



Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
Mailing Date: September 17, 2025

Presbyterian Home in the Presbytery of Huntingdon
[REDACTED]

220 Newry Street
Hollidaysburg, Pennsylvania 16648

RE: Presbyterian Home
220 Newry Street
Hollidaysburg, PA 16648
License #34340

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on May 20, 2025, May 21, 2025, August 12, 2025, and August 13, 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 34340 dated June 20, 2025 to June 20, 2026 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 September 17, 2025 to March 17, 2026.

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]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

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]

Facility Information

Name: *PRESBYTERIAN HOME* License #: *34340* License Expiration: *06/20/2026*
 Address: *220 NEWRY STREET, HOLLIDAYSBURG, PA 16648*
 County: *BLAIR* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *PRESBYTERIAN HOME IN THE PRESBYTERY OF HUNTINGDON*
 Address: *220 NEWRY STREET, HOLLIDAYSBURG, PA, 16648*
 Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/29/2000* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *59* Waking Staff: *44*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *05/21/2025*

Inspection Dates and Department Representative

05/20/2025 - On-Site: [REDACTED]
 05/21/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *50* Residents Served: *30*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *4*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *30*
 Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *29* Have Physical Disability: *1*

Inspections / Reviews

05/20/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/23/2025*

06/27/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *07/21/2025*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/03/2025*

Inspections / Reviews (*continued*)

07/07/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 07/21/2025

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: 07/21/2025

09/03/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 07/21/2025

Reviewer: [REDACTED] Follow-Up Type:

14c - Building Renovations

1. Requirements

2600.

14.c. If a building is structurally renovated or altered after the initial fire safety approval is issued, the home shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority. This documentation shall be submitted to the Department within 15 days of the completion of the renovation or alteration.

Description of Violation

The building was structurally altered with the installation of an electronic maglock on the patio door in 2023. The home did not submit a new fire safety approval or written certification that a new fire safety approval is not required from the appropriate fire safety authority.

Plan of Correction

Accept [redacted] - 07/07/2025)

The home will submit a fire safety plan drawing revision for approval local code authority by 7/21/2025 requesting adjustments to the current egress access and signage, which will address the patio door in question. The mag lock on the patio door will be disengaged until approval for the mag lock and change in exit signage is approved and replaced with an audible sounding alarm in the interim.

The Personal Care Administrator and the Director of Environmental Services were educated by the Executive Director on 6/26/2025 that per regulation 14c, building alterations must be submitted to the appropriate fire safety authority and approved prior to alterations taking place.

Maintenance staff will conduct weekly audits beginning after 7/1/2025 for two months to ensure that the new exit door signage is visible. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Proposed Overall Completion Date: 07/21/2025

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

26c - QM Improvement

8. Requirements

2600.

26.c. The quality management plan shall include the development and implementation of measures to address the areas needing improvement that are identified during the periodic review and evaluation.

Description of Violation

The home's quality management plan, completed on 4/4/25, included a section for "Reportable Incidents: 8" but did not include the development and implementation of measures to address the areas needing improvement.

Plan of Correction

Accept [redacted] - 07/07/2025)

The next quality management meeting will be held on 7/10/2025 and will be held quarterly moving forward.

Education was provided to Personal Care Administrator by the Executive Director on 6/26/25 that per regulation 26c, the Quality Management plan should implement measures to address areas needing improvement.

The Executive Director will audit quality management plans quarterly for two quarters starting after the 7/10/2025 meeting for documentation of development and implementation of measures to address areas needing improvement. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

26c - QM Improvement (*continued*)

Licensee's Proposed Overall Completion Date: 07/10/2025

Implemented (█) 08/26/2025)

57c - 2 Hours/Day

12. Requirements

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

There are 30 residents in the home, 29 of which have mobility needs, requiring a minimum of 59 hours of direct care service per day.

- *On 5/11/25, only 57 hours of direct care staffing was provided.*
- *On 5/18/25, only 56.5 hours of direct care staffing was provided.*
- *On 5/16/25, only 56.5 hours of direct care staffing was provided.*

Plan of Correction

Accepted (█) - 07/07/2025)

The PC Administrator implemented a standardized mobility assessment tool that is housed in the electronic health record. This tool was implemented after the initial mobility assessments were completed. These were completed on all residents on 5/22/2025 by the PC Administrator and home nursing staff to determine appropriate staffing. This assessment will take place for each resident upon admission, quarterly, and with any significant changes in care needs. The PC Administrator will keep an up-to-date list of resident mobility needs to refer to when creating schedules and checking daily staffing.

The Personal Care Administrator will be provided with training by the Executive Director by 7/21/2025 on how to calculate the staffing needs based on mobility needs.

Personal Care Home Administrator (or designee) will audit staffing daily at the start of the day for 5 days, and then weekly for 4 weeks beginning after 7/1/2025 to ensure that the correct hours of direct care service have been met. If it appears that staffing hours will not be met, the schedule will be adjusted to meet the requirement. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented (█) - 08/26/2025)

57d - Waking Hours

13. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On █ 25, a total of 59 hours of direct care was required. However, only 36 of the required hours, or 61 percent,

57d - Waking Hours (continued)

were provided during waking hours.

On 5/16/25 and 5/18/25, a total of 59 hours of direct care was required. However, only 42.5 of the required hours, or 72 percent, were provided during waking hours.

Plan of Correction

Accept [redacted] - 07/07/2025)

The Personal Care Administrator will be provided with training by the Executive Director on 6/26/25 on how to calculate the staffing needs based on waking hours. The PC Administrator will refer the waking hours calculations/regulation 57d when creating the schedule as well as daily when assessing staffing. The Personal Care Home Administrator will audit staffing daily for 5 days beginning after 7/1/2025, and weekly for 4 weeks to ensure that the correct hours of direct care service have been met. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

65b - Rights/Abuse 40 Hours

14. 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:
 - 2. Emergency medical plan.

Description of Violation

The following staff members did not receive training in the home's emergency medical plan within the first 40 scheduled working hours:

- staff member B, [redacted] 25.
- staff member C, [redacted] /25.

Plan of Correction

Accept [redacted] - 07/07/2025)

Staff members B and C will receive training on the home's emergency medical plan by 7/21/2025. Personal Care staff files will be audited by 7/21/2025 to ensure the staff was educated on the home's emergency medical plan and if they were not, education on the plan will be provided. Education on regulation 65b and the need to educate staff on the emergency medical plan will be provided to the Personal Care Administrator by the Executive Director on 6/26/2025. An audit of each new Personal Care employee will be conducted starting after 7/1/2025 by the Executive Director (or designee) to ensure that staff receive education on the home's medical plan within 40 working hours. The audit will be conducted within the first week of hire. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

66a - Staff Training Plan

17. Requirements

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

Description of Violation

The home did not have a staff training plan for training years 2024 or 2025.

Plan of Correction

Accepted [redacted] - 07/07/2025)

The PC Administrator (or designee) will fill out the 2025 staffing plan for each PC staff member with dates of educations completed year to date. The PC staff will then sign off on the training plan document to confirm that they completed their education modules on the date listed. This will take place before 7/21/2025.

The PC Administrator and PC staff will be educated by the Executive Director by 7/21/2025 that they must complete their education modules and then sign the staffing plan as their education modules are completed, and that per regulation 66a, they should follow the established staff training plan.

Ongoing audits will be conducted monthly by the PC Administrator (or designee) beginning after 7/1/2025 to ensure that PC staff are completing their educations per the establish staff training plan. Audits will be forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] 08/26/2025)

82a - Poisonous Materials

18. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 5/20/25 at 9:18 AM, an unlabeled 16-ounce spray bottle, filled with a chemical scented clear liquid, was found in the first-floor laundry room.

Plan of Correction

Accepted [redacted] - 07/07/2025)

The unlabeled spray bottle was removed from the first-floor laundry room by the Executive Director on 6/16/2025. Both of the home's laundry rooms were inspected on 6/16/25 by the Executive Director and a PC Med Tech for unlabeled chemicals and any found were removed.

Environmental Services and Personal Care staff were educated by the Executive Director on 6/26/2025 that per regulation 82a, poisonous materials shall be stored in their original, labeled containers.

Audits of the laundry areas will be conducted beginning after 7/1/2025 by the Director of Environmental Services (or designee) three times weekly for two months to ensure there are no unlabeled chemicals present. Audit results will be documented and forwarded to the Quality Assurance committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

85e - Trash Outside Home

19. Requirements

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

85e - Trash Outside Home (continued)

Description of Violation

On 5/20/25, the outside dumpster was half full with the lids propped open by two poles. The dumpster was not actively being used.

Plan of Correction

Accepted [redacted] - 07/07/2025)

The lid to the dumpster was immediately closed on 5/20/25 by the Director of Environmental Services. Maintenance staff will be educated on 6/26/2025 by the Executive Director that per regulation 85e, trash receptacle lids are not to be propped open.

Audits will be conducted daily for two months beginning after 7/1/2025 by the Director of Environmental Services (or designee). Audits results will be documented and forwarded to the Quality Assurance committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

101r - Bedroom - shades/drapes/window covering

20. Requirements

2600.

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

Description of Violation

The window blinds in bedroom #1PA were broken and not in good repair. On 5/20/25, at least two slats were broken in half and two additional slats were partially broken.

Plan of Correction

Accepted [redacted] - 07/07/2025)

The blinds in bedroom #1PA were replaced on 6/16/2025 by the Skilled Maintenance Worker. An audit will be conducted by 7/21/2025 by the Director of Environmental Services (or designee) of all resident rooms to ensure blinds were clean and in good repair. If blinds are not clean or in disrepair, they will be replaced. Environmental Services staff will be educated by the Executive Director on 6/26/2025 that per regulation 101r, window treatments should be clean and in good repair.

Audit will be conducted by Director of Environmental Services (or designee) beginning after 7/1/2025 on three random bedrooms weekly for two months to ensure blinds are clean and in good repair. Audit results will be documented and forwarded to the Quality Assurance committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

105g - Lint Removal and Duct Cleaning

21. Requirements

2600.

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

Description of Violation

On 5/20/25 at 9:18 AM, there was an approximate 1-inch accumulation of lint in the lint trap of the dryer in the first-floor laundry room. There were no clothes in the dryer at the time.

105g - Lint Removal and Duct Cleaning (continued)

Plan of Correction

Accept (█) - 07/07/2025)

Lint trap on dryer in the first-floor laundry room was cleaned immediately by the Pc Administrator on 5/20/25.

The lint trap on the second-floor dryer was cleaned on 5/20/2025.

Personal Care and housekeeping staff will be educated on 6/26/2025 by the Executive Director that per regulation 105g, dryer lint is to be removed from the trap after each use.

Audits will be conducted by the Director of Environmental Services (or designee) beginning after 7/1/2025 three times weekly for two months to ensure that the lint traps on both of the home's dryers are cleaned regularly. Audit results will be documented and forwarded to the Quality Assurance committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented (█) 08/26/2025)

121a - Unobstructed Egress

24. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 5/20/25, at 9:07 AM, the emergency exit door leading from the front hallway to the open side patio/porch was locked with an engaged magnetic lock that requires a key FOB to disengage. The door was marked as an exit and residents are not provided a key FOB to have at all times.

Plan of Correction

Accept (█) 07/07/2025)

The home will submit a fire safety plan drawing revision for approval local code authority by 7/21/2025 requesting adjustments to the current egress access and signage, which will address the patio door in question. The mag lock on the patio door will be disengaged until approval for the mag lock and change in exit signage is approved and replaced with an audible sounding alarm in the interim.

The Personal Care Administrator and the Director of Environmental Services were educated by the Executive Director on 6/26/2025 that per regulation 14c, building alterations must be submitted to the appropriate fire safety authority and approved prior to alterations taking place.

Maintenance staff will conduct weekly audits beginning after 7/1/2025 for two months to ensure that the new exit door signage is visible. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented (█) - 08/26/2025)

124 - Notice to Fire Department

25. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

124 - Notice to Fire Department (continued)

Description of Violation

The home has not notified the local fire department of the assistance needed to evacuate in an emergency. A notification was sent on 4/29/25; however, the notification only includes 1 resident with mobility needs and the home currently serves 29 residents with mobility needs.

Plan of Correction

Accept [redacted] - 07/07/2025)

No residents had any ill effects as a result of this practice.

The PC Administrator will notify the local fire department prior to 7/21/25 indicating the address of the home, location of the bedrooms, and assistance needed to evacuate in the event of an emergency. Documentation of this notification will be kept.

Education was provided to the Personal Care Administrator and Director of Environmental Services by the Executive Director on 6/26/2025 that per regulation 124, the home must notify the local fire department of the address, bedroom location, and assistance needed to evacuate.

An audit will be conducted monthly for two months beginning after 7/1/2025 by the Executive Director to ensure that the notice to the fire department is sent with any changes to the home's evacuation needs. Audit results will be documented and forwarded to the Quality Assurance committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

132d - Evacuation

27. Requirements

2600.

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

Description of Violation

During the fire drill on 3/4/25 at 2:45 AM, residents evacuated to a fire safe area in 6 minutes and 38 seconds. The home's maximum safe evacuation time specified in writing by a fire safety expert on 1/29/25, is 6 minutes.

Plan of Correction

Accept [redacted] - 07/07/2025)

No residents were harmed by this practice.

A fire drill will be conducted by 7/21/2025 and will be performed under the 6-minute time frame.

PC clinical and ancillary staff will be educated by Personal Care Home Administrator by 7/21/2025 that per regulation 132d, residents must be evacuated to a fire safe area in under 6 minutes.

Audits will be conducted on all PC fire drills by the Director of Environmental Services (or designee) beginning after 7/1/2025 for two months to ensure that residents are evacuated in under 6 minutes. If they are not, the drill will be repeated within one week until the appropriate evacuation time is achieved. Minutes of the fire drill will be kept documenting root causes for any delays in evacuation time. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] 08/26/2025)

132h - Designated Meeting Place

28. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Multiple resident interviews indicated that residents do not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction

Accept [redacted] - 07/07/2025)

No residents were harmed by this practice

A fire drill will be conducted prior to 7/21/2025 and all residents will be evacuated to fire safe areas.

Personal Care clinical and ancillary staff will be educated by the Personal Care Administrator on 6/26/2025 that per regulation 132h, all residents must be evacuated to a fire safe area during a fire drill. All residents will be educated by the PC Administrator (or designee) by 7/21/2025 that they are to evacuate to a fire safe area during a fire drill. Maintenance staff will be educated by the Director of Environmental Services by 7/21/2025 to note in the "any problems" section of the fire drill form if any residents did not evacuate and why. Further education will then be provided to the resident by the PC Administrator (or designee) and documented.

Audits will be conducted on all Personal Care fire drills by the Director of Environmental Services (or designee) beginning after 7/1/2025 for two months to ensure that all residents are evacuated to a fire safe area during the drill. If they are not, the drill will be repeated until all residents evacuate to a fire safe area. Within a week of the fire drill, the PC Administrator (or designee) will interview a random sample of 3 residents to ask if they are evacuating during the fire drill. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Not Implemented [redacted] - 08/26/2025

132i - Testing Fire Alarm

29. Requirements

2600.

132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drill on 9/19/24, the fire alarm was not sounded.

Plan of Correction

Accept [redacted] - 07/07/2025)

No residents were harmed by this practice

A fire drill will be conducted prior to 7/21/2025 and the alarm will be sounded.

Maintenance staff will be educated by the Personal Care Administrator on 6/26/2025 that per regulation 132i, a fire alarm or smoke detector shall be set off during each fire drill.

Audits will be conducted on all Personal Care fire drills by the Director of Environmental Services (or designee) beginning after 7/1/2025 for two months to ensure that the fire alarm was sounded for each drill. If they are not, the drill will be repeated with the alarm sounding. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

133.2 - Exit Signs Direction

30. Requirements

2600.

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

There are multiple locations in the home where the exit or way to reach the exit was not immediately visible as follows:

- *Access to a secondary exit was not marked with readily visible signs indicating the direction to travel from resident bedrooms #8 and #9.*
- *Access to a secondary exits was not marked with readily visible signs indicating the direction to travel from the bedrooms located on the second-floor which includes resident room #28.*
- *Access to exits were not marked with readily visible signs indicating the direction to travel from resident bedrooms #33, #34, #35, and #40.*

Plan of Correction

Accept [redacted] - 07/07/2025)

Exit signs were added to areas where they were not visible on 6/19/2025 by the Maintenance Specialist.

Areas of the home were audited by the Executive Director on 7/2/2025 to ensure that exit signs were visible from each resident room. Areas requiring additional exit signage will have exit signs placed by 7/21/2025.

Personal Care Administrator and Director of Environmental Services were educated by the Executive Director on 6/26/2025 date that per regulation 133.2, exits shall be marked with readily visible signs indicating the direction to travel.

Maintenance staff will conduct audits beginning after 7/1/2025 once weekly for two months to ensure that the new exit signage is visible. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

141b1 - Annual Medical Evaluation

31. Requirements

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]/25. The resident's previous medical evaluation was completed on [redacted]/24.

Resident #2's most recent medical evaluation was completed on [redacted]24. The resident's previous medical evaluation was completed on [redacted]/22.

Repeated violation - 5/29/24, et al.

Plan of Correction

Accept [redacted] - 07/07/2025)

No residents had any ill effects as a result of this practice.

Current residents' medical evaluations will be audited by the Personal Care Administrator (or designee) by 7/21/2025 to ensure they were completed annually. If they have not been completed within a year, they will be updated.

The Personal Care Administrator and the Personal Care staff will be educated by the Executive Director on 6/26/2025 that, as per regulation 141b1, resident medical evaluations are to be done annually.

141b1 - Annual Medical Evaluation (continued)

An audit of four medical evaluations will be completed by the PC Administrator (or designee) monthly for two months beginning after 7/1/2025 to ensure compliance. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

143a - Emergency Medical Plan

32. Requirements

2600.

143.a. The home shall have a written emergency medical plan that includes the following:

- 1. The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.
- 2. Emergency transportation to be used.
- 3. An emergency-staffing plan.

Description of Violation

The home's written emergency medical plan does not include the hospital or source of health care that will be used in an emergency, emergency transportation to be used, or an emergency-staffing plan.

Plan of Correction

Accept [redacted] - 07/07/2025)

No residents had any ill effects as a result of this practice.

The emergency medical plan policy will be reviewed, and information related to hospital/source of health care, emergency transportation, and emergency staffing plan will be added by the PC Administrator (or designee) by 7/21/2025.

The Personal Care Administrator was educated by the Executive Director on 6/26/25 that per regulation 143a, the home's emergency medical plan shall contain the hospital/source of health care to be used in an emergency, the emergency transportation to be used, and an emergency staffing plan.

Personal Care Home Administrator will complete audits of the Grab and Go binder monthly x 3 months beginning after 7/1/2025, audits will also occur after admissions to assure information is up to date and correct.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

161d - Dietary Needs

33. Requirements

2600.

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

Description of Violation

Resident #2 was prescribed a mechanical soft diet to include ground meats. However, on 5/20/25 at 12:00 PM, the resident was served pureed meats.

161d - Dietary Needs (continued)

Plan of Correction

Accept [redacted] - 07/07/2025)

Resident #2 had no ill effects because of this practice.

A meal was audited on 7/2/2025 to ensure that current residents with modified diets were served the correct diet.

Residents with modified diets records were audited on 7/2/2025 to ensure that the correct diet was listed in accordance with the provider's order.

The dining services staff and the Personal Care staff will be educated by the Executive Director on 6/26/2025 that per regulation 161d, residents' special dietary needs shall be met and documentation of their special dietary needs shall be kept in the resident's record.

An audit will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 once weekly for two months to ensure that residents with modified diets are served the appropriate meal per their provider's order. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] 08/26/2025)

161e - Dietary Alternatives

34. Requirements

2600.

161.e. Dietary alternatives shall be available for a resident who has special health needs or religious beliefs regarding dietary restrictions.

Description of Violation

The home does not provide a dietary alternative to resident #1. The resident requires a pureed diet due to health care needs and is not provided with a choice of menu items which all other residents receive one day in advance. The kitchen staff determine which meal item to serve to resident #1 without the resident's ability to select [redacted] preferred menu option.

Plan of Correction

Accept [redacted] - 07/07/2025)

Resident 1 did not have any ill effects from this practice.

The home's menus contain multiple options for residents to choose which menu items they would like if they are cognitively able to choose. A meal was audited on 7/2/2025 to ensure residents are served the menu items they selected. As of 6/19/2025 the home no longer has any residents receiving pureed diets.

Dining services staff and Personal Care staff will be educated by the Dining Services Director (or designee) by 7/21/2025 on providing alternative pureed items for residents if they choose and following resident's menu selections.

Audits will be conducted on three residents' meals weekly for two months by the Dining Services Director (or designee) starting after 7/1/2025 to ensure that the residents are being served the menu item that they selected. Random audits will continue throughout the year as part of the quality assurance process. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [redacted] - 08/26/2025)

183b - Meds and Syringes Locked

35. 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 5/20/25, resident #2's bottle of Ivizia eye drops was unsecured, unattended, and accessible, on the television stand in the resident's bedroom. Resident #2 is not assessed to self-administer medications.

On 5/20/25, at 9:20 AM, a medication cart was unlocked, unattended, and accessible in a closet off the second-floor kitchenette containing medications for current residents including:

- *Calmoseptine ointment for residents #4, #5 and #6.*
- *Nystatin powder for resident #4.*
- *Aquaphor ointment for resident #7.*

Plan of Correction

Accept [REDACTED] - 07/07/2025)

No residents had any ill effects as a result of this practice.

Resident #2's eye drops were returned to the med cart on 5/20/25 by the PC LPN and the treatment cart on 2nd floor by the kitchenette was secured on 5/20/25 by the PC LPN.

Education will be provided to the Personal Care staff by the Personal Care Administrator on 6/26/2025 that per regulation 183b, no medications or treatments should be left unattended, unlocked, or accessible and should always be secured when not in use.

Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on three random resident rooms and the 2nd floor treatment cart/closet three times weekly for two months to ensure compliance. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [REDACTED] - 08/26/2025)

183d - Prescription Current**36. 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 5/21/25, the following medications prescribed for resident #1 were in the home's medication cart 1; however, the home does not have current or discontinued orders for the medications:

- *Acetaminophen 325mg, take 2 tabs by mouth every 4 hours as needed for mild pain.*
- *Ondansetron 4mg, take 1 tab by mouth every 6 hours as needed for nausea/vomiting for 5 days.*

Plan of Correction

Accept [REDACTED] - 07/07/2025)

Resident #1 had no ill effects because of this practice and the medications without orders were removed from the med cart by the PC LPN on 5/21. Resident #1 discharged from the facility on [REDACTED]/25.

The med carts will be audited by 7/21/2025 by the PC LPN (or designee) to ensure there are no medications present without current orders.

Education will be provided to the Personal Care staff by the Personal Care Administrator on 6/26/25 that per regulation 183d, the med carts shall not contain any medications for residents that do not have a current

183d - Prescription Current (continued)

medication order.

Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on each med cart once weekly for two months to ensure that there are no medications present that do not have a current medication order. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Not Implemented (█) - 08/26/2025

183e - Storing Medications

37. 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 5/20/25, resident #2's medication blister pack, containing acetaminophen 325mg, had holes on the back of two medication pockets, exposing the medication.

Plan of Correction

Accept (█) - 07/07/2025)

No residents had any ill effects because of this practice and the blister pack with holes was disposed of by the PC LPN on 6/1/2025.

Current residents' medication blister packs will be inspected by 7/21/25 by a PC LPN (or designee) for holes exposing the medications. If the packs have holes, the pharmacy will be notified, the exposed medications will be disposed of, and the medications will be replaced.

Education will be provided to the Personal Care staff by the Personal Care Home Administrator on 6/26/2025 that per regulation 183e, medications shall be stored under sanitary conditions and if the medication blister packs contain holes that expose the medication, pharmacy is to be notified, and the medications should be replaced.

Audits will be conducted by the PC Administrator (or designee) beginning after 7/1/2025 on each med cart weekly for two months to ensure that medications in blister packs do not contain holes that expose the medication. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Not Implemented (█) - 08/26/2025

184b - Labeling OTC/CAM

38. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 5/21/25, a dose of 4mg Naxolone Hydrochloride nasal spray was in the home's medication cart 1 and was not labeled with the resident's name. The home was unable to identify whom the medication belonged to.

Plan of Correction

Accept (█) - 07/07/2025)

No residents had any ill effects as a result of this practice. The naloxone hydrochloride was disposed of by the PC LPN on 5/21/2025.

Education will be provided to the Personal Care staff by the Personal Care Administrator on 6/26/2025 that per regulation 184b, medications shall be identified with the resident's name.

184b - Labeling OTC/CAM (continued)

Audits will be conducted on each med cart weekly for two months by the Personal Care Administrator (or designee) beginning after 7/1/2025 to ensure that medications belonging to residents are labeled with the resident's name. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [REDACTED] - 08/26/2025)

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

Resident #1 is prescribed the following medications which were not available in the home on 5/21/25:

- *Atropine care 1% drops, give 2 drops sublingually every 2 hours as needed for secretions.*
- *Milk of magnesia, give 30cc orally as needed for constipation*
- *Tramadol 50mg, give 1 tablet orally every 6 hours as needed for moderate pain.*

Resident #1 is unable to report chest pain and is totally dependent upon staff assistance to administer medications as prescribed. The resident has a current physician's order to administer nitroglycerin .4mg as needed for chest pain-may repeat every 5 minutes for 3 doses, hold for SBP less than 100 (notify md if unrelieved after 3rd dose) do not crush. The home does not have a process in place to determine if or when the resident has a need for the administration of the medication.

Resident #8 is prescribed Lorazepam 0.5mg daily. On 5/20/25, at 9:40 AM the narcotic count for this medication indicated 12 pills were available in the home; however, 24 pills were in the pill packet.

185a - Implement Storage Procedures (continued)

Plan of Correction

Directed [REDACTED] 07/07/2025)

No residents had any ill effects because of this practice. Resident #1 was discharged on [REDACTED] 2025. Resident #1 did not receive any of the PRN medications prior to her discharge, and the medications were available in the home's stat safe supply if needed.

If a resident is identified that cannot effectively communicate their medication needs, the physician will be notified, and an alternative order or solution will be found at the physician's discretion.

The PC Administrator (or designee) will run a missed med report daily to ensure that no medications were missed being documented. If there is no documentation, the PC Administrator will investigate why and correct the issue immediately.

Resident #2s clonidine order was corrected to include a blood pressure check to know when to administer the medication. This was added by the PC LPN on 7/3/2025.

The discrepancy for the narcotic count was because the card had one 0.25mg tablet per space, not 0.5mg per the order and the staff had to give two 0.25mg tablets instead of one. The pharmacy was contacted by the PC LPN on 5/21/2025 and this was corrected.

An audit will be conducted by 7/21/2025 by the PC LPN of current residents to ensure only appropriate medications are being crushed, PRN medications are available, PRN blood pressure medications needing parameters have them and are being obtained prior to administration, and that all narcotic records are accurate.

Personal Care staff will be educated on 6/26/25 by the Personal Care Administrator on the process to ensure only appropriate medications are being crushed, PRN medications are available, PRN medications needing parameters have them and are being obtained prior to administration, and that all narcotic records are accurate.

Audits will be conducted by a PC LPN or designee beginning after 7/1/2025 of three random residents weekly to ensure only appropriate medications are being crushed, PRN medications are available, PRN blood pressure medications needing parameters are included in the order and are being obtained prior to administration, and that all narcotic records are accurate. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

(Directed)

- The Administrator or designee will review the home's current policies and procedures regarding medication administration and provide updates on what staff should do if a resident is having difficulty accepting the ordered route of medication administration and how to administer PRN orders for residents who cannot communicate medical needs effectively. The procedures should include an effective date and identify staff member titles responsible for contacting the physician to clarify orders. Updates will be completed and all staff who administer medications will be educated on the updated policy by 7/21/25.

Directed Completion Date: 07/21/2025

Not Implemented [REDACTED] - 08/26/2025

187a - Medication Record

40. Requirements

2600.

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

187a - Medication Record (continued)

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

Description of Violation

Resident #2 is prescribed miconazole nitrate cream for irritation for rash. However, the resident's May 2025 medication administration record indicated the medication is prescribed for Dementia.

Plan of Correction

Accept [REDACTED] - 07/07/2025)

No residents had any ill effects because of this practice. Resident #2's order for miconazole was updated to correct the diagnosis from "dementia" to "skin irritation" by the PC LPN on 6/20/25.

Current residents' MARs will be audited by a PC LPN (or designee) by 7/21/2024 to ensure that medications have the appropriate diagnosis listed. If not, the diagnosis will be corrected per the physician's order.

Education will be provided to the Personal Care staff by the Personal Care Administrator on 6/26/2025 that per regulation 187a, residents' medication orders must contain an accurate diagnosis for the medication.

Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on three random residents weekly for two months to ensure that each medication order contains an appropriate diagnosis.

Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [REDACTED] 08/26/2025)

187c - Refusal of Medication

41. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 5/16/25 at 8:00 AM, resident #2 refused to take a scheduled dose of aspirin 81mg, atenolol 25mg, clopidogrel 75mg, polyethylene glycol 3350 powder, potassium 10 meq, rasagiline mesylate 1mg, stim lax plus 8.6mg/50m, ivizia eye drops, carbidopa-levodopa 25-100, and nutritional drink supplement. The home did not report the refusals to the resident's doctor as required.

Plan of Correction

Accept [REDACTED] - 07/07/2025)

Resident #2 had no ill effects because of this practice. A communication was placed to her provider on 6/30/25 by the PC Administrator notifying them on her refusal of medications.

Current resident MARs will be audited by 7/21/2025 by a PC LPN (or designee) back through June 1st to ensure that refusals of medications were reported to the provider. If the refusal was not reported, the provider will be notified.

Education will be provided to the Personal Care staff by the Personal Care Administrator on 6/26/2025 that if a resident refuses to take medication or treatment, their provider must be notified timely.

Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on three random residents weekly for two months to ensure that any refusals are reported to their provider. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [REDACTED] - 08/27/2025)

225c - Additional Assessment

46. Requirements

2600.

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

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's assessment, dated [REDACTED]/24, indicates a dietary need of mechanical soft diet. However, the resident's medical evaluation completed on 3/19/25 indicates resident #1 receives a "mechanical soft/pureed meats/nectar thick liquids" diet and as of 5/6/25, utilizes built up utensils for all meals. The resident's assessment was not updated to reflect these changes.

Repeated Violation 1/28/25

Plan of Correction

Accept [REDACTED] - 07/07/2025)

Resident #1 was discharged from the home on [REDACTED] 2025.

Current residents' assessments will be audited by 7/14/2025 to ensure that they reflect any changes to the resident's diet or adaptive equipment.

The Personal Care Administrator and Personal Care staff will be educated by the Executive Director on 6/26/2025 that per regulation 225c, resident assessments should be updated with any significant changes in condition such as changes in diet or adaptive equipment.

Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on three residents weekly for two months to ensure that any changes in diet or adaptive equipment are updated on the resident assessment. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Not Implemented [REDACTED] - 08/26/2025

227c - Support Plan Revision

47. Requirements

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1's assessment was completed on [REDACTED]/24; however, the resident's support plan was not completed.

Plan of Correction

Accept [REDACTED] - 07/07/2025)

Resident #1 was discharged from the facility on [REDACTED]/2025.

Current resident's RASPs will be audited by 7/21/2025 to ensure the support plan was completed within 30 days of the most recent assessment completion date.

Education will be provided to the Personal Care Administrator by the Executive Director on 6/26/2025 that per regulation 227c, The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on one resident support plan weekly for two months to ensure that the support plan was completed within 30 days of the most recent assessment completion date. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

227c - Support Plan Revision (*continued*)

Licensee's Proposed Overall Completion Date: 07/21/2025

Not Implemented [REDACTED] - 08/26/2025

227d - Support Plan Medical/Dental

48. 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

The assessment for resident #3, dated [REDACTED]/24, indicates the need for a hospital bed with hand assist rails. The support plan, dated [REDACTED] 24, does not document the resident's specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction

Accept [REDACTED] - 07/07/2025)

Resident #3's RASP will be updated by the PC Administrator (or designee) to include the need for a hospital bed with hand assist rails, including: resident's specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines

RASPs for current residents using hospital beds and/or assist rails will be audited by the PC Administrator (or designee) by 7/14/2025 to ensure the RASP reflects these needs including: resident's specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines. If it was not present, their RASPs will updated accordingly.

The Personal Care Administrator and the Personal Care staff will be educated by the Executive Director on 6/26/2025 that per regulation 227d, the home shall document in the residents' support plan what services will be made available to resident and update the support plan with any changes.

Audits will be conducted by the Personal Care Administrator (or designee) beginning on 7/1/2025 on three residents weekly for two months to ensure that residents requiring hospital beds, hand assist rails, enabler bars, and bed rails for care are reflected accurately on the RASP and include: resident's specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines. Audit results will be documented and forwarded to the Quality Assurance Committee for review

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [REDACTED] - 08/26/2025)

227e - Self Administer Medication

49. Requirements

2600.

227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

227e - Self Administer Medication (continued)

Description of Violation

Resident #2's assessment, dated [REDACTED]/24, indicates the resident is capable of self-administering medications with assistance remembering schedule, offering medications at prescribed times, and opening container or locked storage area. However, resident #2's medical evaluation, dated [REDACTED]/24, indicates the resident is not assessed to self-administer medications.

Plan of Correction

Accept [REDACTED] - 07/07/2025)

Resident #2 is not capable of self-administering medications. [REDACTED] RASP will be updated by the PC Administrator by 7/21/2025 to reflect [REDACTED]. Records of current residents who can self-administer medications will be audited by 7/21/2025 to ensure that the medical evaluation and the RASP both reflect the same information. Education will be provided to the Personal Care Administrator on 6/26/2025 by the Executive Director that per regulation 227e, the support plan must accurately indicate if the resident can self-administer, receive medication reminders, or receive medication administration. Audits will be conducted by the Personal Care Administrator (or designee) beginning after 7/1/2025 on three random residents weekly for two months to ensure that the residents' medical evaluation and RASPs accurately reflect how the resident takes their medications.

Licensee's Proposed Overall Completion Date: 07/21/2025

Not Implemented [REDACTED] - 08/26/2025

252 - Record Content

50. Requirements

- 2600.
- 252. Content of Resident Records - Each resident's record must include the following information:
 - 23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

Resident #9 passed away in the home in 2024. The home had not obtained, or attempted to obtain, the resident's death certificate.

Plan of Correction

Accept [REDACTED] - 07/07/2025)

The home obtained Resident #9's death certificate and placed it in the resident record. An audit will be conducted by 7/21/2025 of records of residents who passed away in the home since January of 2025 to ensure that death certificates were placed in the closed record. Education will be provided to the Personal Care Home Administrator on 6/26/2025 by the Executive Director that per regulation 252, records of residents who pass away in the home must contain the official death certificate. Audits will be conducted beginning after 7/1/2025 on all residents who pass away in the home for two months to ensure that the record contains the official death certificate. Audit results will be documented and forwarded to the Quality Assurance Committee for review.

Licensee's Proposed Overall Completion Date: 07/21/2025

Implemented [REDACTED] - 08/26/2025)