



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 16, 2025

[REDACTED]
Pappus House
[REDACTED]

RE: Pappus House
66 Big Mount Road
Thomasville, Pennsylvania
17364 Certificate #: 339541

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on 12/17/2024 and 3/5/2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance License #328780 dated September 9, 2024 until September 9, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 16, 2025 to October 16, 2025.

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

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

[REDACTED], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[REDACTED] 942

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

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: *PAPPUS HOUSE* License #: *33954* License Expiration: *09/09/2025*
Address: *66 BIG MOUNT ROAD, THOMASVILLE, PA 17364*
County: *YORK* Region: *CENTRAL*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *PAPPUS HOUSE*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *R-4* Date: *08/10/2023* Issued By: *Jackson Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *10* Waking Staff: *8*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Interim* Exit Conference Date: *03/05/2025*

Inspection Dates and Department Representative

03/05/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* Residents Served: *5*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *5*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *5* Have Physical Disability: *0*

Inspections / Reviews

03/05/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/16/2025*

Inspections / Reviews (*continued*)

03/21/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/03/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 03/25/2025

03/25/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/03/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/03/2025

04/04/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/03/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

182b - Prescription Medication

1. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

- 4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Members A, B, C, and D have not completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies. The staff members administered medications to the following residents:

Staff Member A administered [redacted] to Resident #1 on 3/3/2025, 3/4/2025, 3/5/2025 at 8:00AM.

Staff Member B administered [redacted] to Resident #2 on 3/3/2025 at 8:00AM.

Staff Member C administered [redacted] to Resident #2 on 3/4/2025 at 1:12AM.

Staff Member D administered [redacted] to Resident #1 on 3/1/2025 and 3/2/2025 at 8:00PM.

Plan of Correction

Accept ([redacted] - 03/25/2025)

On 3/5/25, the executive director reviewed the administration of the medications given by the caregivers who had not completed the med administration training to verify medications had been properly given and recorded. Staff Members A, B, C, and D had completed the online portion of the Med Admin course, but needed to complete the classroom portion.

On 3/12/25, the executive director (who has completed the train the trainer program for med administration) conducted the classroom portion of the Med Admin course, handwashing & gloving, and observation for the Staff Members A, B, C, D, as well as 3 other staff members. All staff successfully completed the classroom lessons, and passed handwashing & gloving and medication administration observations that were part of the classroom instruction.

Staff Members A, B, C, and D and the additional 3 staff members will complete (and pass) the multiple choice and written exams of the Med Admin competency course by 3/21/25 to be certified and compliant.

New staff members without a current medication administration certification will be enrolled and will complete the course prior to administering medications.

An audit of all trainings and medication observations will be included in the quarterly Quality Management Reviews and reviewed by the executive director to ensure ongoing compliance. The next QM review is scheduled for 3/31/25 and will include the first audit of medication training and medication observation.

Follow-up - Within the next week, eight staff members (all full-time caregivers) will have successfully completed the Med Tech certification. Five are already complete, and the last 3 are pending the last 2 observations.

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

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

184a - Resident's Meds Labeled

2. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration.

Description of Violation

On 3/5/2025, the pharmacy label for Resident #2's [REDACTED] did not include the current instructions for administration. The pharmacy label includes instructions [REDACTED]. However, the current physician's order states to take [REDACTED].

Plan of Correction

Accept ([REDACTED] - 03/21/2025)

To immediately correct this violation on 3/5/25, the executive director placed a "see MAR" sticker over the incorrect portion of the pharmacy label. (See attached.)

On Monday 3/20/25, the executive director held a staff meeting / training to review inspection summary and other topics. Education on when to use "see MAR" stickers was provided.

An audit of all medication labels, MARs, and doctor orders will be conducted every other week by either the care coordinator or the executive director starting 3/13/25. The executive director will review the results after each audit, as well as during the quarterly Quality Management reviews.

Licensee's Proposed Overall Completion Date: 03/21/2025

Not Implemented ([REDACTED] - 04/04/2025)

185a - Implement Storage Procedures

3. 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 #1 is prescribed [REDACTED]
 [REDACTED] On 3/5/2025 at 2:30PM, this medication was not available in the home.

Plan of Correction

Accept ([REDACTED] - 03/21/2025)

On 3/6/25 the care coordinator contacted the hospice agency of resident 1 to remind them that the [REDACTED] had not yet been received by the pharmacy.

On 3/10/25, the executive director held a staff meeting / training and reviewed that any medication on a resident's med list must be on site.

On 3/13/25 the care coordinator conducted an audit of all medications on site for all residents and their medication lists. These audits will continue to occur every other week to ensure compliance. The executive director will review the audits immediately following, as well as collectively as part of the quarterly Quality Management plan.

The medication was received from the pharmacy on 3/14/25. (See attached.)

Licensee's Proposed Overall Completion Date: 03/17/2025

187a - Medication Record (continued)

Updated medication lists were received from hospice on 3/16/25. The care coordinator will update all MARs by 3/18/25.

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

Not Implemented (█) - 04/04/2025

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

Facility Information

Name: PAPPUS HOUSE License #: 33954 License Expiration: 09/09/2025
Address: 66 BIG MOUNT ROAD, THOMASVILLE, PA 17364
County: YORK Region: CENTRAL

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: PAPPUS HOUSE
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: R-4 Date: 08/10/2023 Issued By: Jackson Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 10 Waking Staff: 8

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 12/17/2024

Inspection Dates and Department Representative

12/17/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 8 Residents Served: 5

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 3
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 5 Have Physical Disability: 0

Inspections / Reviews

12/17/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/12/2025

Inspections / Reviews (*continued*)

01/15/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/17/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 01/21/2025

01/22/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/17/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 02/17/2025

04/10/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/17/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 12/17/2024, the home's most current licensing summary issued by the Department, dated 7/23/2024 was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (█ - 01/22/2025)

To immediately correct this violation, on 12/17/24, the Executive Director added the current licensing summary to the blue Pappus House information binder located in the living room.

To ensure future compliance the E.D. or designee will check contents of the binder to ensure the most current licensing summary is included. This check will take place during the quarterly Quality Management meetings to start Monday, February 3, 2025.

The E.D. will train all staff on the location of the binder and its contents, to include the licensing summary by 1/30/25. A staff training to review this process is scheduled for Friday, 1/24/25. To ensure future compliance, training logs will be reviewed by the ED quarterly as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

On █, Resident █ passed away in the home. The home did not report this incident to the Department.

On █, Resident █ passed away in the home. The home did not report this incident to the Department.

On █, Resident █ passed away in the home. The home did not report this incident to the Department.

Plan of Correction

Accept (█ - 01/22/2025)

To immediately correct this violation, the E.D. took the following steps:

1. Verbally reviewed the Pappus House incident reporting policy with all staff on 12/18/24.
2. Updated PH death procedures to include completing an internal incident report and reportable incident report to be filed with DHS on 12/18/24.
3. Instructed care coordinator to obtain death certificates for all past residents who passed away at Pappus House on 12/18/24.

16c - Written Incident Report (continued)

Executive Director will file incident reports for the residents noted in this violation by 1/24/25. ED will update Incident Binder with these incident reports and proof of communication to the regional office. Death certificates will be kept in the resident files. To ensure future compliance, an audit of the incident reports will be conducted by the ED on a quarterly basis beginning 2/3/25 as part of the Quality Management Plan. The Executive Director is responsible for conducting this audit.

ED will hold training for all staff to further review incident reporting and death procedure. A staff training to review this process is scheduled for Friday, 1/24/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented ([REDACTED] - 03/11/2025)

51 - Criminal Background Check

5. Requirements

2600.

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

Description of Violation

Staff Member A was hired [REDACTED], However, a Criminal Background Check was not obtained for this staff.

Staff Member B was hired [REDACTED]. However, a Criminal Background Check was not obtained for this staff.

Volunteer Staff Member C works approximately once per week at the home. However, a Criminal Background Check was not obtained for this volunteer staff.

Staff Member D began working on [REDACTED] However, a Criminal Background Check was not obtained for this staff until [REDACTED]

Plan of Correction

Accept ([REDACTED] - 01/22/2025)

On 1/15/25, the Executive Director revised the Pappus House Criminal Background Check Procedure to include requesting the PSP background check on the date of hire of a new employee. The E.D. trained the Administrative Coordinator on this revised procedure on 1/15/25.

Copies of PSP background checks were requested from staff A, B, C, and D on 12/23/24 by the Executive Director. All employee files were reviewed on 12/23/24 and any missing items were requested by the Executive Director. The Administrative Coordinator, with the supervision of the E.D., is working to ensure all employee files are updated with a current Criminal Background Check.

51 - Criminal Background Check (continued)

A checklist of contents required in each employee file was created on 1/15/25. To ensure future compliance, employee files will be reviewed by the ED quarterly as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)

63a - First Aid/CPR Training

6. 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 12/2/2024, 12/3/2024, and 12/4/2024, from 6:00PM to 11:00PM, 5 residents were present in the home. During this time, 0 staff were present in the home who were certified in CPR/First Aid.

On 12/5/2024 and 12/6/2024 from 7:00AM to 9:00AM, 5 residents were present in the home. During this time, 0 staff were present in the home who were certified in CPR/First Aid.

On 12/7/2024 and 12/8/2024 from 3:00PM to 11:00PM, 5 residents were present in the home. During this time, 0 staff were present in the home who were certified in CPR/First Aid.

Plan of Correction

Accept (█ - 01/22/2025)

Employee files and training records were reviewed by the ED on 12/23/24. The Executive Director requested copies of CPR/First Aid certifications from any staff who had previously been certified but who had not shared a copy of their certification certificate for their employee file on 12/23/24.

The Executive Director scheduled an onsite CPR/First Aid course on Tuesday, January 28, 2025 for all employees not currently certified to ensure there is always one trained staff person on site at all times.

To ensure future compliance that one CPR/FA-trained staff person is present at all times, all direct care staff trained as Med Techs will also be required to be CPR/FA-trained. This ensures that there is always one adequately trained staff present at all times. The ED is responsible for the hiring and training of staff. This process will be implemented following the training on 1/28/25.

All employee and training records will be reviewed quarterly by the ED as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)

65a - FS Orientation 1st Day

7. Requirements

2600.

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

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

Description of Violation

Staff Member B, whose first day of work was [REDACTED] did not receive orientation on the following topics:

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

Staff Member D, whose first day of work was [REDACTED] did not receive orientation on the following topics:

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

Staff Member A, whose first day of work was [REDACTED], did not receive orientation on the following topics:

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

Volunteer Staff Member C, who began volunteering on [REDACTED] did not receive orientation on the following topics:

65a - FS Orientation 1st Day (continued)

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

Plan of Correction

Accept (█ - 01/22/2025)

By 1/24/25, the Executive Director will draft a revised employee orientation checklist that all employees will sign to ensure they have been trained on all of the following procedures on or before their first day of employment.

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

The E.D. will hold a training for all current staff to review all these procedure to ensure knowledge and compliance on Friday, January 24, 2025 to include Staff Member A, B, and D. Volunteer member C will receive the education at a future date as █ is no longer volunteering due to █. All staff will sign the training log upon completion.

For new employees, an employee file will be started on or before their date of hire. The file and checklist will be reviewed by the ED within 30 days of hire for completion.

To ensure future compliance, all employee files and training records will be reviewed by the ED quarterly as part of the Quality Management Plan to begin on 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)

65b - Rights/Abuse 40 Hours

8. 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.

65b - Rights/Abuse 40 Hours (continued)

Description of Violation

Staff Member B, whose first day of work was [REDACTED] did not complete training in the following topics:

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.

Staff Member D, whose first day of work was [REDACTED] did not complete training in the following topics:

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.

Staff Member A, whose first day of work was [REDACTED], did not complete training in the following topics:

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.

Volunteer Staff Member C, who began volunteering on [REDACTED], did not complete training in the following topics:

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.

Plan of Correction

Accept [REDACTED] - 01/22/2025)

On 1/6/25, the Executive Director has contracted Senior Living University for "onboarding" online training modules for Pappus House to include:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the OAPSA.
4. Reporting of reportable incidents and conditions.

Login credentials were shared with all staff on 1/8/25. Onboarding training modules are due for completion by all staff by 1/30/25. The E.D. will review online training log to ensure that all staff have completed this required training, including Staff Members A, B, and D. Volunteer Member C has received the login credentials, but is on [REDACTED] [REDACTED], so compliance will be reviewed at a later date.

For new employees, an employee file will be started on or before their date of hire. The E.D. has included the training required within the first 40 hours of work in the Employee File Checklist revised on 1/15/25. The E.D. educated the Administrative Coordinator on 1/15/25 that each employee's file must be kept up-to-date with all necessary items

65b - Rights/Abuse 40 Hours (continued)

on the checklist. The file and checklist will be reviewed by the ED within 30 days of hire for completion.

To ensure future compliance, all employee files and training records will be reviewed by the ED quarterly as part of the Quality Management Plan to begin on 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)

65d - Initial Direct Care Training**9. Requirements**

2600.

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

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff Member B, hired █, did not complete the Department-approved direct care training course and pass the competency test as of 12/17/2024.

Staff Member A, hired █, did not complete the Department-approved direct care training course and pass the competency test as of 12/17/2024.

65d - Initial Direct Care Training (continued)

65d - Initial Direct Care Training (continued)**Plan of Correction****Directed (████ - 01/22/2025)**

On 12/23/24, the Executive Director reviewed all employee files to identify which direct care staff had not completed the Initial Direct Care Training course and/or submitted their certificate for their employee file.

Staff Member A had completed the direct care training and competency testing on ██████████. A copy of this certificate was obtained and placed in █████ file on 1/10/25.

Staff Member B was placed on a supervised direct care employment on ██████████. ██████████ completed the direct care training and competency testing on 1/8/25. A copy of the certificate was placed in █████ employee file on 1/10/25.

Staff Member D had completed the direct care training and competency test on ██████████. A copy of the certificate was placed in █████ employee file on 12/23/24.

On 1/15/25, the E.D. educated the Administrative Coordinator that each employee's file must be kept up-to-date with all necessary items on the checklist. The direct care training and competency test certificate are noted to be required to be placed in the file on or before the date of hire.

The file and checklist will be reviewed by the ED within 30 days of hire for completion.

To ensure future compliance, all employee files and training records will be reviewed by the ED quarterly as part of the Quality Management Plan to begin on 2/3/25.

(Directed)

In addition to the above plan of correction:

- Staff Member's A, B and D will receive education from the Administrator by 2/15/2025 on the following topics:
 - (i) Safe management techniques.
 - (ii) ADLs and IADLs.
 - (iii) Personal hygiene.
 - (iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
 - (v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - (vi) Implementation of the initial assessment, annual assessment and support plan.

65d - Initial Direct Care Training (continued)

- (vii) Nutrition, food handling and sanitation.
 - (viii) Recreation, socialization, community resources, social services and activities in the community.
 - (ix) Gerontology.
 - (x) Staff person supervision, if applicable.
 - (xi) Care and needs of residents with special emphasis on the residents being served in the home.
 - (xii) Safety management and hazard prevention.
 - (xiii) Universal precautions.
 - (xiv) The requirements of this chapter.
 - (xv) Infection control.
 - (xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration
- The Administrator or designee will audit all other staff records to ensure they have received training in the identified areas by 2/3/2025. All staff noted to be missing this education will be provided training by 2/15/2025
 - Beginning 2/3/2025, the ED will complete quarterly reviews of staff records to ensure staff have received training in 2600.65(d)(2) and 2600.65(d)(3).
 - Documentation of completed audits and staff education will be kept by the home and available for review by the Department.

Directed Completion Date: 02/15/2025

Implemented (█) - 03/11/2025)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

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

Description of Violation

Resident #2’s most current medical evaluation, dated █, did not include the date resident was evaluated, height, weight, pulse rate, nor temperature.

Resident #3’s most current medical evaluation, dated █, did not include the date the form was completed.

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction

Directed (█ - 01/22/2025)

The Executive Director conducted an audit of the Pappus House Resident Survey binder contents and each document within, including the DME's on 1/10/25.

On 1/10/25, the E.D. trained the Care Coordinator how to ensure each area of the DME is accurately completed. Because we do not have an RN or LPN on staff, the Care Coordinator requested new DME's be completed by the █ physician for residents 2 and 3. These DME's were requested on 1/21/25. As soon as these new DME's are received, they will be reviewed for proper completion and placed in the Resident Survey binder.

To ensure future compliance, DME's will be reviewed by the Care Coordinator and Executive Director quarterly as part of the Quality Management Plan beginning 2/3/25.

(Directed)

In addition to the above plan of corrections, Residents #2 and #3 will have updated DME's completed by 2/15/2025. All other DME's found to be missing areas of completion during the initial audit will be updated by 2/15/2025. Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 02/15/2025

Implemented (█ - 03/11/2025)

182b - Prescription Medication

12. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

- 4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Members B, D, E, and F administered medications to Resident #2 in the month of December 2024. However, as per the Administrator on 12/17/2024, these staff members have not completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction

Directed (█ - 01/22/2025)

The Executive Director successfully completed all portions of the online Med Admin Train the Trainer course and exams by 12/31/24. The in-person course was scheduled for the first possible date - Tuesday, Jan 28, 2025. The E.D. will complete the course and train all future direct care staff administering medications.

182b - Prescription Medication (continued)

An audit of all the direct care staff records was completed by the E.D. on 12/23/24. The Med Tech certification for one direct care staff person was obtained on 12/24/24 and placed in that employee file.

The other direct care staff planned to administer medications are enrolled in the Med Tech course. Their observations will be completed by the E.D. upon completion of [redacted] in-person certification. The goal is to have everyone properly trained and certified within 30 days - 2/28/25.

To ensure future compliance, all employee files and training records will be reviewed by the ED quarterly as part of the Quality Management Plan to begin on 2/3/25. To ensure future compliance, all employee files and training records will be reviewed by the ED quarterly as part of the Quality Management Plan to begin on 2/3/25.

(Directed)

In addition to the above plan of correction, beginning no later than 1/25/2025, the Administrator or designee will review the staff schedule at least one week in advance to ensure there is at least one staff member certified in medication administration on each shift.

Directed Completion Date: 02/03/2025

Not Implemented ([redacted] - 03/11/2025)

183d - Prescription Current

13. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/17/2024 at 5:35PM, [redacted] Resident #2, were in the home's medication cart; however, the medication was discontinued on 11/11/2024.

On 12/17/2024 at 5:35PM, [redacted] Resident #2, were in the home's medication cart; however, the medication was discontinued on 11/27/2024.

Plan of Correction

Accept ([redacted] - 01/22/2025)

To immediately resolve this violation, the two discontinued medications were destroyed by the Executive Director and Care Coordinator on 12/17/24.

On 12/18/24, the E.D. reviewed policies with all staff that only current medications with current doctor's orders are allowed in Pappus House

Medication Audits are conducted bi-weekly by the Care Coordinator. An initial audit was completed on 12/20/24.

183d - Prescription Current (continued)

Audit results are reviewed by the E.D. Audit trends are reviewed by the E.D. quarterly as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█) - 03/11/2025)

184a - Resident's Meds Labeled

14. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

On 12/17/2024 the pharmacy label for Resident #2's █ does not include the current instructions for administration. The pharmacy label includes instructions to give █ █ However, the current physician's order states to take █

Plan of Correction

Accept (█) - 01/22/2025)

To immediately correct this issue, the Executive Director placed a "SEE MAR" sticker on the medication RX label on 12/17/24.

The E.D. reviewed medication policies with staff, including the need for the RX label, MAR, and doctor's order to match exactly on 12/18/24.

Medication Audits are conducted bi-weekly by the Care Coordinator. An initial audit was conducted on 12/20/24. Audit results are reviewed by the E.D. Audit trends are reviewed by the E.D. quarterly as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Not Implemented (█) - 03/11/2025)

186a - Authorized Prescriber

15. Requirements

2600.

186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

The prescription medication, Hydrocortisone cream USP 1%, belonging to Resident #2, was present in the medication cart. However, prescriber's orders for these medications was not available at the home.

186a - Authorized Prescriber (continued)

Plan of Correction

Accept (█ - 01/22/2025)

The Care Coordinator requested a doctor's order for █ on 12/18/24. Upon further discussion, it was determined the resident did not need this █. The █ was destroyed on 1/13/25.

On 12/18/24, the E.D. reviewed medication policies with staff, including the need for doctor's orders for any medication present in the home.

Medication Audits are conducted bi-weekly by the Care Coordinator. An initial audit was conducted on 12/20/24. Audit results are reviewed by the E.D. Audit trends are reviewed by the E.D. quarterly as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)

187a - Medication Record

16. Requirements

2600.

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

- 2. Drug allergies.
- 4. Strength.

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

The December 2024 Medication Administration Records for Residents #1, #2, and #3 do not include the following information:

(2) Drug allergies.

(4) Strength.

(12) Diagnosis or purpose for the medication, including pro re nata (PRN)

Resident #3 is prescribed █. However, the medication strength is indicated as █ on the December 2024 Medication Administration Record.

Plan of Correction

Accept (█ - 01/22/2025)

The Executive Director created a new MAR to be used that includes all the necessary information according to 2600.187a. The new MARs were put into effect starting 1/1/25.

The E.D. reviewed MAR contents with all staff and explained that a MAR must be kept for any prescription on the doctors' orders including █ on 1/1/25.

187a - Medication Record (continued)

Medication Audits, including MAR completion and accuracy of documentation, are conducted bi-weekly by the Care Coordinator. The first audit took place 12/20/24. Audit results are reviewed by the E.D. To ensure compliance, audit trends are reviewed by the E.D. quarterly as part of the Quality Management Plan beginning 2/3/25.

Licensee's Proposed Overall Completion Date: 02/03/2025

Not Implemented (█ - 03/11/2025)

251b - Record Entries Legible

18. 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

Resident #2 is prescribed █. An erroneous administration on 11/3/2024 is not legible due to being scribbled out.

Plan of Correction

Directed (█ - 01/22/2025)

On 1/24/25, the Executive Director conduct a training to ensure all direct care staff know the importance of legible entries in resident records. Staff will sign acknowledgment of this training.

Resident records will be spot-checked during bi-weekly medication audits to ensure ongoing compliance with proper edits being made, as needed. The Care Coordinator will conduct these checks at the same time as the medication audits. Results will be reviewed with the E.D. These checks will also be reviewed by the E.D. quarterly as part of the Quality Management Plan beginning 2/3/25. The training records of direct care staff completing resident records will also be reviewed by the E.D. quarterly as part of the Quality Management Plan beginning 2/3/25.

(Directed)

In addition to the above plan of correction, bi-weekly audits will be completed beginning no later than 2/3/2025. Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 02/03/2025

Implemented (█ - 03/11/2025)