pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
Sent via e-mail [redacted]
July 15, 2025

[redacted]
Owner
Penstate Best Care, Inc.
[redacted]

RE: Haskins House
1009 Rhoads Avenue
Secane, Pennsylvania 19018
License #: 13855

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on April 2 and June 27, 2025 of the above facility, we have determined that your submitted plan of correction for the January 23, 2025 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *HASKINS HOUSE* **License #:** *13855* **License Expiration:** *07/05/2025*

Address: *1009 RHOADS AVENUE, SECANE, PA 19018*

County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *PENSTATE BEST CARE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/28/1997* **Issued By:** *Commonwealth of PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *23* **Waking Staff:** *17*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *01/23/2025*

Inspection Dates and Department Representative

01/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* **Residents Served:** *20*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older:** *17*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability:** *2*

Have Mobility Need: *3* **Have Physical Disability:** *0*

Inspections / Reviews

01/23/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/28/2025*

Inspections / Reviews *(continued)*

03/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/23/2025*

04/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/16/2025*

07/07/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/15/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 1/23/2025, at 9:00 AM, a red binder containing medication audits of all residents was unlocked, unattended, and accessible by the porch entrance in the medication area.

At 10:53 resident records including support plans, contracts, and medical information were unlocked, unattended, and accessible in a closet in the unlocked office.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator removed the medication audit book and locked up in closet on 1/23/25. Administrator will in-service nursing staff and self on Records Accessibility/Storage policy by 3/17/25. Administrator to monitor daily that resident records are kept confidential.

Starting 3/17/25 administrator will utilize a check list to ensure daily that records are kept confidential and locked up.

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

Implemented ([redacted] - 06/27/2025)

42s - Privacy

2. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 1/23/2025 at 9:54 AM, cameras were recording in building including in the resident dining and living area's. The images captured by cameras are not angled to to capture entrances or exits from the home and capture and record images in the common areas used by residents, which is also where where staff of the home frequently administer medications to residents.

Plan of Correction ***Directed ([redacted] - 04/02/2025)***

Administer turned off recording on all cameras on 1/23/25. Administrator to monitor camera daily and ensure recording is not on. Administrator to ensure daily resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures

The video recording was turned off on all on 1/23/25. Signs are posted for video monitor outside the building and all thru out the building. Has been posted since cameras in use. Approx 3yrs. Administrator provided letter to residents and mailed out to responsible parties on 3/28/25. Administrator will incorporate video surveillance notification in future resident contracts.

42s - Privacy (continued)

DIRECTED PLAN OF CORRECTION:
In addition to the above plan, within 48 hours of the receipt of this plan of correction, the administrator or designee shall review all camera video feeds to ensure that privacy is maintained for all residents including areas where medication is being administered. The administrator or designee shall review the camera angles at least monthly to ensure ongoing privacy is maintained. Documentation of monthly review of camera feeds shall be kept in the home and provided to the Department for review upon request.

Directed Completion Date: *04/05/2025*

Implemented ([redacted] - 06/27/2025)

62 - Contact List

3. Requirements

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

Description of Violation

[redacted] *the administrator, maintains a list of staff persons that does not include agency staff. Staff person B who has been working in the home since 2022 is not included on the staff list.*

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

The owner will maintain a separate list of substitute personnel, which includes any agency staff person. The list will be updated whenever a new agency staff person works in the home. The list will include the agency staff's name, number and date first employed. The list will be maintained in the home and made available to the Department upon request.

Licensee's Proposed Overall Completion Date: *03/25/2025*

63a - First Aid/CPR Training

4. Requirements

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

Description of Violation

On 1/18/2025, from 2:00 PM to 3:00 PM, 20 residents were present in the home. During this time no staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 03/18/2025)***

Administrator wrote wrong time by error on schedule for 1/18/25. All other days on schedule that week were 8-3. Administrator wrote the wrong time by mistake. Administrator will ensure when doing schedule that there is 1 staff person who is trained in CPR/First Aid present in the home at all times. Schedule will have CPR/First aid trained nurse on 8-3 and CPR/First aid certified direct care staff in at 3pm daily on schedule.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Implemented ([redacted] - 06/27/2025)

65b - Rights/Abuse 40 Hours

5. Requirements

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

Description of Violation

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

Staff person C completed [redacted] 40th scheduled work hour on or about [redacted] However, this staff person did not complete training in the following topics: reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

I disagree with violation. Multiple different agency nurses are used. They have their documentation from agency work for. However, I do not understand how a nurse who may come in for a shift be expected to do all the in-services when here for one shift. That nurse may not be on shift again for a week or at all. Not sure how but administrator will ensure staff completes mandatory resident rights, emergency medical plan and abuse. Staff B is not currently being used. I disagree with this violation, Staff C completed training on reportable incidents and conditions on 10/13/23. Administrator to ensure staff completes required training of resident rights, emergency medical plan, mandatory reporting and reporting of reportable incidents within 40 scheduled working hours.

Disagree with violation for staff C. I sent mandatory in-service which is related to reportable incidents not resident rights. Attached again
Administrator to add resident rights and abuse training to binder for agency staff with annual training to ensure all agency staff complete.

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

Implemented ([redacted] - 06/27/2025)

65g - Annual Training Content

6. 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.

65g - Annual Training Content *(continued)*

Description of Violation

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable during training year 1/1/2024-12/31/2024

Plan of Correction ***Accept (- 04/02/2025)***

I disagree and goes to top violation. I also do not understand why I had two agency nurses who did not complete in-service yet only one chosen. Again, how is agency nursing going to complete before their shift. Administrator will ensure staff to complete annual training. Staff B is not coming to the facility at this time.

Administrator to add all mandatory in-services to binder and ensure that agency completes when works in facility and monitor monthly that agency employees are completing the required in-services.

Administrator to create a binder with required topics of annual training. Administrator will have a log in book to sign off on to ensure agency staff completes annual training when come into facility and monitor weekly that all agency staff is completing the required training topics.

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

65i - Training Record

7. Requirements

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

Description of Violation

The home's record of direct care staff training for staff person D's orientation does not include date training occurred, length of training, and source of training.

Plan of Correction ***Directed (- 04/02/2025)***

Disagree with this violation. Staff C completed all orientation at time of hire on Employee completed 12hr for year. My calander year goes for one year after hire date. Staff C has training hours for one year from date of hire. Employee did complete training on and every month after that. Administrator to ensure to have record of training with date, source, content, length of course and copies of any certificates.

I still disagree with this violation. The date orientation completion is clear on check list and all orientation papers were completed and in the file. Administrator to audit employee files monthly to ensure all training is completed and dated.

DIRECTED PLAN OF CORRECTION:
Within 10 business days of the receipt of this plan of correction, the administrator shall update the orientation check list to be used to document orientation training for all staff - including ancillary and substitute personnel. The Administrator or designee shall create a form that includes information for the staff persons hire date, the specific date that orientation training is received, each specific topic of training provided, the name and signature of the

65i - Training Record (continued)

person who provided the training to the employee, the length of time for each course or topic. This document shall be used for all new staff and the completed forms shall be kept in the individual employee file and made available for Department review upon request.

Directed Completion Date: *04/12/2025*

Implemented ([redacted] - 06/27/2025)

66a - Staff Training Plan

8. Requirements

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

Description of Violation

The home does not have a staff training plan for the 1/1/2025-12/31/2025 training year.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator completed staff training plan on 1/27/24. Administrator to ensure staff training plan completed on January 1st of the training year.

Administer will have a calendar update to ensure training plan is completed by January 1st of the training year.

Licensee's Proposed Overall Completion Date: *03/25/2025*

Implemented ([redacted] - 06/27/2025)

82b - Poisonous Material Storage

10. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

A citrus cleaner with manufacturer's label indicating "call poison control if ingested", was stored on the floor in the dry food storage area next to food items including a 2-liter bottle of soda and a plastic tub filled with cereal.

A can of shellac with manufacturer's label indicating "call poison control if you feel unwell" was stored on a shelf next to food items including, cans of chili, beans, and jellied cranberry sauce.

Repeat Violation Date: 2/8/2024

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Poisonous materials were removed immediately after inspection on 1/23/25. Owner and kitchen staff to be in-serviced on policy that poisonous materials are stored separately from food, food preparation surfaces and dining surfaces on 2/2/24. Administrator, owner, kitchen staff to monitor safety of food areas daily.

Starting 3/19/25 administrator has an audit tool to ensure daily monitoring of areas to be free of poisonous materials stored near food supply.

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

Implemented ([redacted] - 06/27/2025)

83a - Indoor Temperature

11. Requirements

2600.
83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

On 1/23/2025 the following temperatures were observed throughout the building:

At 9:41 AM it was 64.3 degrees Fahrenheit on the stairs.
At 9:45 AM it was 63.6 degrees Fahrenheit near the table in the living area.
At 10:29 AM it was 62.4 degrees Fahrenheit in the 1st floor bathroom.
At 10:36 AM it was 62.7 degrees Fahrenheit in room 9.
At 10:43 AM it was 66.7 degrees Fahrenheit in room 4
At 10:46 AM it was 61.5 degrees Fahrenheit in room 3
At 10:50 AM it was 64 degrees Fahrenheit in the living area
At 10:56 AM it was 61.8 degrees Fahrenheit near the table in the living area.
At 10:59 AM it was 60.2 degrees Fahrenheit in room 11
At 11:01 AM it was 65.2 degrees Fahrenheit in the 2nd floor bathroom.
At 2:22 PM it was 66.3 degrees Fahrenheit in room 8.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator informed owner of temperature in the building. building is losing a lot of heat when residents go outside to smoke. Owner ordered a magnetic insulated door to install in doorway. Administrator to monitor thermostat daily to ensure the indoor temperature is 70F when residents are in the home. The door to be installed by 3/17/25. Documentation of door will be provided to the department.

On 3/19/25 Clear wind curtain installed on door. It opens easily, door is visible and is not locked. Starting on 3/19/25 the temperature of building to be monitored by staff daily and logged on audit tool.

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

Implemented ([redacted] - 06/27/2025)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 1/23/2025 at 10:13 AM, In the fridge/freezer unit located by the washers, the bottom surface of the freezer was strewn with food debris including corn and other crumbs as well as a dried brown substance smeared under under package of frozen pancakes and a blue plastic tub. Additionally there are multiple areas of a dried puddle of a brown and black substance that is present in multiple areas of the fridge including under the bottom drawers and on the fridge door shelves.

At 10:22 AM a plastic container of cereal was in the kitchen cabinet, the container was not labeled, and the lid was visibly soiled with yellow and brown grime.

85a - Sanitary Conditions (continued)

At 11:23 AM an open bedroom on the 3rd floor was observed to be unlocked and accessible to residents of the home. Staff person A stated that the person residing in this room is not a resident but a "friend of the owner" who is living in the room. The room was observed to have a large accumulation of various debris including, broken furniture, soiled blankets and clothing items, trash and empty plastic bottles and a large number of vitamins and supplements strewn across the floor. The carpet was also visibly dirty. The door to the bedroom could not be fully closed due to the various debris on the floor blocking the doorway.

Plan of Correction ***Directed (- 04/02/2025)***

The fridge was cleaned on 2/28/25. Plastic container was replaced on 2/28//25. Administrator to in-service all staff on 3/17/24 to do daily of check refrigerators and freezers to ensure sanitary conditions. In regard to third floor that area is not a resident occupied floor.

Administrator to have log sheet for all staff to monitor sanitary conditions daily starting 3/19/25.

DIRECTED PLAN OF CORRECTION:
In addition to the above plan of correction, the administrator or designee shall ensure that all areas of the home are clean and free of debris that may pose sanitation, infestation or other hazards to the health and safety of residents in the home. All areas of the building shall be monitored and any areas of the facility that are non-compliant shall be addressed immediately and steps to mitigate the sanitation issue shall be made including removal of any cause of sanitation violation.

Directed Completion Date: *03/28/2025*

Implemented (- 06/27/2025)

85e - Trash Outside Home

13. Requirements

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

Description of Violation

At 8:56 AM there were cardboard boxes next to a large dumpster in the parking lot, a black trash bag on the ground next to the gate, plastic soda bottles in the yard, and multiple old buckets, containers, and a bottle of prestone max oil stacked near the walkway.

Plan of Correction ***Accept (- 04/02/2025)***

Trash removed immediately after informed was there. Administrator will in-service all staff on 3/17/25 of need for trash to be put in covered receptacles outside. Administrator to monitor the outside daily to ensure trash is kept in receptacles. Administrator to send documentation to dept.

Starting 3/19/25 there is a daily check for staff to monitor that all trash is in covered receptacles.

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

Implemented (- 06/27/2025)

87 - Lighting

15. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 1/23/25 at 9:56 AM there was no lighting in the second-floor hallway leading to the emergency fire escape.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

There is a light in hall by emergency exit door. Light was turned on immediately. Resident turns light off. Administrator informed resident that the light needs to always be on. Administrator to monitor daily that the light in hallway leading to emergency fire escape is on.

Starting 3/20/25 staff to utilize check list to monitor daily that the light by emergency exit is on.

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

Implemented ([redacted] - 06/27/2025)

88a - Surfaces

16. 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

A small area rug on the carpeted staircase landing was loose and at an obscure angle that was causing a corner to bunch up against another step, creating a tripping hazard.

In the first-floor hallway near the thermostat a recessed light fixture was descending from a ceiling tile from which it was installed. The ceiling tile had multiple cracks around the edge fixture as well as along the short edge of the tile adjacent to the wall.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Ceiling in the first-floor hallway was repaired on 2/27/25. The rugs in the stairways were removed immediately after inspection. Administrator and owner to monitor the facility daily that floors, walls, ceilings, windows, doors and other surfaces are clean, good repair and free of hazards.

Starting 3/19/25 all staff to utilize a check list to ensure floors, walls, ceiling windows and doors and other surfaces are clean, in good repair and free of hazards.

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

Implemented ([redacted] - 06/27/2025)

89b - Hot Water Temperature

17. Requirements

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

89b - Hot Water Temperature *(continued)*

Description of Violation

On 1/23/25 at 10:29 AM, the hot water temperature at the bathroom measured 130.1 degrees Fahrenheit and at 12:36 PM it was 125.4 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 03/17/2025)***

The water heater was lowered after inspection was over and the temperature of the water in the bathroom was rechecked after an hour and was 115F. Starting 1/24/25 the owner will monitor weekly that the water temperature is between 106F and 120F and adjust accordingly if needed. Owner will immediately utilize a water flow sheet to keep track of the water temperatures.

Licensee's Proposed Overall Completion Date: *03/05/2025*

Implemented ([redacted] - 06/27/2025)

91 - Telephone Numbers

18. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline, on or by the telephone in in the medication area.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

I disagree with this violation. The emergency phone numbers are posted at nurse station by phone on the cabinet door. Administrator to ensure and monitor daily that emergency numbers are posted by the phone

Administrator added to poster to include local police, fire dept and nearest hospital numbers are posted and PA Hotline for residents/visitors to contact DHS to file a complaint. Administrator will monitor daily that sign is posted by phone and is updated accordingly.

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

Implemented ([redacted] - 06/27/2025)

95 - Furniture and Equipment

19. Requirements

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

Description of Violation

On 1/23/2025, the door handle of the refrigerator in the main kitchen was held in place with duct tape.

A smoke detector located on the ceiling in the main kitchen area was broken and hanging from the ceiling tile by the internal wires of the detector.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Directed ([redacted] - 04/02/2025)***

Owner repaired door handle on refrigerator and repaired the hanging smoke detector on 2/28/25. Owner to monitor daily that furniture and equipment is in good repair, clean and free of hazards.

Starting 3/20/25 staff to utilize check list to ensure furniture and equipment is in good repair daily.

DIRECTED PLAN OF CORRECTION:
In addition to the above plan of correction and within 48 hours of the receipt of this plan of correction, the administrator or designee shall completely repair or replace the smoke detector according to the manufacturers instructions. Monthly monitoring of all smoke detectors shall be conducted to ensure they are all mounted correctly. Documentation of the repair or replacement including the date that it was corrected as well as monthly monitoring shall be kept in the home and made available to the Department for review.

Directed Completion Date: *03/31/2025*

Implemented ([redacted] - 06/27/2025)

100b - Removal Snow/Obstructions

20. 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 1/23/2025 at 8:56am, there was approximately 2 inches of accumulation of snow and ice on the ramp leading to the front door and the stairs of the fire escape. The last measurable snow fall/precipitation had occurred several days prior and the obstruction had not been removed.

Plan of Correction ***Directed ([redacted] - 04/02/2025)***

Snow was removed from patio and walkway immediately. Owner to ensure that snow removal company or [redacted] removes snow/ice from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Starting in the fall administrator to have a daily check list for staff to monitor that there is no snow or ice on walkways, ramps, exterior fire escape.

DIRECTED PLAN OF CORRECTION:
The administrator or designee shall conduct a daily inspection of the exterior of the home to ensure there are no obstructions present- including, but not limited to weather related obstructions, trash or other debris that has blown into the area, tree limbs or leaves that may cause a hazardous condition, etc. As this regulation is intended to provide a safe environment for residents to be able to exit the building but to also enjoy the outdoor areas of the home, year round, not just in the fall/winter.

Directed Completion Date: *03/31/2025*

Implemented ([redacted] - 06/27/2025)

101j7 - Lighting/Operable Lamp

21. Requirements

101j7 - Lighting/Operable Lamp *(continued)*

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

Description of Violation

Resident 1 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

I disagree with this violation. The resident has a working lamp by bedside and is capable of turning on and off by self. On 2/27/25 owner installed another lamp at bedside. Administrator/owner to monitor daily that residents have an operable lamp or other source of lighting that can be turned on at bedside.

Starting on 3/20/25 to utilize log sheet to ensure daily that residents have an operable lamp at bedside.

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

Implemented ([redacted] - 06/27/2025)

103e - Left Overs

22. 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.

Description of Violation

There was an unlabeled, undated clear plastic bag of macaroni and cheese leftovers and an unlabeled and undated clear plastic bag of what appeared to be mixed vegetables leftovers in refrigerator in the dry storage area.

Repeat Violation Date 2/8/2024

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Kitchen staff removed unlabeled food immediately. All staff to be in-serviced on 3/17/25 on proper food containment. All staff made aware to monitor daily that food is stored in sealed containers and labeled. Kitchen staff will monitor daily that food is properly stored and labeled.

Starting 3/20/25 staff to monitor daily with log sheet to ensure leftovers are labeled and stored in sealed containers.

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

Implemented ([redacted] - 06/27/2025)

103f - Refrigerator/Freezer Temps

23. 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 1/23/2025 at 10:11 AM the temperature in the freezer in the dry storage area was 10 degrees Fahrenheit.

At 10:24 AM the temperature in the freezer in the main kitchen was 20 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

New thermometers were purchased and placed in freezer in dry storage area and freezer in main kitchen on 3/3/25. On 3/3/25 the freezer in dry storage area and main kitchen now read below 0 degrees. On 3/17/25 administrator to in-service kitchen/care staff to ensure that all refrigerators and freezers have a working thermometer. Kitchen/care staff to monitor daily that fridge is at or below 40F and freezers at or below 0F.

Starting 3/20/25 staff to utilize check list to monitor fridge and freezer temps daily.

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

Implemented ([redacted] - 06/27/2025)

103g - Storing Food

24. Requirements

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

Description of Violation

On 1/23/25, there were multiple unlabeled, undated plastic single use grocery bags containing unknown food items stored in the freezer in the basement dry storage area. The single use grocery bags were loosely tied in knots and not properly sealed in an appropriate container.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Food in freezer was removed immediately. All staff to be in-serviced on 3/17/25 to ensure proper food containment. All staff made aware of need to monitor daily that food is stored in sealed containers and labeled. All staff will monitor daily that food is properly stored and labeled.

Starting 3/20/25 staff to utilize log sheet to ensure food is labeled and in sealed containers daily.

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

Implemented ([redacted] - 06/27/2025)

103i - Outdated Food

25. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 1/23/25, there was an unlabeled, undated plastic containers of cookies sugar in the upper kitchen cabinets.

On 1/23/25, In the downstair refrigerator near the washer and dryers there was a can of flakey biscuits that had an expiration date of 8/9/2023.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Plastic container unlabeled and expired biscuits were immediately removed. Administrator to in-service all staff on 3/17/25 on proper food containment and outdated or spoiled food or dented cans may not be used. All staff to

103i - Outdated Food (continued)

monitor daily that any outdated or spoiled food or dented cans are to be removed and not used.

Starting 3/20/25 staff to utilize log sheet to ensure daily that food is labeled and expired food is discarded.

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

Implemented ([redacted] - 06/27/2025)

107a - Emergency Preparedness

26. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

[redacted] *the administrator does not have the emergency preparedness plan for the local municipality.*

Plan of Correction ***Directed ([redacted] - 04/02/2025)***

I disagree with this violation. Administrator does have an emergency preparedness plan for the municipality. It was not sent out however that is addressed in the next violation. Administrator to ensure to have the emergency plan for the local municipality in the facility.

Administrator marked on calendar to ensure plan sent out when due.

DIRECTED PLAN OF CORRECTION:
Within 10 business days of the receipt of this plan of correction, the administrator or designee shall contact Aston Township's and/or Delaware County's office of emergency management to obtain a current copy of their emergency plans for the area. A copy of this plan shall be maintained along with the homes specific emergency preparedness plan and shall be kept accessible at all times.

Directed Completion Date: *03/25/2025*

Implemented ([redacted] - 06/27/2025)

107d - Procedure Emergency Management Agency Submission

27. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 06/06/2023.

Plan of Correction ***Accept ([redacted] - 03/17/2025)***

Administrator sent the emergency procedures to the local municipality on 2/6/25. Administrator to ensure that the emergency procedures are reviewed, updated and submitted annually to the local emergency management agency annually. Administrator put a note in calendar to ensure procedures are sent when next due.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented ([redacted] - 06/27/2025)

107d - Procedure Emergency Management Agency Submission *(continued)*

109a - Pets

28. Requirements

2600.
109.a. The home rules shall specify whether the home permits pets on the premises.

Description of Violation

The home's resident contracts specifies that no pets are allowed, however, the home has one "house cat" but no rule or policy that explains who is responsible for the animal.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator wrote a policy on 2/4/25 to explain the house rules for pets and who is responsible for the house cat. Administrator to ensure that the policy for the house cat is followed and residents and staff aware of policy.

On 2/4/25 the administrator notified residents in the home of the new policy.

Licensee's Proposed Overall Completion Date: *03/25/2025*

Implemented ([redacted] - 06/27/2025)

109b - Rabies Vaccination

29. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 1/23/25, one cat was present at the home. The home does not have a current certificate of rabies vaccination for this animal.

Plan of Correction ***Accept ([redacted] - 03/18/2025)***

Administrator has appt for cat to get 3 year rabies vaccination on 3/10/25. Administrator to send documentation of vaccination at that time. Administrator to ensure cat on premises has current rabies vaccination from a licensed veterinarian and kept on file. Administrator put a note on calendar to ensure to have next vaccination 3 years after this one.

Licensee's Proposed Overall Completion Date: *03/05/2025*

Implemented ([redacted] - 06/27/2025)

125a - Combustible Storage

30. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

Multiple stacks of cardboard boxes, cardboard cases of Pepsi cans, and an expired cardboard case of Glucerna were stored next to the furnace and between two water heaters in the basement.

A used paint tray in a blue plastic bag was leaning against the stove in the kitchen. The stove was on.

125a - Combustible Storage *(continued)*

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator removed some items immediately upon request on 1/23/25. Owner removed all items on 2/27/25 near heat source. Owner to ensure that there are no combustible or flammable materials near heat source. Owner to monitor daily that no combustible or flammable materials are stored near heat sources or hot water heaters. Disagree with second violation. It was not a paint, tray, it was a griddle which was not in use at the time.

Starting 3/19/25 staff to utilize check list to ensure daily that there is nothing combustible around heater.

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

Implemented ([redacted] - 06/27/2025)

127a - Portable Space Heaters

31. Requirements

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

Description of Violation

On 1/23/25 at 11:04 AM, a portable space heater was observed on the 3rd floor of the building in an unlocked open storage area.

Plan of Correction ***Directed ([redacted] - 04/02/2025)***

I disagree with this violation. The heater was not plugged in and was in storage room on 3rd floor which is not resident floor, because owner purchased it for [redacted] and just stored it there. Administrator to ensure no portable space heaters are used in the building. Administrator to monitor daily that no portable space heaters are in use or in building.

Starting 3/19/25 staff to utilize check list daily to ensure there are no portable space heaters in the building.

DIRECTED PLAN OF CORRECTION:
Within 10 business days of the receipt of this plan of correction, the administrator or designee shall provide training on the prohibition of space heaters in the entire facility. Monitoring for the presence of space heaters shall be conducted throughout the entire facility, including storage areas and other areas that are inaccessible to residents. Any space heaters observed in the facility shall be immediately removed.

Directed Completion Date: *03/31/2025*

Implemented ([redacted] - 06/27/2025)

132c - Fire Drill Records

32. 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 conducted on 11/22/2024 at 10:01 does not include an indication if the time was AM or PM.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept (- 04/02/2025)***

It was filled in immediately at request of DHS employee. Administrator to ensure that indication of am or pm be written on fire drill log.

Administrator to do quarterly reviews of all fire drill records to ensure all required information is present for each drill. Administrator to mark on calendar dates of quarterly reviews due.

Licensee's Proposed Overall Completion Date: *03/25/2025*

Implemented (- 06/27/2025)

132f - Alternate Exit Routes

33. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The side exit was used as one of the exit routes during all fire drills from 2/16/2024 to 1/16/2025. The second-floor fire escape was never used during this time.

Plan of Correction ***Accept (- 04/02/2025)***

I disagree with this violation. Administrator uses front, side and rear door alternation for fire drills. The fire escape is good for a fire, however I do not want any resident injured during a fire drill. Administrator to continue alternating exits with front side and rear doors.

Starting in April administer to add the fire escape exit into rotation to include all exits are used for fire drills.

Licensee's Proposed Overall Completion Date: *03/25/2025*

Implemented (- 06/27/2025)

141b1 - Annual Medical Evaluation

34. Requirements

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

Description of Violation

Resident 2's most recent medical evaluation was completed on . In the resident's file there was a documentation of medical evaluation with an evaluation date of however the document did not list the date the form was completed on and was not signed by a physician, physician's assistant or certified registered nurse practitioner.

Plan of Correction ***Accept (- 04/02/2025)***

Resident medical evaluation was done on and signed by md on Administrator to ensure that medical evaluations are done annually. Administrator has a log of when residents due for medical evaluations to ensure done annually.
Starting 3/19/25 administrator to utilize a chart audit log to monthly monitor for compliance.
Administrator to view charts for compliance monthly starting on 3/19/25 and keep track with chart audit calendar.

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

141b1 - Annual Medical Evaluation *(continued)*

Implemented ([redacted] - 06/27/2025)

144c1 - Smoking Area Guidelines

35. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is the fenced in patio of side of the building. On 1/23/2025 at approximately 9:00 AM a lit cigarette sat on top of a small rectangular trash can that was filled with frozen water and spent cigarettes. The trash can was on the ground and next to the exterior siding of the home. Staff person A stated that the home uses this trash can to empty ashtrays into. This is trashcan is not a fire safe receptacle.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator removed trash can immediately. Administrator/owner to monitor daily that proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ash trays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home,, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Starting 3/19/5 staff to utilize log daily to ensure the use of proper ash trays to ensure fire safety.

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

162e - Menu Changes

36. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 1/23/25, oatmeal and a cheesy omelet were listed on the menu for the breakfast meal. Pancakes were served instead of a cheesy omelet. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator in-serviced kitchen staff on 3/17/25 that a change to menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Administrator to monitor kitchen staff that menu is followed daily and if change occurs it is posted.

Starting on 3/19/20 kitchen staff to monitor daily that menu is scheduled accordingly and any changes to menu are posted in public area prior to meal.

Starting 3/19/25 kitchen staff to utilize log sheet to ensure meal is correct for day and any meal change is posted

162e - Menu Changes (continued)

in public space in advance of meal.

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

Implemented ([redacted] - 06/27/2025)

183b - Meds and Syringes Locked

37. Requirements

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

Description of Violation

On 1/23/202 at 10:36 AM, a tube of Remedy Skin Protectant was unlocked, unattended, and accessible in in room 9.

At 10:52 AM over flow medications for all residents were unlocked, unattended, and accessible in the home's office closet.

At 11:22 AM multiple bottles of over-the-counter medications including omega-3 Fish oil, CoQ10, cinnamon 1000mg pills, and R lipoic acid + were unlocked, unattended, and accessible on the floor, in plastic grocery bags and crates in a bedroom on the 3rd floor. This room was being occupied by a person who was not a staff member or resident.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

I disagree with this violation. First the office closet was not left unattended, I left my office and was right outside door and was back in. Whatever is in my closet in my office was not left unattended. As far as 3rd floor that is not a resident area and 3rd floor is always locked however it was open for inspector to go up and down to use office on 3r floor. Administrator will ensure OTC medication, CAM and syringes are kept in an area or container that is locked. This includes medications and syringes kept in resident room. Administrator in-serviced nursing staff on 2/11/5 on policy and procedures for safe storage, access, security, distribution and use of medications.

Administrator to ensure daily closet is locked and inaccessible to unauthorized person.

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

183e - Storing Medications

38. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 1/23/2025 an insulin aspart flex pen belonging to resident 3, was in the home's medication drawer and not dated with the day it was opened. According to the manufacturer's instructions and a warning label on the pharmacy packaging, the unused portion of the medication should be discarded 28 days after first use.

183e - Storing Medications (continued)

Plan of Correction ***Accept ([redacted] - 03/18/2025)***

Administrator labeled medication immediately. Administrator inserviced nursing staff on 2/11/25 for prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions, and be dated. Starting 2/1/25 and continuing weekly for 3 months administrator will check all medications to ensure no medications are expired and that insulin vials/pens are dated and labeled when open.

Licensee's Proposed Overall Completion Date: *03/05/2025*

185a - Implement Storage Procedures

39. Requirements

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

Description of Violation

On 1/23/25, 6 oxygen tanks were unlocked, unattended, and accessible to resident on the 3rd floor of the building in the hallway at the top of the stairs.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

On 3/3/25 owner removed the oxygen tanks the from 3rd floor. Administrator/owner in-serviced on 2/11/5 on the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Administrator/owner to monitor for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff.

Starting 3/19/25 Administrator and owner to monitor 3rd floor daily for 3 months and then weekly to ensure there is no area on third floor accessible to any unauthorized person.

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

40. Requirements

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

Description of Violation

On 1/22/24 at 11 am resident 5's glucometer had a reading of 343 which was transcribed as 334 on the resident's 1/2025 Medication Administration Record (MAR).

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Administrator aware that numbers were turned around. Administrator to in-service nursing staff on procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff on 2/11/5. Starting 2/1/25 administrator will check documentation of glucometer readings daily to ensure correct numbers. Administrator will then conduct monthly audits of documentation.

Starting 3/19/25 Administrator to utilize a check list to ensure glucometer readings are documented appropriately daily.

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

41. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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

Description of Violation

Resident 5 is prescribed fluticasone prop 50 MCG use 1 spray in each nostril as needed. On 1/23/25 this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 03/18/2025)***

Administrator ordered medication for resident #5 on 1/23/25. Administrator to in-service nursing staff on procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons on 2/11/25. Starting 2/1/15 administrator to check mars weekly to ensure medications on mar are available in the home. Administrator will then do monthly audits to ensure medications on mar are in the home.

Licensee's Proposed Overall Completion Date: *03/06/2025*

42. Requirements

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

Description of Violation

Resident 6 is prescribed Lorazepam 1 MG take ½ tablet by mouth twice daily as needed.
The documentation on the residents 1/2025 Medication Administration Record, the Medication Notes document (on the backside of the residents MAR) and the narcotic inventory log do not match for administration days/times or inventory.

The resident's 1/2025 MAR is initialed as administered for this medication on the following dates:
1/6, 1/7, 1/8, 1/11, 1/12, 1/15, 1/16.

The Medication Notes document on the backside of the residents MAR indicates that this medication was given on these dates/times: 1/6 10 AM, 1/8 11 AM, 1/12 10 AM, 1/13 9 AM, 1/15 10 AM, 1/17 10 AM, 1/18 11 AM, 1/19 9 AM.

The home documents the declining inventory for five separate residents on one log sheet with two "shift" counts per day listed as a D (daytime) and M (evening). The log does not list each administration as a separate line item for each dose removed from the medication container which does not permit for narcotic administration/inventory reconciliation.

The narcotic counts for Resident 6's Lorazepam medication or the narcotic log are as follows:
From 1/1-1/5 - count is documented as 23
From 1/6-1/7 - count is documented as 22
From 1/8-1/11 - count is documented as 21
1/12 -D - count is documented as 20
1/12 - M- count is illegible/written over appearing to be 19 written over 20
1/13 - D - count is illegible/written over appearing to be 19 written over 20
1/13 - M - count is illegible/written over appearing to be 18 written over 20
1/14 - D - count is illegible/written over appearing to be 18 written over 20
1/14 - M - the documented count number is not legible
1/15 - D - count is documented as 17
1/15 - M - count is document as 15

185a - Implement Storage Procedures (continued)

1/16- D and M - count is documented as 14
1/17 - D - count is documented as 14
1/17 - M - count is documented as 19
1/18 - M and D - count is documented as 18
1/19 - D through 1/22 - D - count is documented as 17
1/22 - M and 1/23 - D - count is documented as 7

On 1/23/25 at approximately 2:30pm, a total of 10 HALF pills are present in the medication bottle for Resident 6.

Staff member A could not explain the discrepancy in the logs.

Plan of Correction ***Accept (- 03/18/2025)***

Beginning 2/1/25 and continuing for three months, the administrator will review narcotic sheet weekly to ensure that all entries are complete and legible. On 2/11/25 nursing staff in-serviced on procedures for the safe storage, access, security, distribution and use of medications administrator to educate nursing staff on proper medication and medical equipment. Administrator to monitor daily that narcotic sheet is written in correctly and legible.

Licensee's Proposed Overall Completion Date: *03/06/2025*

187a - Medication Record

43. Requirements

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

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

Description of Violation

Resident 5 is prescribed sliding scale insulin injections before meals, 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350= 8 units, above 351 = 10 units. This medication was administered on 1/22/2025 at 8 AM, 11 AM, and 4 PM; however, the number of units given it is not included on resident 5's 1/2025 medication administration record.

Plan of Correction ***Accept (- 03/18/2025)***

I disagree with this violation. Resident has a sliding scale and whatever blood glucose number is the coverage

187a - Medication Record (continued)

scale written on order sheet from physician is followed and signed off on. The dose that is given goes by physician order on sliding scale. Administrator to in-service staff to on 3/17/25 on proper medication documentation ensure that coverage number be written when medication signed off on. Administrator will start weekly medication audits on 2/1/25 for 3 months to ensure proper documentation.

Licensee's Proposed Overall Completion Date: *03/05/2025*

44. Requirements

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

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

Description of Violation

Resident 5 is prescribed Mupirocin 2% apply to affected area 2 times daily. However, resident's 1/2025 medication administration record does not indicate diagnosis or purpose for the medication.

Plan of Correction ***Accept ([redacted] - 03/18/2025)***

Resident was just prescribed antibiotic and a cream for foot procedure on 1/22/25. The dx was on the antibiotic however not on cream below. Administrator to in-service nursing staff on having diagnosis for medication on Mar on 3/17/25. Starting 2/1/25 administrator to monitor Mar's daily for three months to ensure diagnosis are written for medications. Administrator will then monitor monthly to be in compliance with regulation.

Licensee's Proposed Overall Completion Date: *03/05/2025*

187b - Date/Time of Medication Admin.

45. Requirements

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

Description of Violation

On 1/23/25 at 9:47 AM, resident 7 was administered Venlafaxine HCL Er 150 mg, Xtampza Er 9 mg capsule, Bupropion HCL Sr 100 mg, Fluticasone-Salmeterol 250-50 inhale 1 puff by mouth, Loratadine 10 mg tablet, Pantoprazole Dr 40 mg tablet, Prednisone 5 mg tablet, and Tadalafil 5 mg tablet. Staff person A initialed the MAR for these medications prior to actually administering the medication to the resident. Documentation of the administration is to be completed after the resident is observed to take their medications.

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

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

Staff person A is aware of mistake. Staff person a to ensure medication is signed out of MAR after medication is administered.

Starting on 1/24/25 staff person A to monitor self for ongoing compliance with regulation.

Proposed Overall Completion Date: 03/31/2025

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

251b - Record Entries Legible

46. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On the homes 1/2025 narcotic medication count sheet for resident 6, the actual count numbers are illegible as they are written over top of one another from 1/12 to 1/14.

Plan of Correction ***Accept ([redacted] - 03/18/2025)***

Beginning 2/1/25 and continuing for three months, the administrator will review narcotic sheet daily to ensure all entries are complete and legible. Administrator to in-service nursing staff on 3/17/25 to ensure residents records be permanent, dated and signed by the staff person making entry.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented ([redacted] - 06/27/2025)

254a - Records Discharge/Active

47. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 1/23/25, records for current and discharged residents were unlocked, unattended, and accessible in the home's 3rd office filing cabinets.

Plan of Correction ***Accept ([redacted] - 04/02/2025)***

I disagree with this violation. The room with records was locked. Administrator opened door to the room for inspector to use office for the day. The inspector left room and did not turn knob on door to lock or close the door before coming downstairs. Administrator/Owner to ensure records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Starting on 3/19/25 administrator to have a check list to ensure daily that records are kept in a confidential manner.

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

Implemented ([redacted] - 06/27/2025)