Pennsylvania
Department of Human Services

Sent via e-mail
Sent via e-mail
July 23, 2025

Deer Meadows Operating II, LLC
8301 Roosevelt Boulevard
Philadelphia, Pennsylvania 19152

RE: Deer Meadows Residences
License #: 14126

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on March 20, 2025 and May 2, 2025 of the above facility, we have determined that your submitted plan of correction for the February 11 and 12, 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,

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *DEER MEADOWS RESIDENCES* **License #**: *14126* **License Expiration**: *12/01/2025*

Address: *8301 ROOSEVELT BOULEVARD, PHILADELPHIA, PA 19152*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *DEER MEADOWS OPERATING II LLC*

Address: *8301 ROOSEVELT BOULEVARD, PHILADELPHIA, PA, 19152*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/14/2010* **Issued By**: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/12/2025*

Inspection Dates and Department Representative

02/11/2025 - On-Site: [redacted]

02/12/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *182* **Residents Served**: *76*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Bair 3 and Bair 5* **Capacity**: *39* **Residents Served**: *28*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *76*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

02/11/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/17/2025*

03/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2025*

03/20/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/30/2025*

07/22/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/30/2025*

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

42s - Privacy

1. 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 2/12/2025, resident #1 did not have a shower curtain in [redacted] bathroom.

Plan of Correction ***Accept ([redacted] - 03/20/2025)***

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/13/2025 by the Residential Administrator to correct the violation. Administrator contacted Director of Environmental Services to replace the shower curtain in Resident #1 room. Shower curtain was immediately replaced in room [redacted] by Director.
To enhance the currently compliant operations, on 03/10/2025 the Residential Administrator and Management Members of Deer Meadows began room audits to ensure all Resident rooms and shower areas had a shower curtain to maintain their right to privacy. Audits were completed of all Personal Care Resident Rooms on 3/12/2025, specifically in relation to shower curtains and no other errors in relation to privacy were found.
Effective 4/1/2025 all Personal Care Rooms will have ongoing Room Audits completed on a quarterly basis throughout the year to help ensure compliance in all Resident Rooms (see attached). Findings from ongoing audits will be reported to Administrator, findings will be reviewed and addressed by proper department, report of findings will be reviewed at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

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

42x - Safeguard

2. Requirements

2600.
42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

Resident #2 was admitted to the home [redacted]. The home opened an account to safeguard resident #2's money on 12/2/2024, however the home did not have a safeguard addendum in the resident file or any other method to safeguard the resident's money prior to 12/2/2024.

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

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/17/2025 by Residential Social Worker (RSW) to correct the violation. RSW met with resident #2 to review Safeguard Addendum (see attached). It should be noted that Resident #2 was discharged [redacted] due to family's request for a discharge.
An audit was completed by Administrator to ensure that all Resident records included a Safeguard Addendum on 3/12/2025, no other errors were found. The Safeguard Addendum is reviewed with each resident upon admission and will remain with the Resident Agreement. The Administrator or designee will monitor all new resident agreements for three months to ensure ongoing compliance with the Resident's right to a system to safeguard a resident's money and property is maintained. Any deficiencies will be corrected immediately, and findings will be documented for further review and continuous improvement. (see attached).

42x - Safeguard (continued)

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

Implemented (█ - 05/02/2025)

63b - Current First Aid Training

3. Requirements

2600.
63.b. Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

Description of Violation

Staff persons A were trained in first aid and certified in obstructed airway techniques and CPR by Emergency Care & Safety Institute. This training source is not certified as a trainer by a hospital or other recognized health care organization. This course is an online only course.

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

Upon recognition of violation to 63b- Current First Aid Training, Staff person A was immediately contacted by Administrator for an updated copy of their Current CPR training that was provided by a certified trainer at a recognized health care organization. Copy of training was received (see attached), employee was in compliance. Employee's record was updated with Human Resources department. Administrator completed audit of staff with CPR certification, no other errors found. All CPR certifications of staff were found to be in compliance.
Admin contacted Department, unable to add attachment through portal

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

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 2/12/2025, resident #1's dentures were observed on the soap dispenser in the resident's bathroom without a container.

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

85a- Sanitary Conditions
In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/12/2025 by Residential Health Care Center Coordinator (RHCC). RHCCC obtained a new denture storage container from Central Supply, container was labeled and resident's dentures were cleaned and stored properly.
Effective 4/1/2025 all Personal Care Rooms will have ongoing Room Audits completed on a quarterly basis throughout the year to help ensure compliance in all Resident Rooms (see attached). Findings from ongoing audits will be reported to Administrator, findings will be reviewed and addressed by proper department, report of findings will be reviewed at quarterly QA meeting.
Beginning 4/1/2025-4/30/2025 all Current Residential Direct Care Staff will receive their annual education in relation Oral Care/Hygiene to help maintain compliance in Sanitary Conditions for all Personal Care Residents.

85a - Sanitary Conditions *(continued)*

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

85e - Trash Outside Home

5. 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

On 2/11/2025, the dumpster was uncovered and there was a gray cabinet outside of the dumpster.

Plan of Correction ***Accept (- 03/20/2025)***

Upon recognition of violation 85e, immediate action was taken on 02/11/2025 by Administrator, the cardboard container lid was closed by Administrator and Director of Environmental Services was contacted to place cabinet in open top container. Cabinet was moved by staff the same day into the container.
Education was provided to Director of Plant Operations and Director of Environmental Services and their staff (see attached) regarding policy and procedure in relation to proper disposal of all trash, recycling or waste.
Effective 3/17/2025 a daily visual audit will be completed by a maintenance staff member (as assigned by Department Head), findings will be reviewed by Director of Plant Operations for the next ninety days to ensure any concern is addressed timely and report will be submitted to Administrator at Quarterly QA meeting to be reviewed.

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented (- 05/02/2025)

88a - Surfaces

6. 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 2/11/2025, the paint on the walls on the stairwell leading up to floor #3 and floor #5 were peeling.

On 2/12/2025, the caulk was pulling away on resident #2's bathroom sink.

Plan of Correction ***Accept (- 03/20/2025)***

Upon recognition of violation 85e, immediate action was taken on 02/11/2025 by Maintenance staff to address the fire tower stairwell leading up to floor #3 & floor #5, peeling paint was removed while inspectors were on site, and repair was completed on 2/14/2025 by Maintenance Staff.
An Audit of all fire towers was completed by the Director of Environmental Services on 3/7/2025 (see attached).
Beginning 4/1/2025 All Fire Towers will be audited by the Direct of Plant Operations or designee on a bi-monthly basis to help ensure compliance in Surfaces is maintained. Audit will be ongoing for the next 6 months, Findings will be reviewed at monthly Safety Committee Meeting.
Also in recognition of violation 85e, in relation to Resident #2's bathroom sink, caulking was repaired on

88a - Surfaces (continued)

2/18/2025 by maintenance staff.
Effective 4/1/2025 all Personal Care Rooms will have ongoing Room Audits completed on a quarterly basis throughout the year to help ensure compliance in all Resident Rooms (see attached). Findings from ongoing audits will be reported to Administrator, findings will be reviewed and addressed by proper department immediately, report of findings will be reviewed at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

89a - Water Pressure

7. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 2/12/2024, at approximately 3:15 pm, the home did not have sufficient hot water pressure in resident #3's kitchen sink. The stream was as thin as a pencil.

Plan of Correction ***Accept (- 03/20/2025)***

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/17/2025 by Director of Plant Operations to clean the aerator of the kitchen sink in apt. 340. It was found that the faucet needed to be replaced, and was replaced and work completed on 2/25/2025. (see attached)
Director of Plant Operations began a full audit of each resident bathroom, kitchen and laundry area to ensure hot and cold water had appropriate water pressure throughout the home. Audit was completed by maintenance staff by 3/17/2025 and no further issues were found. Audit will be completed on a monthly basis for the next three months to ensure all areas are checked, findings will be addressed and submitted to Administrator and report reviewed at the upcoming Quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

95 - Furniture and Equipment

8. Requirements

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

Description of Violation

On 2/12/2025, resident #1 did not have the roller to hold the toilet paper in bathroom.

Plan of Correction ***Accept (- 03/20/2025)***

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/13/2025 by Director of Plant Operations, roller to hold toilet paper holder in Resident #1's room was replaced. All Personal Care Rooms were audited by 3/17/2025 and findings were addressed by Administrator and Director Plant Operations.
Effective 4/1/2025 all Personal Care Rooms will have ongoing Room Audits completed on a quarterly basis throughout the year to help ensure compliance in all Resident Rooms (see attached). Findings from ongoing audits will be reported to Administrator, findings will be reviewed and addressed by proper department immediately,

95 - Furniture and Equipment (continued)

report of findings will be reviewed at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented (█ - 07/22/2025)

101j7 - Lighting/Operable Lamp

9. Requirements

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

Description of Violation

On 2/12/2025, resident #1 and resident #2 did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (█ - 03/20/2025)***

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/13/2025 by Administrator. Administrator met with both Resident #1 & #2 to alert them to the violation in their room, and both residents consented to have their side table & lamp that were in the Resident Room of both Resident #1 and #2 to be next to their bed. Administrator completed the furniture & lamp move and confirmed both lamps were working. Administrator also notified family of Resident #1 and Resident #2 of the violation and the need to relocate furniture in resident room. All Personal Care Rooms were checked and audited by 3/17/2025 by Director of Plant Operations & Residential Administrator, no further observations in regards to Operable lamp were found.
Effective 4/1/2025 all Personal Care Rooms will have ongoing Room Audits completed on a quarterly basis throughout the year to help ensure compliance in all Resident Rooms (see attached). Findings from ongoing audits will be reported to Administrator, findings will be reviewed and addressed by proper department immediately, report of findings will be reviewed at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented (█ - 07/22/2025)

181f - Record of Medication

10. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 2/12/2025, resident #3's record did not include a current list of medications. The list in the resident record did not include over the counter Iron 325 mg and the Acetaminophen was 500 mg, however the order is for 325 mg.

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

Upon recognition of violation to 181f- Record of Medication, immediate action was taken by Residential Health Center Coordinator (RHCCC) on 2/12/2025. RHCCC met with resident on 2/13/2025 to review medication list on

181f - Record of Medication (continued)

record, Resident was aware that the Iron 325 mg was discontinued by the Nurse Practitioner on 2/16/2024 per [redacted] request. Resident stated that [redacted] was aware the bottle of Iron 325 mg was present but that [redacted] has not been taking it, and does not wish to take it. Resident agreed to have the Iron bottle stored separately in [redacted] room, RHCCC confirmed the bottle was not left with [redacted] active medications. Resident was also educated in regards to order for 325 Acetaminophen and was aware her bottle was 500mg, [redacted] stated [redacted] doesn't need it and agreed for the 500 mg bottle to be removed and stored in a separate location. Resident has all current medications present and is aware of [redacted] orders. Resident was reminded to notify Staff of any medication changes or concerns.
Beginning 4/1/2025 Resident Health Center Coordinator or designee will complete a monthly audit and review medication list for all residents that self-administer medications to ensure compliance with 181f continues. All findings will be recorded for the next 3 months, and reviewed at the quarter QA meeting.

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

Implemented ([redacted] - 07/22/2025)

183b - Meds and Syringes Locked

11. 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 2/12/2025, a bottle of Robitussin cough chest congestion DM was unlocked, unattended, and accessible in resident #4's bathroom.
Staff person B confirmed that the resident does not self-administer [redacted] medications.

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

Upon recognition of violation to 183b- Meds and Syringes locked, Administrator and Residential Health Center Coordinator immediately corrected the violation. Admin and RHCCC met with Resident #4 to educate [redacted] on the importance of having all medications secured and orders followed from [redacted] physician. Resident agreed to have medication removed from [redacted] room and stated no other medications were in [redacted] room, resident stated he purchased the medication "a while ago" and would notify staff if [redacted] had questions or concerns.
Effective 4/1/2025 all Personal Care Rooms will have ongoing Room Audits completed on a quarterly basis throughout the year to help ensure compliance in all Resident Rooms (see attached). Findings from ongoing audits will be reported to Administrator, findings will be reviewed and addressed by proper department immediately, report of findings will be reviewed at quarterly QA meeting.

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

Implemented ([redacted] - 07/22/2025)

183e - Storing Medications

13. Requirements

2600.

183e - Storing Medications *(continued)*

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 2/12/2025, the following were observed when doing the medication cart review:

Two loose pills were observed on the medication cart for Bair 5.
Senna-Docusate 8.6-50 mg tablet prescribed for resident #2 had an opening on pill #7 of the blister pack.
Temazepam 30 mg capsule prescribed for resident #5 had an opening on pill #1 of the blister pack.
Clonazepam 0.5 mg tablet prescribed for resident #6 had an opening on pill #5 and pill #6 of the blister pack that was covered with tape.
Lorazepam 1 mg tablet prescribed for resident #7 had an opening on pill #16 that was covered with tape.
One daily tab women's vitamin prescribed for resident #8 had an opening on pill #5.
Tramadol HCL 50 mg tablet prescribed for resident #9 had an opening on pill #4, #5, and #6 that was covered with tape.
Lorazepam 0.5 mg tablet prescribed for resident #10 had an opening on pill #1 that was covered with tape.
Tramadol HCL 50 mg tablet prescribed for resident #11 had an opening on pill #1 and #3.

Repeated Violation: 3/11/2024 et al

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

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/12/2025 by Residential Health Center Coordinator (RHCCC). RHCC removed Resident #2, #5, #6, #7, #8, #9, #10, & #11 damaged medications from the medication cart while Human Services Inspector was on site. RHCCC then contacted all residents and appropriate designees (family/POA) regarding medications and the need to either destroy or replace medications immediately. All medication removed and disposed of appropriately (see attached.) In addition, a full Medication Cart Audit was completed by Residential Health Center staff on 2/18/2025 to ensure there were no further errors in storing medications.
To enhance the currently compliant operations, The RHCCC or designee will continue to complete monthly medication cart audits for the next 6 months. Monthly findings will be addressed immediately and findings will be reported to Administrator to be reviewed at Quarterly QA meetings. On 2/25/2025 a mandatory Medication Administration training was held for all Medication Technicians to review regulations and policies and procedures in regards to Medication Administration. (see attached)

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

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #12 is prescribed Senna Oral tablet 8.6 mg at 8:00 pm. However, this medication was not administered to the resident from 1/20/2025 through 2/11/2025 because the medication was not available in the home.

Plan of Correction ***Accept (█ - 03/20/2025)***

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate

187d - Follow Prescriber's Orders (continued)

action was taken on 02/12/2025 by Residential Health Center Coordinator (RHCCC). RHCCC immediately notified and confirmed the order with the Nurse Practitioner, order placed to pharmacy and medication was delivered that evening. Resident #12's guardian was notified of the mediation error. In addition, a full Medication Audit was completed by Residential Health Center staff on 2/18/2025 to ensure there were no further errors or missing medications (see attached).
To enhance the currently compliant operations, The RHCCC or designee will continue to complete monthly medication cart audits for the next 6 months. Monthly findings will be addressed immediately and findings will be reported to Administrator to be reviewed at Quarterly QA meetings. On 2/25/2025 a mandatory Medication Administration training was held for all Medication Technicians to review regulations and policies and procedures in regards to Medication Administration. (see attached)

Licensee's Proposed Overall Completion Date: *03/20/2025*

15. Requirements

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

Description of Violation

Resident #2 is prescribed trazodone HCL tablet 50 mg take one tablet by mouth two times a day at 9:00 am and 9:00 pm for anxiety disorder, unspecified. On 2/12/2025, the agent of the Department was told by staff that resident #1 was administered a one time extra dose of trazodone for agitation on 1/10/2025 at 2:00 pm. The home does not have a physician's order to administer the medication as a PRN.

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

In addition, after notification from the Department on 2/12/2025 that a staff member reported that Resident #2 was administered a medication incorrectly the Administrator immediately began an investigation. A thorough investigation was completed by Administrator and appropriate staff members received counseling immediately. On 2/25/2025 a mandatory Medication Administration training was held for all Medication Technicians to review regulations and policies and procedures in regards to Medication Administration. (see attached). Medication Technicians will continue to receive their required observations as scheduled.

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

201 - Positive Interventions

16. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

The home was aware of concerns regarding resident #2's poor decision making, cognitive decline, and handling of their money. The resident offered money to staff members and people outside the home and offered to purchase whiskey for another resident. On 10/24/2024, the home received a phone call from Hospital because the resident was in their lobby wanting to place bets on horses. Progress notes state that the resident was agitated and confused but remembered that lived at the home but kept banging on the desk and then walked outside and stood in front of the hospital. The residents progress notes indicate the resident was exhibiting behaviors such as agitation and

201 - Positive Interventions (continued)

aggression towards staff and residents in October 2024 and December 2024. Progress notes also indicate the resident was showing signs of confusion in October 2024 and early January 2025. The home did not implement positive interventions to modify or eliminate the behavior until January 24, 2025 when the resident was admitted to the secured dementia care unit.

Plan of Correction ***Accept (- 03/20/2025)***

It should be noted that Resident #2 was discharged due to family's request for a discharge.
To help ensure continued compliance in regards to Positive Interventions the Residential Administrator, Residential Health Center Coordinator or designee will review daily Progress Notes of all Personal Care Residents, on a weekly basis. If any abnormal behavior or significant change is noted, all staff are educated on positive interventions and safe management techniques during orientation and on an annual basis. To help ensure interventions are documented appropriately Progress Notes will be reviewed by Administrator or Residential Health Center Coordinator or designee to audit 50% of behaviors documented have appropriate interventions for behaviors and noted in support plans as needed. Weekly Audits will be submitted to Administrator on a Monthly basis, Monthly findings will be reviewed at Quarterly QA meeting for the next 12 months to ensure continued compliance.
On 2/25/2025 a mandatory Medication Administration training was held for all Medication Technicians to review regulations and policies and procedures in regards to Medication Administration and "Calming the Agitated Resident". (see attached)
Additional Training for all Residential Staff in regards to Positive Interventions and Safe Management Techniques is scheduled for staff in their annual training plan and will be completed by Community Staff Educator.

Licensee's Proposed Overall Completion Date: *03/20/2025*

202 - Prohibitions

17. Requirements

2600.
202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

202 - Prohibitions *(continued)*

Description of Violation

Resident #2 is prescribed Trazodone HCL tablet 50 mg give one tablet by mouth two times a day at 9:00 am and 9:00 pm for anxiety disorder, unspecified. On 2/12/2025, the agent of the Department was told by staff that resident #2 was administered a one time extra dose of Trazodone at 2:00 pm for agitation on 1/10/2025. The home does not have a physician's order to administer the medication as a PRN.

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

After notification from the Department on 2/12/2025 that a staff member reported that Resident #2 was administered a medication incorrectly the Administrator immediately began an investigation. A thorough investigation was completed by Administrator that included statements from various staff. Appropriate staff members received counseling immediately. On 2/25/2025 a mandatory Medication Administration training was held for all Medication Technicians to review regulations and policies and procedures in regards to Medication Administration and "Calming the Agitated Resident". (see attached)

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

221b - Activity Types

18. Requirements

2600.
221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

At 10:00 am, the activity scheduled for Bair 3 and Bair 5 was color by numbers and at 10:45 am it was scattergories. On 2/11/2025, at 11:21 am, the residents were coloring. The home's activities program does not include any activities to engage social, physical, intellectual and recreational activities.

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

In response to the violation on 02/11/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/11/2025 by Administrator. Administrator met with Activity Director and staff member to ensure planned schedule was being followed appropriately. On 2/12/2025 Activity Staff members assignments were switched by Department Head. Appropriate changes to programs will be posted daily if needed by Department Head, otherwise Activity Staff members will follow planned calendar of activities appropriately. Planned Activities do include activities that provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner (see attached calendar). Activity Department Head will conduct daily audits to ensure Activities are occurring as scheduled by staff and will report findings to Administrator on a Monthly basis, this will be ongoing for 12 months, findings will be reviewed at the Quarterly QA meeting. Calendars attached.

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

Implemented (█ - 07/22/2025)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

225c - Additional Assessment *(continued)*

Description of Violation

Resident #1's most recent assessment was completed on [redacted]. Resident #1 was showing signs of confusion prior to [redacted] most recent assessment on the following dates [redacted] yet the home did not perform an additional assessment on resident #1 in response to this change in status.

Repeated Violation: 11/18/2024, 9/30/2024, 3/11/2024 et al

Plan of Correction ***Accept ([redacted] - 03/20/2025)***

It should be noted that Resident #2 was discharged [redacted] due to family's request for a discharge. Upon recognition of violation 225c- Administrator completed an additional training regarding Resident Assessment and Support Plan-RASP with staff (see attached). Administrator or designee will also continue to complete ongoing monthly audits of RASPs to ensure that any significant changes or repetitive behaviors that occur prior to the annual assessment are documented appropriately. Audit will continue for the next 6 months, and findings will be reviewed at Quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

227d - Support Plan Medical/Dental

20. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1's most recent assessment dated [redacted] does not address the resident's behavioral needs of agitation and aggression. Resident's progress notes notated behaviors such as agitation and aggression on the following dates [redacted]

Repeated Violation: 11/18/2024, 3/11/2024 et al

Plan of Correction ***Accept ([redacted] - 03/20/2025)***

It should be noted that Resident #2 was [redacted] due to family's request for a discharge. Upon recognition of violation 227d- Administrator completed an additional training regarding Resident Assessment and Support Plan-RASP with staff (see attached). Administrator or designee will also continue to complete ongoing monthly audits of RASPs to ensure that any significant changes or repetitive behaviors that occur prior to the annual assessment are documented appropriately. Audit will continue for the next 6 months, and findings will be reviewed at Quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ([redacted] - 07/22/2025)

231e - No Objection Statement

21. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

231e - No Objection Statement *(continued)*

Description of Violation

Resident #13 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] The home does not have documentation that the resident and the resident's designated person have not objected to the admission.

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

In response to the violation on 02/12/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/13/2025 by Administrator. Administrator met with Resident #13 and family member to complete the objection statement. Completed statement was added to the resident's record on 2/13/2025. (see attached)
Administrator completed an audit of all Residents residing on Secured Dementia Unit to ensure compliance was maintained in regards to the "No Objection Statement," no further errors were noted. The No Objection Statement is completed and reviewed with each resident upon admission and will remain with the Resident Agreement. The Administrator or designee will monitor all new resident agreements for three months to ensure ongoing compliance with the Resident's "No objection statement". Any deficiencies will be corrected immediately, and findings will be documented for further review and continuous improvement. (see attached).

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

Implemented ([redacted] - 07/22/2025)

233c - Key-Locking Devices

22. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 2/11/2025, at approximately 10:26 am, the directions for operating the home's locking mechanism were not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept ([redacted] - 03/20/2025)***

In response to the violation on 02/11/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 2/11/2025 by the Director of Plant Operations while Department was still on site. Director of Plant Operations immediately replaced the broken sign, and re-posted the directions for the locking mechanism near the door. A full audit of all other doors for the Secured Dementia Unit located on the 3rd & 5th floors was completed on 2/11/2025 by the Director of Plant Operations and no other errors were found. Administrator re-checked all doors on 3/17/2025 and no violations in relation to key-locking devices found.
To enhance the currently compliant operations, the Director Of Plant Operations will continue to audit all Key-locking Devices on a weekly basis for the next thirty days to ensure all requirements are in compliance. Findings will be reported to Administrator monthly and reviewed at the Quarterly QA meeting. (see attached)

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ([redacted] - 07/22/2025)