pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE VILLAGES OF HARMON HOUSE, LLC**
LEGAL ENTITY

To operate **THE VILLAGES OF HARMON HOUSE**
NAME OF FACILITY OR AGENCY

Located at **601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **67** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

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

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 23, 2024** until **August 23, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454541**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: FEBRUARY 23, 2024

[redacted], President
The Villages of Harmon House, LLC
[redacted]

RE: The Villages of Harmon House
601 South Church Street
Mt. Pleasant, Pennsylvania 15666
License/COC #: 454541

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 20, 2023, September 21, 2023, September 22, 2023, December 4, 2023, and December 11, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance (license number 454540) dated September 27, 2023 – July 1, 2024, 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 February 23, 2024 to August 23, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), 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
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

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: *THE VILLAGES OF HARMON HOUSE* **License #:** *45454* **License Expiration:** *07/01/2024*

Address: *601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMON HOUSE, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/06/1988* **Issued By:** *Labor and Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *10/03/2023*

Inspection Dates and Department Representative

09/20/2023 - On-Site: [redacted]

09/21/2023 - On-Site: [redacted]

09/22/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served:** *49*

Special Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *49*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *10* **Have Physical Disability:** *0*

Inspections / Reviews

09/20/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/28/2023*

10/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/03/2023*

11/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/01/2023*

02/01/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/01/2023*

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

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/23 at approximately [redacted] resident #1 reported witnessing staff persons A and B engaging in oral sex at one of the nursing stations. Resident #1 reported the incident to numerous staff persons; however, this incident was not reported to the Department until 10/2/23.

On [redacted]/23, a disruptive, verbal altercation occurred between staff person C and resident #2's family member in residents #2 and #4's shared living unit, which then moved into the hallway; however, this incident was not reported to the Department.

Plan of Correction ***Directed ([redacted] - 11/07/2023)***

Administrator or designee will gather the information and complete the report to the department regarding the verbal altercation no later than 11/6/2023. Administrator or designee will provide education to staff responsible for reportable incidents on 10/30/2023, documentation of the staff education shall be kept in accordance with 2800.65l. Moving forward Administrator or designee will review all incidents to determine if they are reportable and cross reference with the 2800 rcg. (DIRECTED: Beginning on 11/13/23: The administrator shall review all internal incidents daily to ensure all reportable incidents specified in 2800.16a are reported to the Department within 24 hours in accordance with 2800.16c. [redacted] 11/7/23). Reportable incidents will be reviewed monthly at the facility's QA meetings by the administrator or designee. Reportable incidents were reviewed on 10/25/2023. The next review will take place at the end of the month, on 11/27/2023. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 11/7/23).

Proposed Overall Completion Date: 11/06/2023

Directed Completion Date: *11/27/2023*

Not Implemented ([redacted] - 02/01/2024)

25a Resident - residence contract

2. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

On 7/1/23, the residence had a change of legal entity; however, no residence-resident contract addendum was provided to any resident indicating the change of legal entity occurred.

25a Resident - residence contract (continued)

Plan of Correction ***Directed (- 11/07/2023)***

On 10/30/2023, administrator or designee will again attempt to locate the letter that was sent to families prior to the transition to the new legal entity. If unable to locate, the administrator or designee will send a letter to all residents/families indicating the change of ownership that took place on 7/1/2023. This letter will go out no later than 11/10/2023. Residents will be presented with this letter to sign, and letters will be placed in resident's files. New admission contracts will be reviewed at the facility's QM meetings on a quarterly basis to ensure changes are reflected and residents have been notified. (DIRECTED: By 11/27/23: The residence shall conduct a quality management meeting. Documentation of the quality management review shall be kept. 11/7/23).

Proposed Overall Completion Date: 11/10/2023

Directed Completion Date: *11/27/2023*

Implemented (- 02/01/2024)

25c2 Fee schedule

3. Requirements

2800.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Resident #1's residence-resident contract, dated , does not include the amount of charges for each of the assisted living services that are included in resident #1's core service package. This section of resident #1's residence-resident contract is blank.

Resident #2's residence-resident contract, dated does not include the amount of charges for each of the assisted living services that are included in resident #2's core service package. This section of resident #2's residence-resident contract is blank.

Resident #3's residence-resident contract, dated , does not include the amount of charges for each of the assisted living services that are included in resident #3's core service package. This section of resident #3's residence-resident contract is blank.

Plan of Correction ***Directed (- 11/07/2023)***

Resident #1, #2, and #3 will have their contracts and admission documents reviewed on 10/30/2023. Copies of each resident's rate sheet will be made and attached to their current contracts. (DIRECTED: By 11/13/23: Residents #1, #2 and #3 shall be notified in writing of the amount of charges for each of the assisted living services that are included in each resident's core service package. Documentation of the notification shall be kept in each resident's record. 11/7/23). There are no changes to be made in the rates, as the cost of each room and LOC has not changed during this transition. The rate sheets were clearly labeled and in each resident's file upon the date of survey and for this inspection. The administrator or designee will inform residents that there have been no changes to their rates and have each resident acknowledge there were no changes, this acknowledgement by resident or family will be kept in the file. Administrator or designee will conduct a whole house audit to ensure each resident has a fee schedule attached to their contract to meet the regulation. This audit will be completed by 11/17/2023.

25c2 Fee schedule (continued)

Audits will begin after 11/17/23 of 10 resident contracts monthly x 3 months to ensure compliance completed by the administrator or designee. New admissions packets will be reviewed at the facility's QM meetings on a quarterly basis. (DIRECTED: By 11/27/23: The residence shall conduct a quality management meeting. Documentation of the quality management review shall be kept. [redacted] 11/7/23).

Proposed Overall Completion Date: 11/17/2023

Directed Completion Date: *11/27/2023*

Not Implemented ([redacted] - 02/01/2024)

42c Dignity/Respect

4. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted]/23 at approximately [redacted] resident #1 reported witnessing staff persons A and B engaging in oral sex at one of the nursing stations. Staff persons A and B appear to be in a romantic relationship and multiple staff persons indicated there are times when staff persons A and B cannot be found in the residence. Also, staff persons A and B have made repeated public displays of affection within the residence, such as staff person B smacking staff person A's buttocks.

Plan of Correction ***Accept ([redacted] - 11/07/2023)***

Staff member A no longer works at the facility effective [redacted]/2023. Administrator or designee will provide staff education no later than 11/17/2023 on workplace conduct and review facility policies, along with resident rights, documentation of the staff education shall be kept in accordance with 2800.65l. Moving forward, the Administrator or Designee shall interview at least 5 residents monthly, in private, to ensure resident rights are protected x 6 months, interviews will begin the week of 11/17/2023. Documentation of resident interviews will be kept in Administrator's office.

Proposed Overall Completion Date: 11/17/2023

Licensee's Proposed Overall Completion Date: *11/17/2023*

Not Implemented ([redacted] - 02/01/2024)

44b Complaint - no retaliation

5. Requirements

2800.
44.b. The residence shall permit and respond to oral and written complaints from any source regarding an alleged violation of resident rights, quality of care or other matter without retaliation or the threat of retaliation.

Description of Violation

On [redacted]/23, staff person C was providing care to resident #4. Resident #2, who is resident #4's roommate, was on [redacted] telephone with a family member at the time staff person C was in the living unit. While resident #2 was on the telephone, [redacted] requested assistance from staff person C. Staff person C indicated [redacted] did not hear the request for

44b Complaint - no retaliation (continued)

assistance. Resident #2's family member arrived at the residence to address concerns with the quality of care resident #2 was receiving. Upon arrival, a verbal altercation then occurred between staff person C and resident #2's family member in residents #2 and #4's shared living unit, which continued to the 1st floor hallway and ending at the 1st floor nurse's station. Both staff person C and resident #2's family member were screaming and swearing at each other. This incident was witnessed by numerous residents and staff persons.

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Plan of Correction ***Accept (- 11/07/2023)***

At the time of this complaint, staff person C was not to be providing care to resident #2 due to reasons prior to this occurrence. Facility Administrator and designees take all complaints serious. The administrator and designee will be providing education to all staff on the proper way to handle these types of situations, staff member C will be educated independently specific to this situation. This education will take place no later than 11/3/2023 for staff person C, the reset of the staff will be educated no later than 11/17/2023, documentation of the staff education shall be kept in accordance with 2800.65l. This education will include how staff are to respond to any compliant, the resident's rights surrounding complaints, and this education will speak to how staff need to handle themselves in the face of aggressors. Moving forward staff will be instructed to remove themselves from the situation much like staff person C did, and to notify local authorities to remove aggressive family members from the facility. Additionally, the Administrator or Designee shall interview at least 5 residents monthly, in private, to ensure resident rights are protected x 6 months, interviews will begin the week of 11/17/2023. Documentation of resident interviews will be kept in Administrator's office.

Licensee's Proposed Overall Completion Date: *11/17/2023*

Not Implemented (- 02/01/2024)

69 Dementia training

6. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Direct care staff person D, hired on has not received 4 hours of dementia-specific training.

Plan of Correction ***Directed (- 11/07/2023)***

Staff person D has been assigned 4 hours of dementia specific training as of 10/27/2023. This training is through RELIAS learning and will be completed no later than 11/10/2023. (DIRECTED: Documentation of staff person D's dementia training shall be kept in accordance with 2800.65l. 11/7/23). Moving forward all new hires will have this training assigned through RELIAS learning by the Administrator or designee and will complete all computer trainings prior to orienting on the floor, this would ensure all trainings are completed per the 2800 regulations. Administrator or designee will audit RELIAS completion for all staff weekly x 3 weeks and monthly after to ensure compliance beginning the week of 11/17/2023.

69 Dementia training (continued)

DIRECTED: By 11/20/23: The administrator shall develop and implement a new hire checklist to ensure all newly-hired administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 4 hours of dementia-specific training within 30 days of hire. Copies of the completed new hire checklists shall be kept in each newly-hired staff person's record. Documentation of the dementia-specific training shall be kept in each newly-hired staff person's record in accordance with 2800.65l. All staff persons involved in the hiring process shall be educated on the new checklist by 11/20/23. Documentation of the education shall be kept in accordance with 2800.65l. [redacted] 11/7/23

Proposed Overall Completion Date: 11/17/2023

Directed Completion Date: *11/20/2023*

Not Implemented ([redacted] - 02/01/2024)

81b Resident equip – good repair

7. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 9/20/23 at 11:05 AM, resident #2's bed had an uncovered ¼ length bedrail, with one large opening measuring 18" by 10", which poses an entrapment hazard.

Plan of Correction ***Accept ([redacted] - 11/07/2023)***

Resident #2 has been ordered a new bed from hospice, scheduled to arrive at the facility around 11/1/2023, the enabler listed in the violation was removed at the time of inspection. At this time the resident cannot safely utilize an enabler, the new bed being delivered will not have any enablers installed. Administrator or designee conducted an audit of all resident rooms on 10/27/2023 and are in the process of ensuring bed rails, enablers, etc. are within regulatory guidelines. This process, the removal or documentation of enablers, will be completed no later than 11/10/2023. Any enabler, bed rail, etc. that does not meet requirements or that is unnecessary will be removed from the bed. Audits will be conducted, beginning the week of 11/17/23, on all resident rooms with enablers weekly x 3 weeks and monthly indefinitely thereafter to ensure compliance by the Administrator or designee.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented ([redacted] - 02/01/2024)

95 Furniture & Equipment

8. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 9/20/23, the toilet seat riser on the shared toilet in living unit #317 had an "L" shaped crack, approximately 1 ¾"

95 Furniture & Equipment (continued)

by 1 ¼", at the top of the toilet seat.

Plan of Correction ***Directed (- 11/07/2023)***

At the time of inspection, the toilet seat in room 317 was repaired. Education will be provided to all staff persons, no later than 11/17/2023 in regard to the procedures for reporting issues with furniture and equipment to maintenance. Documentation of the education will be kept in accordance with 2800.65l. Moving forward the Administrator or designee, in conjunction with maintenance staff will conduct a whole house audit to be completed no later than 11/10/2023 to ensure all resident rooms have furniture and equipment that is in good repair, clean and free of hazards. Administrator or designee will a sample of 10 resident rooms weekly x 3 weeks and monthly x3 months thereafter to ensure compliance. (DIRECTED: The weekly audit of 10 resident rooms shall begin on 11/20/23. 11/7/23).

Proposed Overall Completion Date: 11/17/2023

Directed Completion Date: *11/20/2023*

Not Implemented (- 02/01/2024)

101j7 Lighting/operable lamp

9. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 9/20/23, resident #7's bedside lamp could not be turned on/off at bedside.

Plan of Correction ***Accept (- 11/07/2023)***

At the time of inspection Resident #7s lamp's bulb was replaced and the lamp was working correctly by end of day. Moving forward the Administrator or designee, in conjunction with maintenance staff will conduct a whole house audit to be completed no later than 11/10/2023 to ensure all resident rooms have working bedside lamps. Education will be provided to all staff regarding 2800.101j7 no later than 11/17/2023, and documentation will be kept in accordance with 2800.65I. Administrator or designee will a sample of 10 resident rooms weekly x 3 weeks and monthly indefinitely thereafter to ensure compliance. Audits to begin the week of 11/17/2023

Licensee's Proposed Overall Completion Date: *11/17/2023*

Not Implemented (- 02/01/2024)

132c Fire drill records

10. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 8/31/23 at 3:12 PM does not include the amount of time it took to

132c Fire drill records (continued)

evacuate the residents in minutes and seconds, or if any problems were encountered.

Plan of Correction ***Accept (- 11/07/2023)***

At the time of inspection, regional supervisor provided education to the previous administrator and the current clinical coordinator in regard to documenting in minutes and seconds. Administrator, Clinical Coordinator, and Maintenace staff are responsible for conducting fire drills. Education will be provided no later than 11/17/2023 to the staff responsible for conducting/documenting fire drills in the facility. Facility Administrator or designee will review all fire drill documentation to ensure times are documented correctly no later than 11/10/2023. Moving forward Administrator or designee will audit fire drill records monthly to ensure proper documentation is taking place. Audits will take place the last working day of each month starting on November 30th, 2023.

Licensee's Proposed Overall Completion Date: *11/17/2023*

Not Implemented (- 02/01/2024)

132d Evacuation

11. Requirements

2800.
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 residence.

Description of Violation

The residence does not have documentation from a fire safety expert within the past year indicating if residents are to evacuate the building to a public thoroughfare during fire drills, or if the residence has internal fire-safe areas.

Plan of Correction ***Directed (- 11/07/2023)***

Prior to the change of ownership in July of 2023, the facility did conduct a supervised fire drill by a fire safety expert. This documentation was sent as part of the initial change of ownership inspection as it is required documentation to be provided for the change of ownership to occur. Administrator and designee reached out to the FSE on 10/30/2023, FSE is able to provide updated letter no later than 11/30/2023. (DIRECTED: By 11/30/23: The administrator shall review the updated documentation from the fire safety expert to ensure the documentation indicates if residents are to evacuate the building to a public thoroughfare during fire drills, or if the residence has internal fire-safe areas. Documentation of the updated letter from the fire safety expert shall be kept. 11/7/23). Moving forward the Administrator or designee will schedule future fire safety experts in advance and keep documentation on file in the office and electronically. (DIRECTED: Beginning on 11/30/23: The administrator shall review all annual documentation from the fire safety expert within 24 hours of receipt to ensure complete and accurate documentation is obtained, which includes documentation indicating if residents are to evacuate the building to a public thoroughfare during fire drills, or if the residence has internal fire-safe areas. 11/7/23).

Proposed Overall Completion Date: 11/30/2023

Directed Completion Date: *11/30/2023*

Not Implemented (- 02/01/2024)

141a Medical evaluation

12. Requirements

2800.

141a Medical evaluation *(continued)*

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.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

No medical evaluation was completed for resident #8, who was admitted to the residence on [redacted]

Plan of Correction ***Directed ([redacted] - 11/07/2023)***

Resident #8 will be seen by provider no later than 11/10/2023, and a new ADME will be created. (DIRECTED: By 11/10/23: A copy of resident #8's new medical evaluation shall be kept in resident #8's record. [redacted] 11/7/23). Moving forward, Administrator or designee will conduct a baseline audit of all medical evaluations. Audit will be completed by 11/10/23. Any resident found without an ADME will be scheduled to see their provider no later than 11/30/23. Beginning 12/1/23 a sample of 10 resident charts will be audited monthly x 3 months to ensure compliance. While audits are being completed the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. Additionally, the home will implement a new admission checklist ensuring all important forms are completed timely. (DIRECTED: The administrator shall implement the new admission checklist by 11/20/23. Copies of the completed new admission checklists shall be kept in each newly-admitted resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 11/20/23. Documentation of the education shall be kept in accordance with 2800.65l. [redacted] 11/7/23).

Proposed Overall Completion Date: 11/30/2023

Directed Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/01/2024)

187a Medication record

13. Requirements

2800.

187a Medication record *(continued)*

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

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

Description of Violation

Resident #2's September 2023 medication administration record (MAR) does not include a diagnosis or purpose for numerous medications, to include the following:

- *Cholecalciferol (vitamin D3)-125 mcg tablet*
- *Levothyroxine-50 mcg tablet*
- *Nateglinide-60 mg tablet*
- *Tramadol-50 mg tablet*

Resident #3 is prescribed Hyoscyamine 0.125mg tablet-Take 1 tablet by mouth every 4 hours as needed; however, this medication is not included on resident #3's September 2023 MAR.

Plan of Correction ***Directed (- 11/07/2023)***

On 9/21/23 resident #3 had Hyoscyamine added to EMAR. No later than 11/1/2023, the Clinical coordinator or designee will ensure resident #2 has diagnoses attached to each of medication orders. The administrator or designee will conduct a baseline audit no later than 11/10/2023 to ensure each resident has a diagnosis associated with ordered medication. All residents will have diagnoses added no later than 11/24/23. Administrator or designee will conduct education for all staff no later than 11/17/2023 on 2800.187a, documentation of the training will be kept in accordance with 2800.65l. Moving forward Administrator or designee will audit 5 random resident EMARs weekly x 3 weeks, then monthly (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 11/7/23) to ensure compliance.

Proposed Overall Completion Date: 11/24/2023

Directed Completion Date: *11/24/2023*

Not Implemented (- 02/01/2024)

225b Assessment content

14. Requirements

2800.
225.b. The assessment must, at a minimum include the following:
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted], indicates diagnoses of seizure disorder, non-diabetic proliferative retinopathy, manic episode, and depression; however, these diagnoses are not included on resident #1's most recent assessment, dated [redacted]

Resident #1's most recent assessment, dated [redacted], indicates resident #1 has no problems with orientation to time, place and person, irritability, judgment, agitation or aggression; however, according to resident #1's progress notes, resident #1 has had numerous behavioral issues, to include the following:

- *9/3/23: Resident #1 answered the nurse's station phone and stated [redacted] owns half the building and [redacted] can do what [redacted] wants.*
- *8/26/23: Resident #1 was walking around carrying [redacted] and lipstick. Resident #1 was also found sitting at the desk alone on the 4th floor.*
- *Resident #1 was yelling and screaming at staff persons. Resident #1 was also screaming [redacted] was forced to take medications and hit another resident.*

On 9/20/23, a 1/4 length bedrail was present on resident #2's bed; however, resident #2's assessment, dated [redacted] indicates resident #2 is independent with transferring in/out of bed/chair, ambulation and turning/positioning in bed/chair.

On 9/20/23, a 1/4 length bedrail was present on resident #5's bed; however, resident #5's assessment, dated [redacted], indicates resident #5 is independent with transferring in/out of bed/chair, ambulation and turning/positioning in bed/chair.

Resident #5's medical evaluation, dated [redacted] includes diagnoses of diabetes, hypertension, osteoarthritis, gastro-esophageal reflux disease, muscle weakness, overactive bladder, hypothyroidism, and schizophrenia; however, these diagnoses are not included on resident #5's assessment, dated [redacted]

Plan of Correction ***Directed ([redacted] - 11/07/2023)***

Resident #1, #2, and #5 will all have quarterly assessments completed no later than 11/3/2023 by the Administrator or designee and their assessments will reflect the most up to date needs. (DIRECTED: By 11/8/23: The administrator shall ensure copies of resident #1, #2 and #5's updated assessments are placed in their resident records. [redacted] 11/7/23). Staff responsible for ASP will be reeducated on the ASP requirements, as well as the home's procedures for updating resident ASP's as resident care needs change no later than 11/17/2023 by the regional VP. Moving forward a whole house audit of resident ASPs will be completed no later than 11/17/2023. Documentation of the training will be kept in accordance with 2800.65l. Updates will be made to ASPs where needed and these updates will be complete for all residents no later than 11/30/2023. Starting 12/1/2023, monthly audits of 5 resident ASPs will be completed [redacted] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION [redacted] 11/7/23. DIRECTED: Beginning on 12/1/23: The administrator shall review 5 resident assessments monthly to ensure accuracy and completeness. [redacted] 11/7/23). to ensure compliance with this violation. While audits are being completed the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. (DIRECTED: The spreadsheet shall be created by the administrator by 11/15/23. Beginning on 12/1/23, the administrator shall review and update the spreadsheet monthly. [redacted] 11/7/23).

Proposed Overall Completion Date: 11/30/2023

225b Assessment content *(continued)*

Directed Completion Date: *12/01/2023*

Not Implemented (- 02/01/2024)

227c Final support plan - revision

15. Requirements

2800.
227.c. The final 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. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

On 9/20/23, a 1/4 length bedrail was present on resident #2's bed; however, the bedrail is not indicated on resident #2's most recent support plan, dated

Plan of Correction ***Directed (- 11/07/2023)***

Resident#2 will have a quarterly assessment completed no later than 11/3/2023 by the Administrator or designee and the support plan will reflect the most up to date needs. (DIRECTED: By 11/8/23: The administrator shall ensure copies of resident #2's updated support plan is placed in resident #2's record. 11/7/23). Staff responsible for ASP will be reeducated on the ASP requirements, as well as the home's procedures for updating resident ASP's as resident care needs change no later than 11/17/2023 by the regional VP. Moving forward a whole house audit of resident ASPs will be completed no later than 11/17/2023. Documentation of the training will be kept in accordance with 2800.65l. Updates will be made to ASPs where needed and these updates will be complete for all residents no later than 11/30/2023. Starting 12/1/2023, monthly audits of 5 resident ASPs will be completed (UNACCEPTABLE PORTION OF PLAN OF CORRECTION 11/7/23. DIRECTED: Beginning on 12/1/23: The administrator shall review 5 resident support plans monthly to ensure accuracy and completeness. 11/7/23). to ensure compliance with this violation. While audits are being completed the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. (DIRECTED: The spreadsheet shall be created by the administrator by 11/15/23. Beginning on 12/1/23, the administrator shall review and update the spreadsheet monthly. 11/7/23).

Proposed Overall Completion Date: 11/30/2023

Directed Completion Date: *12/01/2023*

Not Implemented (- 02/01/2024)

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

Facility Information

Name: *THE VILLAGES OF HARMON HOUSE* **License #:** *45454* **License Expiration:** *07/01/2024*

Address: *601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMON HOUSE, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/06/1988* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *56* **Waking Staff:** *42*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *12/04/2023*

Inspection Dates and Department Representative

12/04/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served:** *47*

Special Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *20* **Are 60 Years of Age or Older:** *46*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *9* **Have Physical Disability:** *0*

Inspections / Reviews

12/04/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/31/2023*

Inspections / Reviews *(continued)*

01/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/09/2024*

01/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/11/2024*

02/01/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/11/2024*

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

15a Resident abuse report

1. Requirements

2800.

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

Description of Violation

On [redacted]/23, direct care staff person A reported at approximately [redacted] a.m., resident #1 was found on the 3rd floor in front of resident #2's bedroom [redacted] by direct care staff person B.

When direct care staff person A arrived on 3rd floor [redacted] witnessed direct care staff person B at the doorway of room [redacted] with resident #1 against the wall next to room [redacted], staff person B was flailing [redacted] arms and yelling at the resident about not being allowed on the 3rd floor in resident #2's room. Resident #1 was heard yelling "[redacted]" replying," I am allowed on any floors I want, as long as I don't go in anyone's room." Direct care staff person B, responded "because you want [redacted] you can't be in this room on this floor."

Direct care staff person A intervened stating, "OK, we can't do this" trying to deescalate the situation and move resident #1 back to [redacted] room on the 4th floor. However, direct care staff person B, followed behind yelling and mocking resident #1, "I'm resident #1, [redacted]." Direct care staff person A told direct care staff person B, "you can't talk to resident #1 or anyone like that, STOP!" Direct care staff person A reported resident #1 was very upset over the comments made by direct care staff person B. However, the incident was not reported the local Area Agency on Aging until approximately 2:00 p.m. on [redacted]/23.

Plan of Correction ***Accept ([redacted] - 01/04/2024)***

As of [redacted]/2023, staff person B no longer works in the facility. Regional support re-educated facility administration on 12/27/2023 on OAPSA, and reporting requirements within. On 11/22/2023, staff underwent on the spot abuse training, staff were educated on treating individuals with dignity and respect on 11/17/2023. Moving forward the Administrator will lead all abuse allegations and staff will report any allegation to the administrator in real time. Staff person A will be educated on what could have been done differently in this specific situation no later than 1/5/2024. No later than 1/12/2024 the facility will implement new policy on the procedures of reporting allegations. Staff will be educated on the policy/procedures surrounding abuse allegations and have a refresher education on 2800.42c. This education will take place no later than 1/12/2024.

Licensee's Proposed Overall Completion Date: *01/12/2024*

Not Implemented ([redacted] - 02/01/2024)

[redacted]

15b Resident abuse-superv plan (continued)

[redacted]

Violation withdrawn [redacted] 2/15/2024

[redacted]

42c Dignity/Respect

3. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted]/23, direct care staff person A reported at approximately [redacted] a.m., resident #1 was found on the 3rd floor in front of resident #2's bedroom [redacted]) by direct care staff person B.

When direct care staff person A arrived on 3rd floor [redacted] witnessed direct care staff person B at the doorway of room [redacted] with resident #1 against the wall next to room [redacted], staff person B was flailing [redacted] arms and yelling at the resident about not being allowed on the 3rd floor in resident #2's room. Resident #1 was heard yelling [redacted] replying," I am allowed on any floors I want, as long as I don't go in anyone's room." Direct care staff person B, responded "because you want [redacted], you can't be in this room on this floor."

42c Dignity/Respect (continued)

Direct care staff person A intervened stating, "OK, we can't do this" trying to deescalate the situation and move resident #1 back to [redacted] room on the 4th floor. However, direct care staff person B, followed behind yelling and mocking resident #1, "I'm resident #1,[redacted] Direct care staff person A told direct care staff person B, "you can't talk to resident #1 or anyone like that, STOP!" Direct care staff person A reported resident #1 was very upset over the comments made by direct care staff person B.

Plan of Correction ***Accept ([redacted] - 01/02/2024)***

Staff member B no longer works at the facility. Administrator or designee will provided staff education on 11/17/2023 on workplace conduct and reviewed facility policies, along with resident rights, documentation of the staff education shall be kept in accordance with 2800.65l. Moving forward, the Administrator or Designee shall continue to interview at least 5 residents monthly, in private, to ensure resident rights are protected x 6 months, interviews began the week of 11/17/23 and will continue until April of 2024. Documentation of resident interviews will be kept in Administrator's office.

Licensee's Proposed Overall Completion Date: *12/26/2023*

Not Implemented ([redacted] - 02/01/2024)

225b Assessment content

4. Requirements

2800.
225.b. The assessment must, at a minimum include the following:

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted], indicates diagnoses of seizure disorder, non-diabetic proliferative retinopathy, manic episode, and depression; however, these diagnoses are not included on resident #1's most recent assessment, dated [redacted]

On [redacted], resident #1 was deemed an incapacitated person by Westmoreland County courts and legal guardianship by Area Agency on Aging was ordered, due to dementia and depression. Resident #1's most recent assessment, dated [redacted] indicates resident #1 has no problems with orientation to time, place and person and judgment, and minimal supervision needs; however, according to resident #1's progress notes, and interviews, resident #1 has had numerous behavioral issues, to include:
** Questioning resident #1 what [redacted] is doing or where going the resident will often say, "I'm going to work, I have to get ready for work." '[redacted]."*

Interviews indicate resident #1 has taken a special interest in resident #2. Multiple occasions where resident #1 was changing clothing multiple times a day, [redacted]. When the behaviors are addressed resident #1 reportedly becomes argumentative, agitated and verbally aggressive. Interviews indicated that resident #1 comes onto the 3rd floor [redacted] with resident #2, to include: [redacted]/23 between [redacted] p.m. and [redacted] a.m., was trying to get into resident #2's bedroom all night prior to the incident.
** [redacted]/23: [redacted] a.m. resident #2 was found in resident #1's bedroom on 4th floor, out of breath, face flushed [redacted]*
** [redacted]23: at approximately [redacted] a.m. resident #1 attempted to enter resident #2's room on 3rd floor. Resident #2 told staff that "resident #1 promised [redacted] something and the resident is staying." However, staff did now know what resident #1 promised the resident.*

225b Assessment content *(continued)*

Plan of Correction ***Accept (- 01/02/2024)***

Resident #1, and #2 will all have quarterly assessments completed no later than 1/2/2024 by the Administrator or designee and their assessments and support plan will reflect the most up to date needs. Staff responsible for ASP have been reeducated on the ASP requirements, as well as the home's procedures for updating resident ASP's as resident care on 11/17/2023 by the regional VP. A whole house audit was completed and updates are being made to ASPs from a prior POC. Documentation of the training will be kept in accordance with 2800.65l. Updates will be made to ASPs where needed and these updates will be complete for all residents no later than 1/8/24. Continuing on 1/1/24: The administrator or designee shall review 5 resident assessments monthly to ensure accuracy and completeness to ensure compliance with this violation. While audits are being completed the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. The spreadsheet was created by the administrator on 11/15/2023. Continuing on 1/1/24, the administrator shall review and update the spreadsheet monthly.

Licensee's Proposed Overall Completion Date: *01/08/2024*

Not Implemented (- 02/01/2024)

227c Final support plan - revision

5. Requirements

2800.
227.c. The final 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. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident #1 is assessed with minimal supervision needs. Also has no assessed needs for orientation of time, place or person and judgement. However, the residents support plan dated 23, does not address the numerous behavior issues or how the home will meet the behaviors observed by staff and/or documented in the progress notes.

The resident is assessed as requiring minimal supervision in the home; however according to interviews resident #1 seeks out attention and is currently fixated on resident #2 since the residents . Resident #1 has been noted changing clothing multiple times a day, When the behaviors are addressed resident #1 reportedly becomes argumentative, agitated and verbally aggressive. Interviews indicated that resident #1 comes onto the 3rd floor with resident #2, to include: the night of 23 between p.m. and a.m., was trying to get into resident #2's bedroom all night prior to the incident.
** /23: a.m. resident #2 was found in resident #1's bedroom on 4th floor, out of breath, face flushed*
** /23: at approximately a.m. resident #1 attempted to enter resident #2's room on 3rd floor. Resident #2 told staff that "resident #1 promised something and is staying." However, staff did now know what resident #1 promised the resident.*
** When questioned about being on the wrong floor the resident will tell staff, "I'm going to work or I'm getting ready for work." " ," and so on. These behaviors are not addressed in the resident's support plan and does not indicate how the home will meet the needs to ensure the residents safety.*

Plan of Correction ***Accept (- 01/02/2024)***

Resident #1, and #2 will all have quarterly assessments completed no later than 1/2/2024 by the Administrator or designee and their assessments and support plan will reflect the most up to date needs. Staff responsible for ASP

227c Final support plan - revision (continued)

have been reeducated on the ASP requirements, as well as the home's procedures for updating resident ASP's as resident care on 11/17/2023 by the regional VP. A whole house audit was completed and updates are being made to ASPs from a prior POC. Documentation of the training will be kept in accordance with 2800.65l. Updates will be made to ASPs where needed and these updates will be complete for all residents no later than 1/8/24. Continuing on 1/1/24: The administrator or designee shall review 5 resident assessments monthly to ensure accuracy and completeness to ensure compliance with this violation. While audits are being completed the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. The spreadsheet was created by the administrator on 11/15/2023. Continuing on 1/1/24, the administrator shall review and update the spreadsheet monthly.

Licensee's Proposed Overall Completion Date: *01/08/2024*

Not Implemented ([redacted] - 02/01/2024)

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

Facility Information

Name: *THE VILLAGES OF HARMON HOUSE* **License #:** *45454* **License Expiration:** *07/01/2024*

Address: *601 SOUTH CHURCH STREET, MT. PLEASANT, PA 15666*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMON HOUSE, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/06/1988* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *51* **Waking Staff:** *38*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *12/11/2023*

Inspection Dates and Department Representative

12/11/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served:** *43*

Special Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *24* **Are 60 Years of Age or Older:** *42*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

12/11/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/12/2024*

01/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/25/2024*

01/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/31/2024*

02/01/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2024*

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

85d Trash cans – kitchen/bath

2. Requirements

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 10:30 AM, the trash can in the shared bathroom of living unit #102 was uncovered and approximately 1/4 full of trash.

Plan of Correction ***Directed (- 01/25/2024)***

On 12/11/23, trash can was emptied and a lid was placed on it immediately.
Trash in all resident rooms is emptied daily by housekeeping staff in the morning and as needed throughout the day by Direct Care Staff. An inservice was held on 12/12/23 for housekeeping and direct care staff addressing this issue. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2800.65L. 1/25/24). Both departments have been instructed on 12/12/23 to make sure if trash can lid is missing to report to the Administrator and Maintenance to have it repaired or replaced. The Administrator or designee will continue daily room audits to ensure garbage can lids are in place in shared rooms.

Direct care staff will do rounds on each floor daily and sign that it is completed. Please see attachment. Clinical Coordinator or Administrator will review daily.

Proposed Overall Completion Date: 01/31/2024.

Directed Completion Date: *01/31/2024*

Implemented (- 02/01/2024)

101j7 Lighting/operable lamp

3. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At approximately 10:45 AM, resident #4's bedside lamp was approximately 5 feet from resident #4's bed and could not be turned on/off from bedside.

Plan of Correction ***Directed (- 01/25/2024)***

Resident #4 requests that lamp not be on the nightstand, prefers it on dresser. A battery operated Puck Light has been placed on wall beside bed which can easily reach, installed 12/12/2023. A walkthrough inspection was completed, on 12/12/23, by the Clinical Coordinator to ensure that all residents have a bedside lamp or lighting source within reach and that all were operable.

Inservice was held on 12/12/23. All staff were instructed that upon entering a resident's room to ensure that there is an operable bedside light/lighting source within reach. When staff finds an inoperable lamp/lighting source,

101j7 Lighting/operable lamp (continued)

(DIRECTED: Documentation of the staff education shall be kept in accordance with 2800.65L. [redacted] 1/25/24). Maintenance will be alerted to repair or replace immediately.

Please see the attachments for Mandatory Room Rounds (Inservice completed on 1/24/24) which include checking rooms for lamps daily. The Administrator or Clinical Coordinator will review sign off sheet daily and complete random room audits to ensure compliance. (DIRECTED: Beginning on 1/31/24: The administrator/designee shall inspect 5 resident bedrooms daily for one month then weekly thereafter to ensure each resident has an operable lamp other source of lighting that can be turned on/off at bedside. [redacted] 1/25/24).

Proposed Overall Completion Date: 01/25/2024

Directed Completion Date: *01/31/2024*

Not Implemented ([redacted] - 02/01/2024)

132i Testing fire alarm

4. Requirements

2800.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

According to the residence's fire drill records, the fire alarm was not activated during the fire drill conducted on 9/28/23 at 5:47 AM.

Plan of Correction ***Directed ([redacted] - 01/25/2024)***

On the day of the drill, the alarm was operational, however, this drill was ran using the coded message at the fire box, and the alarm did not audibly sound as part of the practice. On 12/27/2023 [redacted] Fire Protection Engineer, was asked to come to the facility to do the annual Fire/Safety Inspection. At that time, a fire drill was observed by [redacted]

On 12/27/23, the Environmental Service Director who is responsible for conducting fire drills was educated that during all fire drills that the alarm is to be activated per DHS, and explained the difference between SNF and ALF.

Administrator and Environmental Service Director will meet monthly to review fire drill records to ensure compliance. (DIRECTED: Beginning on 1/31/24: The administrator shall review the home's fire drill records monthly to ensure the fire alarm is set off during each fire drill. [redacted] 1/25/24).

Proposed Overall Completion Date: 01/24/2024

Directed Completion Date: *01/31/2024*

Implemented ([redacted] - 02/01/2024)

224a2 30 days prior to admission

7. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

224a2 30 days prior to admission *(continued)*

Description of Violation

Resident #1 was admitted to the residence on [redacted]; however, no assessment was completed for resident #1.

Resident #2 was admitted to the residence on [redacted]; however, resident #2's assessment was not completed until [redacted].

Plan of Correction ***Directed ([redacted] - 01/25/2024)***

The facility is disputing this citation. The facility Administrator has implemented and updated their spreadsheet to track ADME, Assessments, and support plans the week of 1/1/24. This spreadsheet will be utilized moving forward to ensure compliance with this regulation. However, at the time of inspection, according to the regulatory compliance guide the facility has a 15 day grace period for 2800.224 regardless of if the individuals meet criteria excluding them. Please see the first paragraph from the state issued ASP form. "Chapter 2800 requires initial assessments, "preliminary" support plans, and "final" support plans. The regulations require that the initial assessment and preliminary support plan be completed 30 days prior to admission unless the resident is being admitted directly to the residence from an acute care hospital, is being admitted to escape from an abusive situation, or has no alternative living arrangement, in which case the residence must complete the documents within 15 days after admission. However, the Department allows a 15-day grace period following admission for completion of the required documents for all residents, not just those who meet the exception criteria."

****1/24/24: Resident 1's ASP was completed on 12/12/23 by Clinical Coordinator.*

Administrator will review all resident records to ensure compliance by 1/31/24.

Tracking Spreadsheet was updated to reflect ASP to be completed 30 days prior to admission. Clinical Coordinator will be responsible for updating and reviewing spreadsheet to ensure compliance. Clinical Coordinator and Administrator will review weekly. (DIRECTED: The weekly reviews of the tracking spreadsheet shall begin on 1/31/24. [redacted] 1/25/24)

DIRECTED: By 1/31/24: The administrator shall develop and implement a new admission checklist to ensure a written initial assessment that is documented on the Department's assessment form is completed for all newly-admitted residents within 30 days prior to admission unless one of the conditions contained in paragraph 2800.224a(3) apply. Copies of the completed new admission checklists and completed assessments shall be kept in each newly-admitted resident's record. All staff persons involved in completing resident assessments shall be educated on this regulation and the new checklist by 1/31/24. Documentation of the staff education shall be kept in accordance with 2800.65L. [redacted] 1/25/24).

Proposed Overall Completion Date: 01/31/2024

Directed Completion Date: *01/31/2024*

Not Implemented ([redacted] - 02/01/2024)

224c1 Initial SP-30 days prior/adm

8. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #1 was admitted to the residence on [redacted]; however, no support plan was completed for resident #1.

Resident #2 was admitted to the residence on [redacted] however, resident #2's support plan was not completed until [redacted].

Plan of Correction ***Directed ([redacted] - 01/25/2024)***

The facility is disputing this citation. The facility Administrator has implemented and updated their spreadsheet to track ADME, Assessments, and support plans the week of 1/1/24. This spreadsheet will be utilized moving forward to ensure compliance with this regulation. However, at the time of inspection, according to the regulatory compliance guide the facility has a 15 day grace period for 2800.224 regardless of if the individuals meet criteria excluding them. Please see the first paragraph from the state issued ASP form. "Chapter 2800 requires initial assessments, "preliminary" support plans, and "final" support plans. The regulations require that the initial assessment and preliminary support plan be
completed 30 days prior to admission unless the resident is being admitted directly to the residence from an acute care hospital, is being admitted to escape from an abusive situation, or has no alternative living arrangement, in which case the residence must complete the documents within 15 days after admission. However, the Department allows a 15-day grace period following admission for completion of the required documents for all residents, not just those who meet the exception criteria."

***1/24/24: Resident 1's ASP was completed on 12/12/23 by Clinical Coordinator.*

Administrator will review all resident records to ensure compliance by 1/31/24.

Tracking Spreadsheet was updated to reflect ASP to be completed 30 days prior to admission. Clinical Coordinator will be responsible for updating and reviewing spreadsheet to ensure compliance. Clinical Coordinator and Administrator will review weekly. (DIRECTED: The weekly reviews of the tracking spreadsheet shall begin on 1/31/24. [redacted] 1/25/24)

DIRECTED: By 1/31/24: The administrator shall develop and implement a new admission checklist to ensure a written preliminary support plan is completed for all newly-admitted residents within 30 days prior to admission to the residence unless one of the conditions contained in paragraph 2800.224c(2) applies. Copies of the completed new admission checklists and completed support plans shall be kept in each newly-admitted resident's record. All staff persons involved in completing resident support plans shall be educated on this regulation and the new checklist by 1/31/24. Documentation of the staff education shall be kept in accordance with 2800.65L. [redacted] 1/25/24).

Proposed Overall Completion Date: 01/31/2024

Directed Completion Date: *01/31/2024*

224c1 Initial SP-30 days prior/adm *(continued)*

Not Implemented ([redacted] - 02/01/2024)