



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MONARCH MEADOW LLC**

LEGAL ENTITY

To operate **MONARCH MEADOW**

NAME OF FACILITY OR AGENCY

Located at **490 COOLSPRING STREET, UNIONTOWN, PA 15401**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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To provide **Personal Care Homes**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **49**

(MAXIMUM CAPACITY)

or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

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 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 18, 2023** until **August 18, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **449440**

[Signature]
ISSUING OFFICER

[Signature]
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 628 – 04/23



Emailing Date: August 18, 2023

[REDACTED]
Monarch Meadow LLC
490 Coolspring Street
Uniontown, Pennsylvania 15401

RE: Monarch Meadow
License #: 44944

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on June 30, 2023 and July 6, 2023, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in dark ink that reads "Juliet Marsala". The signature is written in a cursive, flowing style.

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: MONARCH MEADOW **License #:** 44944 **License Expiration:** 09/15/2023
Address: 490 COOLSPRING STREET, UNIONTOWN, PA 15401
County: FAYETTE **Region:** WESTERN

Administrator

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

Legal Entity

Name: MONARCH MEADOW LLC
Address: 490 COOLSPRING STREET, UNIONTOWN, PA, 15401
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 11/20/1997 **Issued By:** Labor and Industry
Type: Other **Date:** 11/30/2020 **Issued By:** North Union Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 39 **Waking Staff:** 29

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint, Provisional **Exit Conference Date:** 07/06/2023

Inspection Dates and Department Representative

06/30/2023 - On-Site: [REDACTED]
07/06/2023 - On-Site: [REDACTED]

General Information

License Capacity: 49 **Residents Served:** 28

Secured Dementia Care Unit

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

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 28
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 11 **Have Physical Disability:** 0

Inspections / Reviews

06/30/2023 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow Up Date: *07/28/2023*

07/28/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: *08/03/2023*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission* Follow Up Date: *08/03/2023*

08/03/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: *08/03/2023*

Reviewer: [REDACTED]

Follow Up Type: *Exception*

121a - Unobstructed Egress

1. 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 6/30/23, at approximately 9:35 a.m., the main entrance of the home, had a chair outside in front of side B of the home's emergency exit door, preventing immediate egress from the inside of the home.

Plan of Correction

Accept [REDACTED] - 07/28/2023)

On 6/30/2023 at approximately 9:00 am, a resident went outside to drink [REDACTED] coffee and read the newspaper by front door B. When the resident got up to come inside, [REDACTED] did not move the chair out of the way of front door B, nor did the staff move it. On 6/30/2023 at approximately 9:40 am after staff had been notified by DHS Inspectors that a chair was blocking an egress door by front entrance door B, staff immediately moved the chair from blocking front door B.

The Administrator notified all staff of the violation pertaining to 121.a. Stairways, hallways, doorways, passageways, and egress routes, and the safety and importance of this regulation. The Administrator discussed what the facility's plan will be moving forward.

To prevent this violation from occurring again, the direct care staff will begin to implement into their daily rounds that occur before every shift, to check all egress exits for obstructions.

In addition, the facility Administrator or Supervisor will check all exits weekly to assess for unobstructed egress routes.

A record of this weekly inspection will be posted by every egress route with the initials of the person who conducted the weekly inspection and the date the inspection occurred.

A copy of this record will be provided in the next step of the P.O.C.

1. ACTION- The Administrator will notify Direct Care Staff of the violation pertaining to 121.a. stairways, hallways, doorways, passageways, and egress routes, OWNER- Administrator- COMPLETION DATE- 7/20/23.

2. ACTION-The Administrator will notify Direct Care Staff of the Facility's plan moving forward in relation to violation 121.a. Stairways, hallways, doorways, passageways, and egress routes. OWNER- Administrator- COMPLETION DATE- 7/20/23.

3. ACTION- Direct Care Staff will assess egress areas after each resident's use. OWNER- Direct Care Staff- COMPLETION DATE- Start date 7/20/23 and will continue after each resident's use.

4. ACTION-Direct Care Staff assesses all egress areas at the beginning of each shift during rounds. OWNER-Direct Care Staff- COMPLETION DATE-Start date 7/20/23 and will continue before each shift.

5. ACTION-Develop a record and sign-off sheet to check all egress areas. OWNER-Administrator-COMPLETION DATE- 7/24/23.

6. ACTION- Weekly inspection of all egress routes. OWNER-Administrator or Supervisor. COMPETION DATE- Start 7/24/23 then on a weekly basis.

Licensee's Proposed Overall Completion Date: 07/20/2023

Implemented [REDACTED] - 08/03/2023)

133.1 - Exit Signs

2. Requirements

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

On 6/30/23, at approximately 11:45 a.m., exit door "G" leading to the outside deck area, is not considered an emergency exit door. However, there is no sign indicating that it is not an emergency exit.

Plan of Correction

Accept [REDACTED] - 07/28/2023)

The reason for the sign not being on the door is that a staff member removed the sign and put it on the wall of the corridor, just inside door G. On 6/30/2023 at approximately 12:00pm after DHS inspectors notified the office manager of this violation, a sign stating, "THIS IS NOT AN EMERGENCY EXIT" was immediately printed and posted on door G.

The Administrator notified all staff of the violation relating to 133.1 Exit Signs, and the safety and importance of this regulation.

The Administrator discussed what the facility's plan will be moving forward.

The Direct Care Staff will begin to implement on their daily rounds that occur before the beginning of each shift, to assess that this sign, "THIS IS NOT AN EMERGENCY EXIT" is present on door G.

The facility Administrator or Supervisor will check door G posting for a sign stating "THIS IS NOT AN EMERGENCY EXIT" on inspection rounds done weekly. A record of this weekly inspection will be posted by door G with the initials of the person who conducted the weekly inspection and the date the inspection occurred. A copy of this record will be provided in the next step of the P.O.C.

1. ACTION- The Administrator will notify Direct Care Staff of the violation pertaining to 133.1 Exit Signs. OWNER-Administrator- COMPLETION DATE- 7/20/23.

2. ACTION-The Administrator will notify Direct Care Staff of the Facility's plan moving forward in relation to violation 133.1 Exit Signs. OWNER- Administrator- COMPLETION DATE- 7/20/23.

3. ACTION- Direct Care Staff will assess for the presence of a sign posted on door G stating, "THIS IS NOT AN EMERGENCY EXIT" on rounds at the beginning of each shift. OWNER-Direct Care Staff. COMPLETION DATE-Start Date 7/20/23 and then at the beginning of each shift moving forward.

4. ACTION-Develop a record and sign-off sheet to check for the presence of a sign on door G stating, "THIS IS NOT AN EMERGENCY EXIT". OWNER-Administrator-COMPLETION DATE- 7/24/23.

5. ACTION- Weekly inspection of door G for sign present stating, "THIS IS NOT AN EMERGENCY EXIT". OWNER-Administrator or Supervisor. COMPETION DATE- Begin on 7/20/23 then at the beginning of each shift moving forward.

Licensee's Proposed Overall Completion Date: 07/20/2023

Implemented [REDACTED] 08/03/2023)

184a - Resident's Meds Labeled

3. Requirements

184a - Resident's Meds Labeled (*continued*)

2600.

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

Description of Violation

Resident #1 is prescribed Levemir INJ Flexpen, inject 22 units Sub Q every day with lunch; However, the pharmacy label does not include the dosage instructions.

Plan of Correction

Accept [REDACTED] 07/28/2023)

On 7/6/2023, DHS inspectors informed the facility RN and Administrator that there was no pharmacy label that included the dosage instructions accompanying the Levemir Flexpen for resident #1. This occurred due to the facility not having a proper compliance check in place for regulation 2600.184.a.

The facility RN immediately provided the pharmacy label with dosage instructions for the Levemir Flexpen in question.

The RN called the pharmacy to have all labels delivered for any insulin pen that did not have a label attached with the proper dosage instructions on 7/7/23.

The facility RN reviewed all of the residents at the facility who had insulin pens to ensure that the insulin pens had a pharmacy label that included the dosage instructions, on 7/7/2023.

The Administrator notified all staff of the violation relating to 184.a. Residents Meds Labeled, and the safety and importance of this violation, reviewed on 7/20/23.

The Administrator discussed what the facility's plan will be moving forward on 7/20/23.

The facility RN Educated all Med Techs on 7/20/23 and 7/21/23 that all insulin pens must be labeled with a pharmacy label that includes the resident name, medication name, route, how many units to inject, and frequency. This pharmacy label can either be attached directly to the insulin pen or placed in a clear Ziplock bag to travel directly with the insulin pen. A copy of this education record will be provided in the next step of the P.O.C.

The Administrator will develop a record of this weekly audit with the initials of the person who conducted the weekly audit and the date the audit occurred.

A copy of this record will be provided in the next step of the P.O.C.

The Administrator or RN will create and complete a weekly compliance check for correct pharmacy label dosage instructions with insulin pens starting on 7/24/23.

1. ACTION- The RN called the pharmacy to have all labels delivered for any insulin pen that did not have a label attached OWNER- facility RN. COMPLETION DATE- 7/7/23.

2. ACTION- The Administrator will notify Direct Care Staff of the violation pertaining to 184.a Resident's Meds Labeled. OWNER- Administrator- COMPLETION DATE- 7/20/23.

3. ACTION-The Administrator will notify Direct Care Staff of the Facility's plan moving forward in relation to violation 184.a Resident's Meds Labeled. OWNER- Administrator- COMPLETION DATE- 7/20/23.

4. ACTION- The facility RN Educated all Med Techs that all insulin pens need to have dosage instructions. OWNER- facility RN. COMPLETION DATE-7/20/23 and 7/21/23.

5. ACTION- The facility RN Educated all Med Techs that all insulin pens are labeled with pharmacy label that includes: resident name, medication name, route, how many units to inject, and frequency. OWNER-facility RN.

184a - Resident's Meds Labeled (continued)

COMPLETION DATE-7/20/23 and 7/21/23.

6. ACTION- The facility RN Educated all Med Techs that all insulin pen pharmacy labels can either be attached directly to the insulin pen or placed in a clear Ziplock bag to travel directly with the insulin pen. OWNER-facility RN. COMPLETION DATE-7/20/23 and 7/21/23.

7. ACTION-Create a record and sign-off sheet with initials and date to check for the presence of insulin pen pharmacy labels on or with each insulin pen in a zip lock bag. OWNER-Administrator -COMPLETION DATE- 7/24/23.

8. ACTION- Weekly inspection of correct pharmacy label dosage instructions on each individual insulin pen or in a zip lock bag with insulin pen. OWNER-Administrator or facility RN COMPLETION DATE- Starting date 7/24/23 then weekly inspections.

Licensee's Proposed Overall Completion Date: 07/20/2023

Implemented () - 08/03/2023