pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ABODE CARE OF MONROEVILLE LLC**
LEGAL ENTITY

To operate **ABODE CARE OF MONROEVILLE**
NAME OF FACILITY OR AGENCY

Located at **2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146**
(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 **66** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 14, 2025** until **November 14, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **451192**

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: MAY 14, 2025

[redacted] Leal Entity Representative
Abode Care of Monroeville LLC
2560 Stroschein Road
Monroeville, Pennsylvania 15146

RE: Abode Care of Monroeville
License/COC #: 451192

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 25, 2024, October 31, 2024, January 15, 2025, January 16, 2025, and February 21, 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), mistreatment or abuse of residents being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 451191) dated October 18, 2024 – April 18, 2025, and 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); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4) (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from May 14, 2025 to November 14, 2025.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
15(b)	II	36	$5	$180	5 calendar days from mailing date of this letter
42(b)	II	36	$5	$180	5 calendar days from mailing date of this letter

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

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

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

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

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ABODE CARE OF MONROEVILLE* **License #:** *45119* **License Expiration:** *04/18/2025*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*

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

Administrator

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

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA, 15146*

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/04/2012* **Issued By:** *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *45* **Waking Staff:** *34*

Inspection Information

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

Reason: *Fine* **Exit Conference Date:** *10/31/2024*

Inspection Dates and Department Representative

10/25/2024 - On-Site: [redacted]

10/31/2024 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *33*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *12*

Have Physical Disability: *2*

Inspections / Reviews

10/25/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/13/2024*

11/14/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/20/2024*

11/21/2024 - POC Submission

Submitted By [redacted] **Date Submitted:** *11/30/2024*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/30/2024*

03/13/2025 - Document Submission

Submitted By [redacted] **Date Submitted:** *11/30/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 10/19/24 at 8:10 AM, resident #1 reported an allegation of abuse via email to [redacted] the home's administrator, involving staff person A towards resident #1; however, this allegation of abuse was not reported to the local Area Agency on Aging until 10/25/24 at 3:00 PM.

REPEAT VIOLATION: 7/9/2024, et. al.

Plan of Correction ***Accept [redacted] 11/21/2024)***

1. Administrator received email on 10/20/24 @9:30am from resident #1. Administrator met with resident #1 on 10/20/2024 @11:00am to address [redacted] complaint. Resident stated [redacted] was changed by nightshift. Administrator acknowledged and apologized to resident for miscommunication between both staff members. Administrator was unaware that [redacted] had to report an abuse allegation because resident stated [redacted] was changed, although late. Administrator was re-educated by DHS representatives on reporting all allegations of suspected abuse or neglect, on 10/25/2024. Administrator reported the incident on 10/25/2024 to protective services.

2. Administrator held a resident meeting on 11/8/2024 explaining complaint procedures, who to report complaints to and how to report complaints. Administrator held an all staff meeting on 11/6/2024 re-educating staff members on complaint procedures, who to report complaints to and how to report complaints. On or before 11/30/24 all staff will receive training on abuse and neglect and abuse reporting procedures in accordance with the Older Adult Protective Services Act. Documentation of all staff training will be kept in accordance to 2600.65i. Daily stand up meetings with management have been implemented on 77/78/2024. Administrator or designee will discuss any resident incidents that have been mentioned within 24 hours to ensure immediate an timely reporting. All doucmentation will be placed on file in accordance to 260075b. DON or desginee will be responsible for reporting abuse to AAA and OHS when reicived or witnessed should Administrator not be present in the home.

3. A new procedure will be implemented by 11/30/24 related to reporting of all incidents or suspected incidents that includes reporting incidents immediately, regardless of internal investigation. Administrator implemented daily stand up meetings on 11/18/2024 to review any incidents that have been reported within 24 hours from any resident or staff member along as review any ongoing incident reports that have been reported. Documentation of meetings will be placed on file. Administrator has reached out to fellow ED from sister commnity on 11/7/2024 to assist in training of all staff including the administrator and Designee. The Administrator with designee alongside completed training on 11/5/2024 from North Hampton University on prevention of Abuse and Neglect, hiring practices and allegations. Quality management meeing is scheduled for 11/25/2024

Licensee's Proposed Overall Completion Date: *11/20/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 03/13/2025)***

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 10/19/24 at 8:10 AM, resident #1 reported an allegation of abuse via email to [redacted] the home's administrator, involving staff person A towards resident #1; however, staff person A continued to work in the home unsupervised on numerous occasions, including during the 3:00 PM-11:00 PM shift on 10/20/24 and 10/21/24.

REPEAT VIOLATION: 7/9/2024, et. al.

Plan of Correction ***Directed [redacted] 11/21/2024)***

1. Staff person A has not been permitted in resident #1's room since 10/17/2024 per resident request. On 10/25/2024 DHS representative instructed Administrator to have a POC to address allegations. Staff person A has been placed on direct supervision with another ataff member since 10/25/2024 while awaiting out come of protective services investigation for abuse. weekly staff shedule shows who is the supervisor that dat for staff person A. Staff person A will be retrained on abuse and neglect and safe handling techniques training on or before 11/30/24. Staff person A will remain on a probationary status for a period of 30 days while on supervision to ensure adequate care is being provided to all residents. Staff person A will also no longer be assigned to resident 1 per resident request.

2. On 10/28/24 the Administrator held a training with all managers to educate them on reportable incidents and conditions. Management is aware in the event of an allegation staff members involved are either on placed on immediate supervision or suspension beginning date incident was reported until investigation is complete. Administrator reviewed with management all incident reporting documentation. All documentation to be placed on file for review. Quality management meeting was held on 10/30/2024 to review incident reports, violation report and other categories. All staff meeting was held on 11/6/2024 to review incident reporting documentation, procedures that need to follow reporting and who to report incidents to. All documentation will be placed on file for review. Daily stand up meetings with management have been implemented on 11/18/2024. Administrator or designee will discuss any resident incidents that have been mentioned within 24 hours to ensure immediate an timely reporting. (DIRECTED: The daily review of incidents shall also include ensuring the immediate suspension or implementation of plans of supervision were implemented for any abuse allegations that were received involving a staff person in accordance with 2600.15b. [redacted] 1/21/24). All doucmentation will be placed on file in accordance to 260015b. DON or desginee will be respoinsible for reporting abuse to AAA and DHS when recieved or witnessed should Administrator not be present in the home. DON or Administrator will be responsible for immediate supervison when allegations of abuse are received or witnessed.

3. Administrator or designee will continue to complete weekly manager meetings. Administrator or designee will continue to hold monthly quality management meetings, next meeting scheduled for 11/25/2024. Administrator or designee will continue to hold monthly staff meetings. Administrator or designee will continue to review resident rights and incident reporting during resident council meetings monthly. All documentation will be placed on file for review. Administrator or designee will hold daily stand up meetings beginning 11/18/2024.

Proposed Overall Completion Date: 11/20/2024

Directed Completion Date: *11/30/2024*

Licensee's Proposed Date for POC Implementation

15b - Supervisor Plan *(continued)*

Not Implemented [redacted] - 03/13/2025)

16c - Written Incident Report

3. 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 10/19/24 at 8:10 AM, resident #1 reported an allegation of abuse via email to [redacted] the home's administrator, involving staff person A towards resident #1; however, this allegation of abuse was not reported to the Department until 10/25/24 at 3:00 PM.

REPEAT VIOLATION: 7/9/2024, et. al.; 5/1/2024, et. al.

Plan of Correction ***Directed [redacted] 11/21/2024)***

1. Administrator received email on 10/20/24 @9:30am. Administrator spoke to resident on 10/20/2024 @11:00am regarding incident. Resident stated [redacted] was changed by nightshift. Administrator explained to resident the miscommunication between both staff members. Administrator was unaware that [redacted] had to report something that wasn't an abuse allegation because resident stated [redacted] was changed. Administrator was re-educated on reporting all allegations, Administrator sent reportable on 10/25/2024.

2. Administrator held a resident meeting on 11/8/2024 explaining complaint procedures, who to report complaints to and how to report complaints. Administrator held an all staff meeting on 11/6/2024 re-educating staff members on complaint procedures, who to report complaints to and how to report complaints. Both staff and residents understand we have 24 hours from date of incident to report complaints. Administrator will meet weekly with both staff and residents individually at least 2 staff members and 2 residents once a week to express their needs, implemented 6/2024. Documentation of intreviews will be kept. Quality management meeting was held on 10/30/2024 to review exit interview and reports, next meeting scheduled for 11/25/2024. All documentation is placed on file. Resident council planned for 11/26/2024. Administrator will review complaint procedure with residents again. Daily stand up meetings with management have been implemented on 11/18/2024. Administrator or designee will discuss any resident incidents that have been mentioned within 24 hours to ensure immediate an timely reporting. (DIRECTED: The daily stand up meetings shall also include a review of all internal incidents to ensure all incidents specified in 2600.16a are reported to the Department within 24 hours in accordance with 2600.16c. [redacted] 11/21/24). All doucmentation will be placed on file in accordance to 260015b. DON or desginee will be respoinsible for reporting abuse to AAA and DHS when reicived or witnessed should Administrator not be present in the home. On or before 11/30/2024 all staff persons will be re-educated on all reportbale incidents specified in 2600.16a as well as timeline of reporting to department in accordance to 2600.16c. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 11/21/24).

3. Administrator or designee will now send any and all incident reports to agencies regardless of internal investigating. Administrator will continue to hold daily and monthly manager meetings. Administrator or designee will continue to hold monthly staff meetings. Administrator will continue to hold weekly staff and resident interviews. Administrator or designee will continue to hold monthly quality management meetings. Administrator or designee

16c - Written Incident Report (continued)

will continue to review complaint procedures with residents during monthly resident council meetings. All documentation will be placed on file for review. All documentation will be placed on file according to 2600.65i

Proposed Overall Completion Date: 11/20/2024

Directed Completion Date: *11/30/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 03/13/2025)***

42b - Abuse

4. 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

On numerous occasions, resident #1 was left in a soiled brief for extended periods of time. One instance occurred approximately 3 weeks ago at approximately 9:45 PM. During that time, staff person A started to change resident #1, then left resident #1 with an open and soiled brief to go obtain gloves. Staff person A never returned to finish providing care to resident #1 and resident #1 was left in bed with the open and soiled brief until approximately 12:30 AM, when staff person B finished providing the care to resident #1. The 2nd instance occurred the morning of 10/19/24, when staff person A failed to provide incontinence care to resident #1 from approximately 4:00 AM-7:00 AM. Resident #1 indicated these incidents made resident #1 cry, feel angry and feel humiliated.

REPEAT VIOLATION: 7/9/2024, et. al.; 5/1/2024, et. al.; 2/22/2024

Plan of Correction ***Directed [redacted] 11/21/2024)***

1. Resident #1 refuses care on numerous occasions. Incident #1 one was on 10/17/2024 around 8:00pm. Staff person A changed resident #1. [redacted] began yelling [redacted] brief wasn't on properly. Staff person A tried to fix it, resident kept yelling. Staff person A excused [redacted] to go find help. Staff person A came into Administrator office and explained incident. Administrator walked down to room to investigate situation and another staff person (not staff person B) came to assist in repositioning brief. Resident #1 stated " I don't want [redacted] in my room" Administrator told staff person A [redacted] s not allowed in [redacted] room per [redacted] request. Staff person A hasn't entered room since. Second incident was reported to administrator via email by resident. Administrator received email on 10/20/2024. Administrator entered the home at 11am on 10/20/2024 to investigate. Administrator spoke to resident regarding request that staff person A was not permitted to care for [redacted] per [redacted] request on 10/17/2024, [redacted] did not refuse to change [redacted] Administrator spoke to both staff persons involved on 10/19/2024 and the circumstances that lead to the miscommunication. Both staff members provided statements. Resident was changed approximately ½ hour later. Resident never mentioned any abuse, humiliation or crying during interview to executive director. During meeting with Administrator resident stated "I was changed, thank you honey for coming to check on me, I appreciate it" .Staff person A has been placed on direct supervision with another ataff member since 10/25/2024 while awaiting out come of protective services investigation for abuse. weekly staff shedule shows who is the supervisor that dat for staff person A. Staff person A will be retrained on abuse and neglect and safe handling techniques training on or before 11/30/24. Staff person A will remain on a probationary status for a period of 30 days while on supervision to ensure adequate care is being provided to all residents. Staff person A will also no longer be assigned to resident 1 per resident request.

42b - Abuse (continued)

2. All staff meeting held on 11/6/2024 to re-educate all employees on procedures to take when dealing with resident care needs and review incident reporting forms. Administrator held resident meeting on 11/8/2024 to re-educate them on resident rights and complaint procedures. Administrator has been in contact with local ombudsman on 11/8/2024 to come and re-educate both staff and residents on rights. Meeting is anticipated to be held on or before 11/30/24 . (DIRECTED: Documentation of the training provided by the Ombudsman shall be kept in accordance with 2600.65i. [redacted]11/21/24). Administrator continues to hold weekly manager meetings implemented 7/2024 reviewing complaints from staff and residents. All documentation is placed on file. Administrator continues to meet with both staff and residents individually at least once a week at least 2 staff members and 2 residents to express their needs, implemented 6/2024. Documentation is kept on file. Quality management meeting was held on 10/30/2024 to review incident reports. Next QM meeting to be held on 10/25/2024. All documentation will be placed on file. Resident council planned for 11/26/2024. Administrator will review complaint procedure and rights with residents again.

3. Administrator or designee will now send any and all incident reports to agencies regardless of internal investigating. Administrator or designee will continue to hold weekly management meetings. Administrator or desgnee will continue to hold monthly staff meetings. Administrator or diesgnee will continue to hold weekly staff and resident interviews. Administrator or designee will continue to hold monthly quality management meetings. Administrator or desginee will continue to review complaint procedures with residents during monthly resident council meetings. All documentation will be placed on file. Administrator will involve local ombudsman when necessary. All documentation will be placed on file.

Proposed Overall Completion Date: 11/20/2024

Directed Completion Date: *11/30/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented*** [redacted] ***03/13/2025)***

101j1 - Mattress Fire Retardant

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

An approximate 14" section of resident #2's mattress was concaved and sunken in on the top-right side and does not properly support resident #2. Resident #2 indicated [redacted]has reported the issue with the mattress numerous times to staff persons; however, a new mattress has not been provided to resident #2.

101j1 - Mattress Fire Retardant *(continued)*

Plan of Correction ***Accept [redacted] 11/21/2024)***

1. 10/25/24 mattress was replaced while dhs inspector on site. DHS representative verified it with photos.

2. Administrator performed monthly physical site checklist reviewing all resident mattresses on 10/28/2024. Documentation of monthly resident bed cecks will be kept. Administrator spoke to resident #2 on 10/25/2024 and educated [redacted] on complaint procedure. Administrator held a resident meeting on 11/8/2024 explaining complaint procedures, who to report complaints to and how to report complaints. Administrator held an all staff meeting on 11/6/2024 re-educating staff members on complaint procedures, who to report complaints to and how to report complaints. Weekly management meeting held on 10/28/2024 reviewing complaint procedures and exit interview. Quality management meeting was held on 10/30/2024 to review incident reports and exit interview.

3. A new procedure was implemented on 11/08/24 that Administrator or maintenance director will complete monthly physical site checklists to include all resident mattresses. Administrator or desginee will continue to hold weekly staff and resident interviews at least 2 staff members and 2 residents. Administrator or desginee will continue to hold weekly management meetings. Administrator or designee will continue to hold monthly quality management meetings next meeting scheduled for 11/25/2024. Administrator will continue to review complaint procedures ith residents monthly during resident council meetings.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ABODE CARE OF MONROEVILLE* **License #:** *45119* **License Expiration:** *04/18/2025*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*

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

Administrator

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

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA, 15146*

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/04/2012* **Issued By:** *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *61* **Waking Staff:** *46*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Interim* **Exit Conference Date:** *01/16/2025*

Inspection Dates and Department Representative

01/15/2025 - On-Site: [redacted]

01/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *33*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *28*

Have Physical Disability: *1*

Inspections / Reviews

01/15/2025 - Full

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

02/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/07/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/23/2025*

02/27/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/07/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/08/2025*

03/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/07/2025*

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 1/15/25 at approximately 11:39 a.m., the only licensing inspection summaries posted on the bulletin board near the television room were dated 5/1/24 and 7/9/24. However, the licensing inspections completed on the following dates were not posted: 9/20/24, 2/22/24, and 11/28/23

Plan of Correction ***Accept [redacted] - 02/18/2025)***

Executive director corrected this on 1/15/2025 with inspectors present in the building. On 01/15/25 inspections that were done over the past calendar year have been posted at the front of the building for public view. Executive director will ensure that the inspections are updated as needed in order to comply with 2600 3.c
As of 0130/25 a new procedure has been put into place for weekly rounds with the Executive Director and DON. Executive director has added the inspection verification to the rounds checklist to monitored week. The Executive Director or Designee will be responsible for ongoing compliance.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 03/13/2025)***

17 - Record Confidentiality

2. 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 1/15/25 at 11:40 a.m., there was a plastic binder-sleeve with licensing inspection summaries from 5/1/24 and 7/9/24 that had the resident privacy coding attached to include the following residents' names:
5/1/24
** Resident #1*
** Resident #2*
** Resident #3*
7/9/24
** Resident #4*
** Resident #5*
** Resident #6*
** Resident # 7*

Repeat violation 11/28/23 et al.; 7/9/24 et al.

Plan of Correction ***Accept [redacted] - 02/18/2025)***

Resident privacy coding was removed on 1/15/2025 with inspectors present. Executive director will ensure that all privacy coding is removed from the inspection summaries moving forward before putting the summary out for public view. This will also be added to weekly rounds check list to ensure compliance with 2600-17

17 - Record Confidentiality (continued)

As of 01/309/25 the Executive director or designee will monitor the inspection summaries weekly to maintain compliance. The Executive Director or Designee will be responsible for ongoing compliance.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

18 - Compliance With Laws

3. Requirements

2600.

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act Enactment Act of June 23, 2016 indicates:
Section 3 Facility powers and duties.
(a) Installation. –
(1) An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from any fossil fuel-burning device or appliance . . ."
** However, the carbon monoxide detector located in the furnace room of the B hallway was located approximately two feet above the furnace.*
** However, the carbon monoxide detector located in the furnace room of the C hallway was located approximately two feet above the furnace.*

The Clean Indoor Air Act (CIAA), Act 27 of 2008, prohibits smoking in public places and workplaces. The CIAA also requires that no smoking signs or the international no smoking symbol must be prominently posted and properly maintained where smoking is not permitted. However, on 1/15/25 at approximately 11:50 a.m., there were no signs at the main entrance to the home indicating whether or not the home permits smoking.
According to the Influenza Awareness Act standards of July 2016, a home is required to post a copy of the Influenza Awareness Poster in a public and conspicuous place. However, on 1/15/25 at approximately 11:50 a.m., a copy of the Influenza Awareness Poster was not posted the home.

Plan of Correction ***Accept [redacted] 02/27/2025)***

New CO detectors were purchassed on 1/16/2025, and mounted throughout areas where gas appliances are in use. Detectors are >15' from all appliances to comply with industry standards and to remain compliant with 2600-18.
Detectors are dated and are now on a bi-weekly check that is being done by the newly hired maintenance director or designee as of 01/30/25
Executive Director or designee be responsible for ongoing compliance
New No smoking signs have been purchased and are posted at both the front and back entrances and part of the weekly audit to check for placement of the signs every Thursday.
The influenza poster was updated per DHS email and is now posted on the Big Board in the front of the building for public view.
See attached

Licensee's Proposed Overall Completion Date: *02/28/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

25a - Written Contract and Review

4. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

On 1/15/25, at 12:15 p.m., there was no contract for resident #6, admitted to the home on [redacted]

Repeat violation 11/28/23 et al.

Plan of Correction ***Accept*** [redacted] ***- 02/27/2025)***

On 01/17/25 resident #6's contract was reviewed by the resident and Executive Director as per 2600.25. As of 01/31/25 a new procedure will be in place that requires all admissions contracts and facility paperwork will be completed prior to the admission by the Marketing. This procedure will include the Executive Director signing off on the file prior to admission.
The Executive Director or designee will review and monitor all new resident contracts and be responsible for ongoing compliance.
An audit will be completed by 2/28/2025 by the Admissions director for all current residents to insure that the resident contracts are complete
A new P&P has been created to insure compliance moving forward and the Admissions director has been trained on that policy

Licensee's Proposed Overall Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***03/13/2025)***

26a - Quality Management Plan

5. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's Quality Management Plan indicates "This plan will be done on a six-month review basis. The home has no documentation when the last Quality Management Meeting was held.

Plan of Correction ***Accept*** [redacted] ***02/18/2025)***

On 01/25/25 The Executive director has established a QM team compiled of both the management team and from the general staff.
QM meeting will take place in the first quarter of this year on March 5th, 2025, and will continue every quarterly thereafter to ensure compliance with 2600-26a All QM members will receive a copy of the meeting notes and the QM binder will be kept in the office of the Executive Director.
The Executive Director or designee will be responsible for ongoing compliance,

Licensee's Proposed Overall Completion Date: *03/05/2025*
Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***03/13/2025)***

[redacted]

[redacted]

[redacted] Withdrawn - [redacted] 4/23/25

[redacted]

51 - Criminal Background Check

7. Requirements

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

Description of Violation

Ancillary staff person A was hired on [redacted] However, a Pennsylvania State Police criminal background check was not completed for staff person A until [redacted]

Direct care staff person B was hired on [redacted] However, a Pennsylvania State Police criminal background check was not completed for staff person [redacted]

Direct care staff person C was rehired by the home on [redacted] However, the most recent Pennsylvania State Police criminal background check was completed [redacted]

Plan of Correction ***Accept [redacted] 02/27/2025)***

As of 01/30/25 a new procedure was put into place All new employees of the home will have a criminal history completed before their start date by the Executive Director or designee.
A new policy has been created along with a employee file check list to be followed for all new employees.
An audit of the current employee files will be completed no later than 2/28/2025

Licensee's Proposed Overall Completion Date: *02/28/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

54a - Direct Care Staff

8. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff *(continued)*

Description of Violation

The home provided a high school transcript for direct care staff person B. However, the transcript does not indicate that the staff person actually obtained a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted]02/27/2025)***

An audit of the employee files by the ED and DON will be completed no later than 2/28/2024. A new policy has been put into place along with a new hire checklist to insure compliance moving forward.

A copy of staff person B's high school transcripts has been given to the ED for verification and has been added to staff person B's file.

Licensee's Proposed Overall Completion Date: *02/28/2025*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted]03/13/2025)***

64a - Admin Training

9. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.
3. A Department-approved competency-based training test with a passing score.

Description of Violation

[redacted] *the home's administrator, did not have documentation of completing an orientation program approved and administered by the Department.*

[redacted] *the home's administrator, did not have documentation of completing the Department-approved competency-based training test with a passing score.*

Plan of Correction ***Accept [redacted]02/27/2025)***

Copies of the orientation and license have been attained and have been added to Staff person D's file.

Licensee's Proposed Overall Completion Date: *02/26/2025*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted]03/13/2025)***

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics *(continued)*

7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person E, hired [redacted] did not receive training in any of the topics 2600.65f during the 2024 staff training year.

Plan of Correction ***Accept [redacted] 02/18/2025)***

On 02/17/25 a monthly training will be held by AMI/RISE and the Executive director and will cover all required training topics on 2600.65f for all employees. By 02/28/25 staff person E will be trained on all the direct care direct care topics, and all records will be held in accordance with 2600.f. Moving forward compliance with 2600.65.f will be reviewed at the next Quality Meeting. The Executive Director or designee will be responsible for ongoing compliance.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

65g - Annual Training Content

11. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Ancillary staff person A, hired [redacted] did not receive any of the topics in 2600.65g during the 2024 staff training year.

Direct care staff person E, hired [redacted] did not receive training in any of the topics 2600.65g during the 2024 staff training year.

Plan of Correction ***Accept [redacted] 02/18/2025)***

On 02/17/25 a monthly training will be held by AMI/RISE and the Executive director and will cover all required training topics on 2600.65f and 2600.65g for all employees. By 02/28/25 staff person E and staff person A will be trained on all the direct care direct care topics, and all records will be held in accordance with 2600.g Moving forward compliance with 2600.65.f will be reviewed at the next Quality Meeting. The Executive Director or designee will be responsible for ongoing compliance.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 03/13/2025)***

66a - Staff Training Plan

12. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home has not developed a 2025 staff training plan.

Plan of Correction ***Directed [redacted] 02/27/2025)***

A new annual training plan has been created and trainings have begun. Trainings to match with 2600-66a have been added to insure compliance to the trainings. Training content and sign in sheets will be kept in the 2025 training manual located in the office of the Executive Director for review. Trainings will be performed by the DON, Executive Director and additional trainings will be provided by AMI rise monthly on-going.

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall audit the creation of an annual staff training plan through the quality management review process. 2/27/25[redacted]

Directed Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented[redacted] 03/13/2025)***

85d - Trash Receptacles

13. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

There were three large uncovered grey trash cans in the kitchen. Food preparation was only being done near the trash can near the range. There was only one trash can lid available in the kitchen.

Plan of Correction ***Accept [redacted] 02/27/2025)***

The Dining manager and dietary staff will insure that trash receptacles are covered daily when not in use. The weekly audit being done on Thursdays with the Executive Director, Maintenance Director, Admissions Director, and the DON will inspect and audit the receptacles located in the kitchen weekly to insure that equipment is in place and in good repair.
Audits began on 2/20/2025 and can lids were present and on the receptacles in good repair.

Licensee's Proposed Overall Completion Date: *02/26/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

88a - Surfaces

14. 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 1/15/24 at 10:00 a.m., there was a hole measuring approximately 1 foot X 1.5 foot in the ceiling in A Hall behind the reception area. There was a crack in the drywall perpendicular to length of the hall from the hole all the way to the adjoining wall.

88a - Surfaces *(continued)*

Plan of Correction ***Directed [redacted] 02/27/2025)***

On 1/30/2025 the ceiling was repaired and on 1/27/2025 the leaking pipe was repaired and replaced it at the junction to prevent any future issues.
the Executive Director, Maintenance Director, Admissions Director, and the DON will inspect and audit al areas to insure that the entire facility is in good repair
Audits began on 2/20/2025

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 5 days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.88(a) and the home's policy and procedures for maintaining compliance with the regulation. 2/27/25 JK

Directed Completion Date: *03/04/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

89b - Hot Water Temperature

15. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 1/16/25 at 11:17 a.m., the hot water temperature in the bathroom between shared resident room #303 and #304 measured 131.9 degrees Fahrenheit.

On 1/16/25 at 11:39 a.m., the hot water temperature in the bathroom in resident room #313 measured 129.6 degrees Fahrenheit.

On 1/16/25 at 11:55 a.m., the hot water temperature in the shared bathroom between rooms #213 and #214 measured 125.2 degrees Fahrenheit.

On 1/15/25 at 12:15 p.m., the hot water temperature of the water at the sink in the common bathroom near the television room measured 126.5 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] 02/27/2025)***

On or before 02/14/25 The newly hired maintenance director has adjusted all hot water heaters used by residents down to below
120 degrees. On or before 02/14/25 The Maintenance Director will monitor water temps for 10 days on a log. Maintenance director will then log water temps monthly to ensure compliance with 2600-89b. The Maintenance Director or designee will be responsible for ongoing compliance. Training will be completed at the all staff meeting taking place on 2/27/2025 by the Maintenance Director.
Log is attached

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

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 03/13/2025)***

100b - Removal Snow/Obstructions

16. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 1/15/25 at approximately 11:15 a.m., there was approximately 2.5–3 inches of snow covering the deck and egress route leading from the dining room exit near the entrance to the kitchen. The deck leads to a gate with a wheelchair ramp to the back of the home near the shed and dumpster.

On 1/15/25 at 11:25 a.m., the exit from B hall near the nursing office had a build-up of ice outside on the sidewalk that prevented the emergency exit door from opening more than approximately 45 degrees.

Plan of Correction ***Directed [redacted]02/27/2025)***

The third party snow removal company GPC landscaping removed snow from the deck at 10:45 am on 1/15/2025.
GPC also salted the entrances after plowing the road and driveway leading up to the building at 11:45am GPC has added the deck to the contract on 1/15/2025 per verbal agreement with the Executive Director. Bill Attached.
The Maintenance Director has been made aware of the change to the contract but will also monitor entryways and the deck during an after a snowfall event in coordination with GPC landscaping.
the Executive Director, Maintenance Director, Admissions Director, and the DON will inspect and audit the entrances and deck when and snow is present during the weekly walkthrough

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 5 days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.100(b) and the home's policy and procedures for maintaining compliance with the regulation. 2/27/25 JK

Directed Completion Date: *03/04/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented ([redacted] 03/13/2025)***

101j1 - Mattress Fire Retardant

17. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 1/15/25 at 10:22 a.m., resident #8's mattress had a 28" long tear along the foot of the mattress exposing the foam stuffing. Also, there is an approximately 18" section of mattress that was concave and sunken in the center.

On 1/15/25 at 10:24 a.m., resident #9's mattress had an approximately 18" section that was concave and sunken in the middle right side. The resident indicates [redacted]bed has a large dip in the middle and that [redacted]places towels and blankest to fill the hole in the mattress for support.

101j1 - Mattress Fire Retardant *(continued)*

Plan of Correction ***Accept [redacted] - 02/27/2025)***

On 01/15/245, the mattress in resident #8's and #9's room were replaced while inspectors were in the building and verified.
Staff will receive training at the all staff meeting on 2/27/2025 regarding identifying and reporting resident mattresses that are damaged and in need of replacement. The Maintenance director will replace any mattresses found to be damaged and discard the old and damaged mattress.
A new policy and procedure has been created to outline the steps for the identification and procedure to replace and or repair.

Licensee's Proposed Overall Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 03/13/2025)

101j3 - Bed/Linens/Pillows/Blankets

18. Requirements

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

Description of Violation

On 1/15/25 at 10:24 a.m., resident #9's white mattress cover sheet was stained with numerous small black spots and a large brown smear approximately 3"X1.5". The pink top sheet had an approximately 6" tear in it.

Plan of Correction ***Directed [redacted] - 02/27/2025)***

New linens have been ordered and put into use on the units. Staff will be trained at the all staff meeting on 2/27/2025 to identify and discard any damaged linen items. Resident #9's mattress cover that was torn and soiled was thrown out on 1/15/2025 after inspectors identified the item.
Staff will be instructed at the training to discard any damaged linen items and report that items have been thrown out to the Executive Director to track when linens stocks are running low. Linens overstock is being stored in the facilities garage under lock and key and is managed by the Executive Director and the DON to disperse linens accordingly when linen stocks are running low.

Proposed Overall Completion Date: 02/28/2025

DIRECTED
Within 5 days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.101(j)(3) and the home's policy and procedures for maintaining compliance with the regulation. 2/27/25 [redacted]

Directed Completion Date: *03/04/2025*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 03/13/2025)

103e - Left Overs

19. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

On 1/15/25 at approximately 11:00 a.m., there was a 5-pound plastic Rotelli Pasta Salad container that had left over Jello salad from last night's dinner in the stainless-steel double door refrigerator. The container was not labeled and dated with the current contents.

On 1/15/25 at approximately 11:00 a.m., there were five unlabeled brown bags of what kitchen staff stated are steak fries in the stainless-steel double door upright freezer in the food storage area.

Plan of Correction ***Accept [redacted] 02/27/2025)***

A new policy and procedure has been put into place along with a daily log to identify any food items that may have come from the food vendor not labeled or dated. Food that is not dated and labeled by the manufacturer will be labeled by Dining Manager using dated stickers that have been made available to the staff.
the Executive Director, Maintenance Director, Admissions Director, and the DON will inspect and audit the food items in the kitchen and stock room weekly to insure that food is labeled and dated.

Licensee's Proposed Overall Completion Date: *02/26/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

103f - Refrigerator/Freezer Temps

20. Requirements

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

Description of Violation

On 1/15/25, at approximately 10:45 p.m., there was no thermometer in the small Frigidaire chest freezer by the door in the food storage room in the ancillary area of the home.

Plan of Correction ***Accept [redacted] 02/18/2025)***

On 01/16/25 a new thermometer was purchased and is now present in the chest freezer. On 01/16/25 the Executive Director educated the dining director on 2600.103.f. Moving forward the Kitchen staff will check temperatures and thermometers daily on a log and a log was placed on all freezers and refrigerators to be check daily and signed off by the kitchen staff completing the
temperature check. The Dining Director or designee will be responsible for ongoing compliance.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

123b - Emergency Procedures Posted

21. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 1/15/25 at approximately 12:00 p.m., neither the home's nor the local municipality's emergency preparedness plans were posted in a public and conspicuous place.

123b - Emergency Procedures Posted *(continued)*

Plan of Correction ***Accept [redacted] 02/18/2025)***

On 01/16/25, The Emergency Preparedness binder was located and surrendered to inspector while they were present in the building. The binder is now available at the reception desk in a conspicuous area in the front of the building.
As of 02/14/25 During weekly rounds building rounds the Executive Director will continue to monitor for compliance with 2600 123b. The Executive Director or designee will be responsible for ongoing compliance.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

127a - Portable Space Heaters

22. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 1/16/25 at 11:21 a.m., there was a Honeywell Space heater operating in resident #6's room.

Plan of Correction ***Accept [redacted] 02/27/2025)***

Space Heaters have been added to a prohibited items list that is going out to the families with the April Billing run.
All space heaters have been removed from resident care area's and are being stored in the garage until the families can retrieve them from the building.
The new Prohibited items policy will be added to all new admission paperwork so that families are informed of the items that are not allowed in the building from admission date.
Any space heaters that are found post 2/28/2025 will be removed immediately by the person who discovers the item. The family will be contacted by the Executive Director to reinforce the homes policy of prohibited items and their removal from the building
Staff will receive the Prohibited items Policy at the all-staff meeting on 2/27/2025.

Licensee's Proposed Overall Completion Date: *02/28/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

132a - Monthly Fire Drill

23. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home's fire drill records indicate that there were no fire drills conducted in October 2024, November 2024 and December 2024.

Plan of Correction ***Accept [redacted] 02/27/2025)***

A Maintenance Director has been hired and a fire drill was performed 2/14/2025, a fire drill will be performed monthly as per the 2600-132a regulation to remain compliant.
A new policy and procedure has been created to insure that fire safety in the building is being followed accordingly to the policy. Staff was educated on this policy after the fire drill performed on 2/14/2025 and is attached.

Licensee's Proposed Overall Completion Date: *02/26/2025*

Licensee's Proposed Date for POC Implementation

132a - Monthly Fire Drill *(continued)*

Implemented [redacted] 03/13/2025)

132b - Safety Inspection/Fire Drill

24. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home had no documentation of a fire safety inspection being completed.

Plan of Correction ***Directed [redacted] 02/27/2025)***

Documents have been received and have been added to the emergency prepardness manual located in the lobby, as well as being added to the Policy and Procedure Manual in the office of the Executive Director. The Maintenance Director has also added a copy to his fire safety manual.
The Executive Director, Maintenance Director, Admissions Director, and the DON will inspect and audit the food items

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall audit the home's fire drill record annually to ensure a fire safety inspection and fire drill are conducted by a fire safety expert shall annually. Documentation of this fire drill and fire safety inspection shall be kept. 2/27/25[redacted]

Directed Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation

Implemented [redacted] 03/13/2025)

132d - Evacuation

25. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum designated evacuation time determined by a fire safety expert within the past year. The home exceeded an evacuation time of 2 minutes and 30 seconds for the following fire drills:
8/12/24 at 10:00 a.m. - the evacuation time was 3 minutes and 07 seconds.
7/7/24 at 6:00 p.m. - the evacuation time was 2 minutes and 47 seconds.
5/24/24 at 4:30 a.m. - the evacuation time was 4 minutes and 05 seconds.

Plan of Correction ***Directed [redacted] - 02/27/2025)***

Documents have been received and have been added to the emergency prepardness manual located in the lobby, as well as being added to the Policy and Procedure Manual in the office of the Executive Director. The Maintenance Director has also added a copy to his fire safety manual.

132d - Evacuation (continued)

the Executive Director, Maintenance Director, Admissions Director, and the DON will inspect and audit the food items
Evacuation time is 5 mins per [redacted] *and the evacuation times listed above fall well within those parameters, meeting the standard evacuation time.*

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall audit the home's fire drill record monthly to ensure all resident are evacuated to a fire safe area designated by a fire safety expert of the safe area outside of the home within the time specified by the home's fire safety expert. 2/17/15 [redacted]

Directed Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***03/13/2025)***

132e - Fire Drill Sleeping Hours

26. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home's most recent sleeping hour fire drill was held 5/24/24 at 4:30 a.m.

Plan of Correction ***Directed*** [redacted] ***02/27/2025)***

The Maintenance Director will conduct an unannouced sleeping fire drill on the night of March 5th 2025.
The last sleeping fire drill was completed in August of 2025 according to the records that I was able to find.
Monitoring has started as 2/20/2025 as part of the weekly facility walking audit.
The staff was trained on the fire drill safety on 2/14/2025 after the fire drill was completed by the Maintenance Director.

Proposed Overall Completion Date: 03/05/2025

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall monitor the fire drill record monthly to ensure a fire drill is held during sleeping hours once every 6 months. 2/27/25 [redacted]

Directed Completion Date: *03/05/2025*
Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***03/13/2025)***

132g - Fire Drills Days/Times

27. 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

The home routinely schedules three staff on the 11:00 p.m.-7:00 a.m. shift to include on 1/15/25, 1/14/25, 1/13/25

132g - Fire Drills Days/Times (continued)

and 1/12/25. However, no fire drill has been conducted with three staff since 5/24/24 at 4:30 a.m.

Plan of Correction ***Directed [redacted] 02/27/2025)***

A fire drill was performed during daylight hours on 2/14/2025 by the Maintenance Director (see Attached) The Maintenance Director will perform a sleeping hours fire drill on the night of 3/5/2025. Next fire drill will be scheduled for the evening shift and will be determined by the Maintenance Director and the Executive Director.
Staff was trained on Fire Prevention and Safety on 2/14/2025 after the fire drill was completed.
Fire Safety Training with [redacted] will be scheduled for April 2025 to remain in compliance with 2600-132g

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall audit the home's fire drill record monthly to ensure 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. 2/27/25 [redacted]

Directed Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 03/13/2025)***

141a 1-10 Medical Evaluation Information

28. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident # 6's medical evaluation (DME) dated [redacted] does not include a medication regimen.

Plan of Correction ***Accept [redacted] 02/27/2025)***

An audit has begun and will be completed by 3/7/2025 by the DON and [redacted] ADON to insure that all resident records are complete with all compliance items to be present.
Resident #6's evaluation has been completed by Dr. [redacted] on 2/5/2025 and is attached and medication regime has been updated and also signed by Dr. [redacted]

Licensee's Proposed Overall Completion Date: *03/07/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

144c2 - Smoking Area Distance

29. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's smoking policy indicates that "the designated smoking areas are located outside each exit of the back (2) living rooms of the building." However, the home's designated smoking area is actually located outside the main front exit in the parking lot.

Plan of Correction ***Accept [redacted] 02/27/2025)***

On 01/20/25 No Smoking signs have been purchased and placed at exits outside each exit of the back (2) living rooms of the building in question to ensure safety and compliance with 2006-144c. On 01/20/25 the homes smoking policy was updated to reflect the correct smoking area located outside the main front exit in the parking lot. The corrected Smoking Policy will be given to the residents and all staff on or before 02/20/25. The Executive Director will audit these signs on Thursday afternoon audit walkthroughs to insure that signs are in good repair and in place

Licensee's Proposed Overall Completion Date: *02/26/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented ([redacted] 03/13/2025)***

161d - Dietary Needs

30. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #12 is ordered a mechanical soft diet. However, on 1/15/25 at 12:15 p.m., the resident was served cut up turkey in gravy, scalloped potatoes and whole Brussel sprouts the size of 1".

Plan of Correction ***Accept [redacted] 02/27/2025)***

The Executive Director and the DON did a training with the dietary and nursing staff on 2/5/2025 to address and educate them on proper mechanical soft foods.
Training is attached.
A list of residents that have a mechanical soft diet has been posted in the kitchen and wellness office. The DON will be responsible for updating the list and communicating any changes to the Dining Manager and nursing staff for resident safety.
The Executive Director, Maintenance Director, Admissions Director, and the DON will review the diet list on the audit walkthrough to insure that the list present and updated.

Licensee's Proposed Overall Completion Date: *02/26/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

162c - Menus Posted

31. 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 menu posted in the dining room only indicates "Week 1." There is no way to determine for what week the menu is in effect.

Repeat violation 5/1/24 et al.; 7/9/24 et al.

Plan of Correction ***Accept [redacted] 02/27/2025)***

Following the inspection on 01/16/25 the Executive Director posted specific dates on the menus. On 01/20/25 the Executive Director secured a new system involving Reinhart Foods to ensure menus are dated and clea[redacted] Executive Director, Maintenance Director, Admissions Director, and the DON will inspect menus during weekly walking audits and the Executive Director will post updated menu's every Friday afternoon for the following weeks

Licensee's Proposed Overall Completion Date: *02/26/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

185a - Implement Storage Procedures

32. 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

The home's Policy for Safe Use of Medications indicates in #2 that "Medications are to be signed for and placed in med cart or in refrigerator by med tech."

Resident #11 had two narcotic cards of 15 pills each for Tramadol HCL 50 mg - take one tablet by mouth every 12 hours for pain. The homes' Controlled Substance Disposition Record does not include the date received or received by (name of nurse). These sections are blank on the form.

Plan of Correction ***Accept [redacted] 02/27/2025)***

A new policy an procedure has been added to the existing medication management procedure. The DON on 2/6/2025 did a training on medication chain of custody and proper documentation regarding it. See attached. The DON and ADON have requested that if possible all narcotics be delivered from the pharmacy during regular business hours to insure compliance for the chain of custody. Any new narcotics that are prescribed will be reviewed by the DON or ADON to insure chain of custody compliance and proper documentation entry into the residents chart.

Licensee's Proposed Overall Completion Date: *02/26/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

187d - Follow Prescriber's Orders

33. Requirements

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

Resident #10 is prescribed Diclofenac Sodium 1% gel apply 4 grams topically to bilateral knees three times as day. The entry for this medication on the resident's January 2025 medication administration record (MAR) indicates Diclofenac sodium 1% gel – apply 4 grams (see enclosed measuring guide) to bilateral knees three times a day. However, there are four administration times for this medication at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. on the MAR. According to staff person F, Assistant Director of Resident Care, the medication pops up on the electronic MAR for each administration time and if it is documented, it has been administered. The medication has been administered four times daily from 1/1/25 8:00 AM through 1/15/25 at 8:00 AM.

Plan of Correction ***Directed [redacted] 02/27/2025)***

On 01/16/25 the order was verified with the MD and the order was updated to correctly reflect the on the EMAR resident #10 to receive Diclofenac Sodium 1% gel apply 4 grams topically to bilateral knees three times as day.
In cooperation with [redacted] Hospice who was the ordering entity. This was fixed onsite with inspectors present at the time. DON will monitor along with [redacted] ADON for any med changes that may occur due to a resident change.
Training was performed by the DON on 2/6/2025 regarding proper medication orders and how to verify them with the MD.
The Director of Nursing and Assistant Director of nursing will be responsible for ongoing compliance by verifying medication orders with both the pharmacy and the prescribing MD. Ancillary agencies must also submit any medication changes in writing to the DON to verify at the time of the change.

Proposed Overall Completion Date: 02/26/2025

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall file an incident report with the Department regarding the medication error. 2/27/25 [redacted]

Within 1 day of receipt of the accepted plan of correction: The administrator shall document the medication error and the prescriber's response shall be kept in the resident's record. 2/27/25 [redacted]

Within 1 day of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall audit all resident MARs monthly to ensure compliance with Regulation 2600.187(d). 2/27/25 [redacted]

Directed Completion Date: *02/28/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

223a - Description of Service

34. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

223a - Description of Service *(continued)*

Description of Violation

The home did not have a description of services and activities that the home will provide.

Plan of Correction ***Accept [redacted] 02/18/2025)***

On 01/16/25 the home did have a written description of the services and activities that the home provides in the home contract which is given to each resident upon admission. However, the Executive Director at the time was new to the facility and had not realized that the contract provided this information. Additionally, at the time of inspection, the description of services was forwarded to the building from the New York office and is now posted in the front of the building on a large community board. Executive Director will continue to monitor for compliance The written services were provided to the state onsite during the inspection once the Executive Director secured this information from the home office. Moving forward, the Executive Director and the Marketing DIRECTOR will be responsible to ensure that each resident receives this information upon admission.

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

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

225c - Additional Assessment

35. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #6's assessment, dated [redacted] was not updated for the diagnoses included on the physician orders signed on [redacted] to include: Cholesterol, Joint pain caused by arthritis, seizures, Addison's Disease, Neuropathy, anti-ich, fungal skin infections, low blood pressure, asthma.

Resident #10's assessment, dated [redacted] was not updated for the diagnoses included on the physician orders signed on [redacted] to include: Constipation, Depression-Diabetic Neuropathy, Cholesterol, stomach acid, decreasing ocular pressure.

Resident #11's assessment, dated [redacted] was not updated for the diagnoses included on the physician orders on [redacted] o include: Seizures, anxiety, mood disorder, pain, schizophrenia, restlessness, nausea/vomiting.

Plan of Correction ***Accept [redacted] 02/27/2025)***

On 01/16/25 the DON working in cooperation with MD's CRNP and other entities has verified and added all missing diagnoses to all residents' charts to match with the MD diagnosis. On 01/16/25 the Executive Director re-educated the DON and ADON on 2600.225c. Resident #6's DME was updated and signed on 2/5/2025 by Dr. [redacted]
Resident #10's DME was updated and signed by Dr. [redacted] on 2/6/2025
Resident #11 CTB [redacted] while on [redacted] Hospice. See Attached Report.
An audit has started performed by the DON and ADON to insure all resident DME's are correctly updated and the audit will be completed by 3/7/2025

Licensee's Proposed Overall Completion Date: *03/07/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 03/13/2025)***

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

Facility Information

Name: *ABODE CARE OF MONROEVILLE* **License #:** *45119* **License Expiration:** *04/18/2025*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*

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

Administrator

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

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*

Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA, 15146*

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *06/04/2012* **Issued By:** *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *52* **Waking Staff:** *39*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *02/21/2025*

Inspection Dates and Department Representative

02/21/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *36*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *35*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *16* **Have Physical Disability:** *0*

Inspections / Reviews

02/21/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/10/2025*

Inspections / Reviews *(continued)*

03/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/12/2025*

03/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/11/2025*

03/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/10/2025*

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

95 - Furniture and Equipment

1. Requirements

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

Description of Violation

The towel bars were in disrepair on the back of both of the doors in the shared bathroom between bedrooms 108 and 110 as follows:
- The bathroom door for bedroom 108: The towel bar bracket on the left side of the door was missing and no towel bar was present
- The bathroom door for bedroom 110: The towel bar was missing, however, both brackets were present

Plan of Correction ***Accept [redacted] - 03/07/2025)***

These were replaced and put back into service and double checked during weekly audit round on 3/2/2025. The Executive Director, Maintenance Director, Admissions Director and the DON, have started weekly audit rounds to insure that all items in the facility are in good repair. A new policy and procedure has been put into place and trainings took place at the all staff meeting pertaining to damaged linen as well as resident room items such as the towel bar. Staff will report any issues to the Management team and the Maintenance director will replace or repair any damage that is found. Executive Director and DON will audit the progress to insure that the items are in good working repair.

Licensee's Proposed Overall Completion Date: *03/02/2025*
Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 03/13/2025)***

127a - Portable Space Heaters

2. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

There was a portable space heater in in the room of resident #2. The resident indicated it has been used for the past 4 months.

Plan of Correction ***Accept [redacted] 03/10/2025)***

All space heaters have been removed from resident care area's and placed into the garage. The families have been notified to retrieve them and a " Prohibited Items list has been created and will be distributed to the families on the April billing run by the Corporate office. An all-staff meeting took place on 2/27/2025 at 1500 and staff was instructed and educated on the new Fire Policy and Procedure then and during the last fire drill that took place on 2/14/2025. Staff will report any and all heating devices to the DOM, Executive Director if they find any prohibited items during daily rounds.
The Executive Director, Maintenance Director, DON and Admissions Director are doing weekly rounds to identify any prohibited items that might be found and removing them immediately for family removal.
All space heaters were removed during the weekly walkthrough audit completed on 3/27/2025 by both the Executive Director and the Maintenance Director.

Licensee's Proposed Overall Completion Date: *03/07/2025*
Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 03/13/2025)***

224a - Preadmission Screen Form

3. Requirements

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

Description of Violation

Resident #1, admitted [redacted] does not have a preadmission screening.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

This document was present both in the chart and the prescreen folder that the DON keeps in [redacted] office. Please see attached.
A resident chart audit is ongoing and will be completed on 3/7/2025 per the POC from the annual state inspection. This audit will be sent in with that POC once completed no later than 3/7/2025.

A resident chart audit tool has been created for all new admissions and will begin upon admission with the Marketing Director to check off [redacted] documents, it then follow the medical paperwork to the chart where the DON or the ADON will continue to use the audit to insure that all of the documents have been received and/or completed within the time frames laid out by the DHS.
The weekly audit walkthrough will include the Executive Director checking and insuring that the chart audit tools have been completed and any issues will be directed to the DON/ADON for completion.

Proposed Overall Completion Date: 03/07/2025

Licensee's Proposed Overall Completion Date: *03/07/2025*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 03/13/2025)***