Violation**

*There was an accumulation of approximately 1/8" of lint in the lint trap of the middle dryer in the laundry room. There were no clothes in the dryer at the time.*

**Plan of Correction****Accept** [REDACTED] - 04/28/2025)

*Immediately on 4/9/2025 all staff were counseled on the importance of emptying the lint trap after every load. On 4/10/2025 a sign out sheet was made for employees to sign initials that lint trap was emptied, the sign out sheet will be on the dryer. Also, there is a daily reminder posted on the assignment sheets. Admin/designee will monitor daily. A training will take place for all staff on 4/30/2025 on the dangers of a lint trap not being emptied. The training will be completed by the Admin/RCC. This will be reviewed during our quality management meeting quarterly to ensure compliance*

**Licensee's Proposed Overall Completion Date: 04/30/2025**

105g - Lint Removal and Duct Cleaning (*continued*)*Implemented* [REDACTED] *05/15/2025)*

## 121a - Unobstructed Egress

**6. 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**

*The home has an emergency exit door leading to the exterior of the home, in the dining room off Cabin Hallway; however, the door from the hallway to this dining room was locked; blocking the egress route.*

*The home has an emergency exit door leading to the exterior of the home, in the dining room off Farm Hallway; however, the door from the hallway to this dining room was locked; blocking the egress route.*

*The home has an emergency exit door leading to the exterior of the home, in the dining room off Victorian Hallway; however, the door from the hallway to this dining room was locked; blocking the egress route.*

**Plan of Correction***Accept* [REDACTED] *- 04/28/2025)*

*Immediately on 4/9/2025 all staff were notified to not locked the dining room doors. On 4/16/2025 all locks were removed and replaced with unlockable doorknobs.*

*Staff will be trained on 121a-unobstructed egress on 4/30/2025 for all staff. Training will be done by admin/RCC. Documentation will be kept. This will be reviewed during our quality management meeting quarterly to ensure compliance*

**Licensee's Proposed Overall Completion Date:** 04/30/2025

*Implemented* [REDACTED] *- 05/15/2025)*

## 132c - Fire Drill Records

**7. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**Description of Violation**

*The fire drill record for the drill held on 1/30/25 at 6:43 p.m. indicated 38 residents were in the home at the time of the drill; however, only 3 residents were documented as evacuated.*

*The fire drill record for the drill held on 3/26/25 at 7:05 p.m. indicated 37 residents were in the home at the time of the drill; however, only 4 residents were documented as evacuated.*

**Plan of Correction***Accept* [REDACTED] *- 04/28/2025)*

*Immediately on 4/9/2025 the admin had a one-on-one training with maintenance on how to conduct and document a fire drill. Documentation will be kept.*

132c - Fire Drill Records (continued)

On 4/18/2025 maintenance conducted a fire drill on the mid-night shift @ 11:07pm. 37 residents were evacuated by 3 staff members in 7 minutes and 41 seconds. Documentation has been kept. All residents will be evacuated for fire drills. This will be reviewed during our quality management meeting quarterly to ensure compliance

Licensee's Proposed Overall Completion Date: 04/27/2025

Implemented ( ) - 05/15/2025

132g - Fire Drills Days/Times

8. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

According to staff schedules and interviews, the home routinely schedules 3 staff on duty between 11:00 p.m.- 7:00 a.m. However, 4 staff participated in a fire drill conducted on 8/22/24 at 12:00 a.m., and 6 staff participated in a fire drill conducted on 11/9/24 at 6:15 a.m.

Plan of Correction

Accept ( ) - 04/28/2025

Immediately on 4/9/2025 the admin had a one-on-one training with maintenance on how to conduct and document a fire drill. Documentation will be kept.

On 4/18/2025 maintenance conducted a fire drill on the mid-night shift @ 11:07pm. 37 residents were evacuated by 3 staff members in 7 minutes and 41 seconds. Documentation has been kept.

Moving forward, all required night shift fire drill we be done with minimal require staff. This will be reviewed during our quality management meeting quarterly to ensure compliance

Licensee's Proposed Overall Completion Date: 04/27/2025

Implemented ( ) - 05/15/2025

233c - Key-Locking Devices

9. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

There was no code posted for the locking mechanism for the emergency exit door in the dining room off the Farm Hallway.

There was no code posted for the locking mechanism for the emergency exit door in the dining room off the Victorian Hallway.

There was no code posted for either of the locking mechanisms on the outside gates in the courtyard.

Plan of Correction

Accept ( ) - 04/28/2025

Immediately on 4/9/2025 the code was posted for the locking mechanism for the emergency exit door in the dining

**233c - Key-Locking Devices (continued)**

room off the Farm Hallway.

Immediately on 4/9/2025 the code was posted for the locking mechanism for the emergency exit door in the dining room off the Victorian Hallway.

Immediately on 4/9/2025 the code was posted for both of the locking mechanisms on the outside gates in the courtyard.

Starting on 4/11/2025 a weekly walk through will be done by maintenance to ensure that the requirements for 233c-key-locking devices are being met. Documentation will be kept. This will last for 6 weeks and quarterly thereafter.

This will be reviewed during our quality management meeting quarterly to ensure compliance

**Licensee's Proposed Overall Completion Date: 06/04/2025**

**Implemented [REDACTED] - 05/15/2025)**

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

**Facility Information**

Name: *THE NEIGHBORHOODS AT WALDEN'S VIEW* License #: *44681* License Expiration: *06/30/2025*  
Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA 15642*  
County: *WESTMORELAND* Region: *WESTERN*

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: *WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC*  
Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA, 15642*  
Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *08/19/2002* Issued By: *L&I*  
Type: *I-1* Date: *01/15/2015* Issued By: *N Huntingdon Twp*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *78* Waking Staff: *59*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Incident, Fine* Exit Conference Date: *01/16/2025*

**Inspection Dates and Department Representative**

01/10/2025 - On-Site: [REDACTED]  
01/14/2025 - Off-Site: [REDACTED]  
01/15/2025 - Off-Site: [REDACTED]  
01/16/2025 - Off-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *40* Residents Served: *39*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Whole Building* Capacity: *40* Residents Served: *39*

**Hospice**

Current Residents: *7*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *38*  
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *39* Have Physical Disability: *0*

## Inspections / Reviews

## 01/10/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/17/2025*

## 03/04/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *03/19/2025*  
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/11/2025*

## 03/14/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *03/19/2025*  
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *03/19/2025*

## 05/15/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *03/19/2025*  
Reviewer: [REDACTED] Follow-Up Type: *Exception*

## 16c - Written Incident Report

## 1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

## Description of Violation

On [REDACTED]/24, resident #1 became unresponsive. The resident was very lethargic, had low blood pressure and oxygen levels, and was not talking, walking or responding to [REDACTED] name. [REDACTED] arms, head, and trunk were twitching. On 11/27/24, resident #1 was sent to the hospital where [REDACTED] was diagnosed with peripheral edema and dehydration, received treatment and was discharged back to the home the same day. However, the home did not report this incident to the Department.

## Plan of Correction

Accept ([REDACTED] - 03/04/2025)

Immediate action was to complete incident report on 2.10.25 and sent to BSHL via email by compliance director documentation of this report was completed. All hospital transfers that fall under regulation 16c will be reported within 24 hours as required by the 2600.16.c by administrator or administrator designee.

Corrective action will be having training on 16c on 2.26.25 for all direct care staff and management regarding the importance of completing the report within 24 hours. This will be held by admin/management documentation of meeting will be kept along with sign in sheet of who attend

Preventative Action will be a weekly meeting to discuss 2600.16 c. with the first meeting on 2.26.25 for 6 months then twice a month meeting reviewing 2600.16 c between administrator or designee and select team members, documentation will be kept. Along with our weekly am meeting and quarterly review quality management meeting for all POC, reportable and audits with admin/RCC's and extended management team attending with documentation kept in office

Proposed Overall Completion Date: 02/27/2025

Licensee's Proposed Overall Completion Date: 02/27/2025

Implemented ([REDACTED] - 05/15/2025)

## 42b - Abuse

## 2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

## Description of Violation

Resident #1, who was admitted on [REDACTED]/24, had an aggressive behavior history at the PCH were [REDACTED] formerly resided. On [REDACTED]/24 at approximately 10:00 a.m., resident #1 was discharged from the prior PCH due to a doctor's written recommendation, dated [REDACTED]/24, stating, "(Resident #1) needs an advance discharge, and any delay will jeopardize the health safety, and wellbeing of others in the home." The same day, The Neighborhoods at Walden's View admitted resident #1, having received documentation prior to admission of the resident's aggressive behaviors and hospitalizations. On [REDACTED]/24 at approximately 10:55 p.m., resident #1 hit resident #2 in the shoulder with [REDACTED] fist and bit resident #2 on the left hand while in the bathroom both residents shared. Resident #2 sustained a skin tear on [REDACTED]

**42b - Abuse (continued)**

left hand that became infected and required antibiotic treatment.

Repeat Violation: 9/4/24, 6/25/24, 5/14/24 et al.

**Plan of Correction****Directed (█ - 03/14/2025)**

To provide context, this resident was admitted under a care plan that included medication management changes prescribed by MD. Care plan as devised was followed, and the incident with this resident occurred within the first few hours of █ stay as he was adjusting to his new surroundings, and the new medication regiment had not yet had time to take effect. As of the date of this response, no further instances like this have been experienced by this resident or others, suggesting the care plan was thoughtfully prepared and did ultimately benefit this resident. We regret the unfortunate instance that occurred during this resident's transition.

Immediately, resident number 1 and resident number 2 were separated, resident #1 was moved from room █ to room █, resident #1 was put on q15minute checks. Resident #1 rasp was updated on 11/14/2024 by █. Corrective action, training on 42b will be held on 2/26/2025 for all staff and management, in addition to the abuse training done by █ and admin on 1/29/2025. This training will be done by █ and admin. Documentation will be kept. Management reviewed all rasps/care plans 1/29/2025. Identified residents with behaviors.

Preventative action, Rasps/care plans will be updated per regulation and reviewed monthly, this will be on going moving forward. Rasps will be reviewed by all direct care staff and medication technicians emphasizing on triggers and behaviors starting 1/22/2025. A quality management meeting will also occur 2/27/2025 by admin for all POC violations and reportable. Management will attend. Documentation will be kept.

The administrator or designee will privately interview 3 residents regarding their treatment by other residents and staff. Documentation will be kept and will be reviewed at quality management meetings. This will occur weekly for 2 months.

Proposed Overall Completion Date: 02/27/2025

Proposed Overall Completion Date: 03/11/2025

**Directed:**

By 3/19/25, the administrator or designee will update RASPs for residents who were identified with behaviors during the 1/29/25 management review.

█ 3/14/25

**Directed:**

The administrator or designee will privately interview 3 residents regarding their treatment by other residents and staff. Documentation will be kept and will be reviewed at quality management meetings. This will occur weekly for 2 months and monthly thereafter.

█ 3/14/24

## 42b - Abuse (continued)

Directed Completion Date: 03/19/2025

Implemented [REDACTED] - 05/15/2025)

**3. Requirements**

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

**Description of Violation**

Resident #3 was admitted on [REDACTED]/24 while receiving hospice services. On [REDACTED]/7/24 & [REDACTED]/13/24, the resident had unwitnessed falls, began a significant health decline, and the home was instructed by hospice on the use of the comfort kit including administering Lorazepam and Morphine.

On 12/13/24, resident #3 was prescribed Lorazepam 2mg/ml, give 0.25ml (0.5mg) by mouth/under the tongue every 3 hours for anxiety/restlessness. Beginning 12/13/24 at 3:00 p.m., the resident was administered Lorazepam routinely every 3 hours until 12/19/24 at 12:00 a.m. [REDACTED] was not administered this medication on 12/19/24 at 3:00 a.m. or 6:00 a.m.

On 12/16/24, resident #3 was prescribed Morphine Sulfate 20mg/ml, give 0.25ml (5mg) under the tongue every 4 hours for pain / air hunger; however, this medication was not administered until 12/17/24 at 12:00 p.m., and then was administered every 4 hours until 12/19/24 at 12:00 a.m. [REDACTED] was not administered this medication on 12/19/24 at 4:00 a.m.

On [REDACTED]/24 at 7:17 a.m., the home's staff called hospice to indicate that resident #3 was found in [REDACTED] bedroom without any vital signs of life during the morning rounds. Staff interviews were unable to indicate the times between 12:00 a.m. and approximately 7:00 a.m., during shift change, when the resident was last observed. The resident was pronounced deceased on the resident's date of death.

Repeat Violation: 9/4/24, 6/25/24, 5/14/24 et al.

**Plan of Correction**

Directed ([REDACTED] - 03/14/2025)

Immediate action, administrator spoke with [REDACTED] pharmacy, found where error occurred during transfer. Verbally educated medication technicians. Corrective action, training on 42b will be held on 2/26/2025 for all staff and management, in addition to the abuse training done by [REDACTED] and admin on 1/29/2025. This training will be done by [REDACTED] and administrator emphasizing on neglect. Documentation will be kept. Preventative action, a quality management meeting will also occur quarterly and will start on 2/27/2025 by admin for all POC violations and reportable. Management will attend. Documentation will be kept. The administrator or designated staff person qualified to administer medication will observe 2 medication passes and documentation of passes for all staff administering medication. Observation will include comparing medications

**42b - Abuse (continued)**

administered to the resident MAR to ensure all resident medications are administered and documented according to the orders of the prescriber. Documentation of observations will be kept and reviewed at Quality Management Meetings. This will occur weekly for 2 months

Proposed Overall Completion Date: 02/27/2025

Proposed Overall Completion Date: 03/11/2025

Directed:

By 3/19/25, weekly for 2 months and monthly thereafter, the administrator or designated staff person qualified to administer medication will observe 2 medication passes and documentation of passes for all staff administering medication. Observation will include comparing medications administered to the resident MAR to ensure all resident medications are administered and documented according to the orders of the prescriber. Documentation of observations will be kept and reviewed at Quality Management Meetings.

Directed Completion Date: 03/19/2025

Implemented [REDACTED] - 05/15/2025)

**142c - Consent for Treatment****4. Requirements**

2600.

142.c. If a resident has a serious medical or dental condition, reasonable efforts shall be made to obtain consent for treatment from the resident or the resident's designated person.

**Description of Violation**

On [REDACTED] 24, at approximately 10:55 p.m., resident #1 hit resident #2 with [REDACTED] fist in the shoulder, and bit resident #2 on the left hand while in the bathroom both residents shared. Resident #2 sustained a skin tear on [REDACTED] left hand.

On [REDACTED] /24, resident #2 was seen by the home's physician and prescribed Bactroban ointment as needed for [REDACTED] left hand. However, the ointment was never administered to the resident. Between 11/11/24 and 11/19/24, resident #2's hand became infected. On [REDACTED] /24, the resident was seen by the home's physician and was prescribed oral Doxycycline for the infection.

**Plan of Correction**

Accept [REDACTED] - 03/14/2025)

Immediate action, on 1/10/25 administrator assessed resident #2 left hand. Verbally spoke with medication technicians.

Corrective action, training on 142c will be held on 2/26/2025 for all staff and management, skin assessments will be documented twice a week during showers, training done by [REDACTED] and admin and on 1/29/2025. Staff will turn in shower sheets to admin/designee for review once completed. This training will be done by [REDACTED] and admin. Documentation will be kept. Admin/designee will review 2x's weekly. This started 2/26/2025.

Staff will be educated on signs and symptoms of commonly used PRN medications. This education/training will be done by [REDACTED] and occur on 2/26/2024. Documentation will be kept.

142c - Consent for Treatment (continued)

Preventative action, a quality management meeting will also occur quarterly and will start on 2/27/2025 by admin for all POC violations and reportable. Management will attend. Documentation will be kept.

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

Implemented ( ) - 05/15/2025)

187d - Follow Prescriber's Orders

5. Requirements

2600.

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

Description of Violation

On [redacted]/24, resident #2 was seen by the home's physician and prescribed Bactroban ointment as needed for a skin tear on [redacted] left hand. However, the ointment was never administered to the resident. On 11/19/24, resident #2's hand became infected, and [redacted] was seen by the home's physician and prescribed oral Doxycycline for the infection.

On [redacted]/24, resident #3 was prescribed Lorazepam 2mg/ml, give 0.25ml (0.5mg) by mouth/under the tongue every 3 hours for anxiety/restlessness. However, this medication was not administered on 12/19/24 at 3:00 a.m. and 6:00 a.m.

On [redacted]/24, resident #3 was prescribed Morphine Sulfate 20mg/ml, give 0.25ml (5mg) under the tongue every 4 hours for pain / air hunger; however, this medication was not administered until 12/17/24 at 12:00 p.m. and was not administered on 12/19/24 at 4:00 a.m.

Repeat Violation: 5/14/24 et al.

Plan of Correction

Accept ( ) - 03/14/2025)

Immediate action, administrator spoke with [redacted] pharmacy, found where error occurred during transfer. Verbally educated medication technicians. Corrective action, Training on 187d will be done on 2/26/2025 for all direct care staff and management. This training will be done by admin/management. Documentation will be kept. The home will follow the directions of the prescriber and will be reviewed by admin and or admin designee twice a week x6months and then weekly thereafter. (looking for expired medication, missing medication, medication not reviewed) MD to be notified with in 24 hours. Documentation will be kept.

Preventative action, a quality management meeting will also occur 2/27/2025 by admin for all POC violations and reportable. Management will attend. Documentation will be kept. Weekly exception report will be printed and reviewed for 6 months by admin/RCC and then monthly as a double check to ensure no expired medication, missing medication, medication are being reviewed, refusal of medication or waiting on pharmacy. Documentation will be kept.

Proposed Overall Completion Date: 02/27/2025

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

Implemented ( ) - 05/15/2025)