COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **ST STEPHENS LIVING CENTER LLC**
LEGAL ENTITY

To operate **ST. STEPHEN'S LIVING CENTER**
NAME OF FACILITY OR AGENCY

Located at **1075 CHESTNUT STREET, NANTY GLO, PA 15943**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

PROVISIONAL

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 **44** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restictions:

This certificate is granted in accordance with the Public Welfare 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 **January 30, 2013** until **April 20, 2013**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **327361**

Robert E. Robinson
ISSUING OFFICER

[signature]
DIRECTOR

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.

PW 628 – 01/11

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JAN 3 0 2013

Mr. Stephen Rodrigues, President/CEO
St. Stephen's Living Center, LLC
St. Stephen's Living Center
1075 Chestnut Street
Nanty Glo, Pennsylvania 15943

Dear Mr. Rodrigues:

As a result of the Department of Public Welfare's (Department) licensing inspection on July 9, 2012, July 11, 2012, October 15, 2012 and October 16, 2012 of the above personal care home, the violations specified on the enclosed Violation Report were found.

Based on violations with 55 Pa.Code Ch. 2600, your current license #327360 dated April 20, 2012 to April 20, 2013 is REVOKED. A FIRST PROVISIONAL license, effective January 30, 2013 to April 20, 2013 is being issued based on your plan to correct the violations as specified on the Violation Report. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation.) Your FIRST PROVISIONAL license is enclosed.

All violations specified on the Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Human Services Licensing so that compliance can be verified.

Pursuant to 62 P.S. 1085-1087 and 55 Pa.Code §§ 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violations unless fully corrected on or before the mandated correction date.

55 Pa.Code Chapter 2600 Section no.	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
42b	II	32	$5	$160	5 calendar days from mailing date of this letter
60a	II	32	$5	$160	5 calendar days from mailing date of this letter
225c	III	32	$3	$96	15 calendar days from mailing date of this letter
227d	III	32	$3	$96	15 calendar days from mailing date of this letter

A fine will be assessed on a daily basis beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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 Public Welfare in accordance with 1 Pa.Code Part II, Chs. 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:

Jacob Herzing, Enforcement Manager
Human Services Licensing
Department of Public Welfare
Room 631 Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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,

Ronald Melusky
Director

Enclosures
License
Violation Report

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: ST STEPHEN S LIVING CENTER	**License Number:** 327360
Address: 1075 CHESTNUT STREET, NANTY GLO, PA 15943	**County:** Cambria
Administrator: Debra Gabor	**Region:** CENTRAL
Legal Entity Name: ST STEPHEN'S LIVING CENTER LLC	
Legal Entity Address: 1075 CHESTNUT STREET, NANTY GLO, PA 15943	

Certificate(s) of Occupancy
C-2 LP
01/26/1989
L&I

Staffing Hours
Resident Support: NM **Total Daily Staff:** 49 **Waking Staff:** 37

Type of Inspection: Partial **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)
Complaint

On-Site Inspections Dates and Department Representatives On-Site
07/09/2012: Erb, Jaime; Loudenslager, Lynn
07/11/2012: Erb, Jaime; Loudenslager, Lynn

Off-Site Inspection Dates and Inspectors, If Applicable

Other Details
Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 44

Number of Residents Served: 40

Secured Dementia Care Unit in Home: No

Area:

Secured Dementia Unit Capacity, if Applicable:

Number of Residents who:

RECEIVED TIME AUG. 21. 1:12PM

Violation Report: 32738 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

✓ **1. REGULATION 55 Pa.Code §2600**
2600.23(a) - A home shall provide each resident with assistance with activities of daily living as indicated in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
The assessments and support plans for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12 indicate that the resident requires assistance with incontinence care. On 7/9/12, all the dining room chairs were covered with disposable incontinence pads. During staff interviews, it was confirmed that staff do not have enough time to change all twelve residents when needed. The incontinence pads are needed because the resident's saturated adult brief may leak onto the upholstery of the chair in which the resident is sitting.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The home is providing each resident with assistance with activities of daily living as indicated in the residents assessment and support plan. This includes residents #1, #2, #3, #5, #10, #11, and #12. Residents #4, #6, #7, and #9 have moved on and are no longer residents of home.
Additional staff have been hired for all three shifts. A Bowel and Bladder program has been put in place. The staff is required to monitor the incontinent residents every hour, and to provide assistance as required.
The Administrator will monitor the Bowel and Bladder program for its effectiveness, and will report the findings to the Quality Management Team.

The monitoring will be ongoing.

Continued - see attached - pg. 2A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page): Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Deborah Gabor Administrator
Date: 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction Implementation status as of 10/15/12 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☑ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

RECEIVED TIME AUG. 21. 1:12PM

2600.23(a)

Based on the needs of the residents as indicated in their assessments and support plans those residents who are incontinent have been put on the bowel and bladder program. What this program does is to have staff on all three shifts to monitor the residents on the bowel and bladder program. Staff, check on the residents who are on the program frequently and as needed. Those residents that need to go the restroom are taken. Assistance is provided.

The Administrator monitors the program regularly for its effectiveness. The results of the monitoring program are reported annually to the Quality Management Team consisting of the Administrator, the Assistant Administrator, the Director of Staff, and a Direct Care Staff. The team reviews the findings and gives its input when needed.

The bowel and bladder program will be ongoing.

Violation Report: 32738 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION
On 6/24/12, Resident #15 was released from the hospital with care instructions for a fractured shoulder and contusion of the lower extremity. An orthopedic referral was sugguested with special advice for the home to follow up with an orthopedic surgeon the following day, 6/25/12. The home did not contact an orthopedic surgeon until 7/11/12, 17 days later.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Residents are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.
Resident #15 was seen by an orthopedic doctor on 07/11/2012.
The Administrator will monitor all discharge instructions from the hospital for timely compliance with follow up appointments for the residents. All follow-up appointments will be scheduled immediately.
A report will be submitted to the Quality management Team for review.

Continued - see attached pg. 3A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

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The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/15/12 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☑ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

2600.42(b)

Prior to a resident being discharged from the hospital to the home the nurse calls with a report on the residents' current status. On return to the home the resident is sent with discharge instructions. The Administrator reviews the instructions for follow up appointments. Any appointments will be scheduled immediately by the Administrator or designee.

The Administrator and or designee will monitor for compliance.

Violation Report: 32738 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.42(c) - A resident shall be treated with dignity and respect.

2a. DESCRIPTION OF VIOLATION
On 7/9/12 In the afternoon, Resident #12 entered the main living room in a wheelchair. There were more than twelve residents sitting in the living room. Resident #12 was unclothed below the waist. Staff person A was alerted by an inspector to assist Resident #12. During staff interviews, it was confirmed that in addition to Resident #12, Resident #14 requires supervision to ensure he/she is completely clothed in common areas.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

All residents are treated with dignity and respect. Resident #12 is being monitored on the Bowel and Bladder program by the staff. Resident #14 has moved on and is no longer a resident here. The Administrator will monitor for compliance. Any findings will be submitted to the Quality management Team for review.

Continued - see attached pg. 4A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/15/12 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☑ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

2600.42(c)

Resident # 14 is no longer a resident of the home. Resident #12 is on the bowel and bladder program. Staff, on all three shifts monitor the resident regularly and assist the resident to the restroom as needed. The staff also makes sure that the resident is appropriately dressed.

The Administrator and or designee will monitor for compliance.

Monitoring of the resident will be ongoing.

Violation Report: 32736 - 07/00/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.60(a) - Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan

2a. DESCRIPTION OF VIOLATION
The home's census on 7/9/2012 was 40 residents, including one resident who needs to be fed by staff; 12 residents who require incontinence care by staff; and 9 residents who have been designated as needing assistance to evacuate in an emergency. 5 require two people to assist in transferring. The routine staffing pattern consists of 2-3 staff persons at any given time of day to provide direct care services, housekeeping, laundry, dining services and activities. Staff interviews confirmed that the current staffing levels are not sufficient to meet the care needs of the residents or to be able to evacuate the residents in the event of an emergency.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Staff is provided to meet the needs of the residents as specified in the resident's assessment and support plan.
The homes census on 7/9/2012 was 40 residents.
The total hours staffed on 7/9/2012 was 76 hours.
For Dining, Housekeeping, and laundry sixteen (16) staffing hours were allocated on 7/9/2012.
Direct care hours for 7/9/2012 were 60 hours. Required hours were 48 hours.
The home was in compliance with being able to meet the needs of the residents as specified in the resident's assessment and support plan.

Continued - see attached pg. 5A.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/08/2012	10/24/2011	

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator   Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☑ Not Implemented

2600.60(a)

The home's census as of 9/26/2012 is 34 residents. Three of the residents are immobile. These three residents have been designated as needing assistance to evacuate during an emergency. The home has held several fire drills during the past several months during which the home was able to demonstrate that all the residents were able to be moved to a fire safe area in the allotted time designated by a Fire Safety Expert. Presently there are no residents who need to be fed by staff. There is only one resident who needs two person assist in transferring to a wheelchair and one person to transport to the fire safe area. There are two residents who need one person assist in ambulating to the fire safe area.

The routine staffing pattern presently consists of approximately seventy hours of resident care of which twelve hours are allocated for housekeeping, laundry and dining services.

This current staffing level is sufficient to meet the care needs of the residents and to be able to evacuate the residents in the event of an emergency.

The Director of Staff monitors the staffing levels regularly, and reports her findings to the Administrator who monitors for compliance.

Violation Report: 32738 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.63(a) - At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

2a. DESCRIPTION OF VIOLATION
During the period of 7/1/12 through 7/10/12, from 11:00pm to 7am, 40 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR is present in the home at all times.
Staff member J's copy of having completed the requirements for standard First aid is enclosed. The certificate is good for 3 years from 9/16/2010.

Continued - see attached pg. 6A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

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The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [x] Not Implemented

2600.63(a)

During the period of 7/1/12 through 7/10/12 there was one staff member present employee J, who is certified in first aid, obstructed airway techniques and CPR.

On July 16th 2012 CPR AND FIRST AID TRAING was held at the home for all staff by [redacted] of Blacklick Valley Ambulance Company.

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600

2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:
(1) Training that includes a demonstration of job duties, followed by supervised practice.
(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
(3) Initial direct care staff person training to include the following:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan.
(vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person A, hired on 6/30/12, began providing unsupervised ADL services on the 7/1/12 2nd shift. The staff person has not completed and passed the Department-approved direct care training course and passed the competency test and has not received training in any of the required topics of section (3) of this regulation. The following direct care staff persons provide unsupervised ADL services. These staff persons have not received training in any of the required topics of section (3) of this regulation:
Staff person B, hired 4/25/12
Staff person C, hired 4/25/12
Staff person D, hired 6/24/12
Staff person E, hired 6/30/12
Staff person F, hired 6/30/12
Staff person G, hired 6/27/12

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See attached pg. 7A.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:
(1) Training that includes a demonstration of job duties, followed by supervised practice
(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
(3) Initial direct care staff person training to include the following:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan.
(vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

2a. DESCRIPTION OF VIOLATION
Direct care staff person A, hired on 6/30/12, began providing unsupervised ADL services on the 7/1/12 2nd shift. The staff person has not completed and passed the Department-approved direct care training course and passed the competency test and has not received training in any of the required topics of section (3) of this regulation. The following direct care staff persons provide unsupervised ADL services. These staff persons have not received training in any of the required topics of section (3) of this regulation:
Staff person B, hired 4/25/12
Staff person C, hired 4/25/12
Staff person D, hired 6/24/12
Staff person E, hired 6/30/12
Staff person F, hired 6/30/12
Staff person G, hired 6/27/12

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Direct care staff persons are trained in the required topics of section (3).
All newly hired Direct Care staff persons will not begin orientation until successful completion and passing the Department-approved direct care training course and passing of the competency test. After passing the competency test and providing the printed certificate, newly hired Direct care staff will be trained in the required topics in section (3).
The Administrator will monitor for compliance, and report any findings to the Quality management Team.

Deborah Gabor
Deborah Gabor Administrator 08/17/2012

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.65(i) - A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

2a. DESCRIPTION OF VIOLATION
Ancillary Staff person H and I, hired 7/11/12, started working in the home on 7/11/12 at approximately 9:00 a.m. During staff interviews conducted at approximately 10:50am, it was discovered that staff person H and I signed off on the completion of an employee orientation form that included the training topics listed below. Staff Person J confirmed that the training for Staff person H and I was not completed on 7/11/12. Staff person H and I also confirmed that the training was not completed even though the orientation forms were signed to indicate completion.

* Fire safety completed by a fire saftey expert or by a staff person trained by a fire safety expert

* Emergency preparedness procedures, recognition and response to crises and emergency situation

* Resident Rights

* The Older Adult Protective Services Act

* Fall and Accident Prevention

* Abuse Training & Mandatory Reporting

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

A record of training including the staff person trained, date, source, content, lengths of each course and copies of any certificates received, will be kept. The Administrator will schedule staff for orientation and on the day of orientation will complete with staff person: Fire safety by a staff person trained by a fire safety expert; Emergency preparedness procedures, recognition and response to crises and emergency situation; Resident Rights; The Older Adult Protective Services Act; Fall and Accident Prevention; Abuse Training and Mandatory Reporting. The Administrator will monitor for compliance. The Administrator will report her findings to the Quality management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION
On 7/9/12, at approximately 10:45am, bathroom #8 had a strong odor of urine. Staff stated that the carpet in bathroom #8 needs to be replaced to remove the odor.

On 7/9/12, at approximately 1:30pm, a soiled incontinence pad was exposed in the dining room garbage can. The garbage can had a lid but it was open at that time. Staff stated the pad was used to protect the dining room chairs.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Sanitary conditions will be maintained.
The carpet in bathroom #8 has been removed and now has vinyl flooring.
All incontinence pads from all dining room chairs have been removed.
All staff have been instructed not to place incontinent pads on dining room chairs, and to keep garbage can lids closed.
The Administrator will monitor for compliance.
The Administrator will report her findings to the Quality Management Team.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/08/2012		

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

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The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 32738 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.85(d) - Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

2a. DESCRIPTION OF VIOLATION
The trash can in the 2nd floor shared women's bathroom did not have a lid. The trash can was filled with paper products soiled with feces.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Trash in kitchens and bathrooms will be kept in covered trash receptacles that prevent the penetration of insects and rodents.
The trash can in the 2nd floor shared women's bathroom has been replaced with a trash can with a lid.
The Administrator will monitor for compliance. The Administrator will report her findings to the Quality management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.88(a) - Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION
In the second floor common room there is a window approximately 35 inches wide. The window has a break in the glass of approxmiately 33 inches wide. The break is covered with duct tape.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Floors, walls, ceilings, doors and other surfaces will be clean, in good repair and free of hazards.

Window World Inc. of Altoona has been contracted to replace the window that has a break in the glass.

The Administrator will monitor for compliance. The Administrator will report her findings to the Quality Management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSZ (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32738 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.102(k) - Use of a common towel is prohibited.

2a. DESCRIPTION OF VIOLATION
Two unlabeled wash clothes were found in the shower of the second floor shared women's bathroom. One of the unlabeled wash clothes was soiled with feces. The bathroom is shared by five women.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The home does not have it's residents use common towels.
The two unlabeled wash clothes that were found in the shower of the second floor shared women's bathroom were removed on the same day by a staff member.
The Administrator will make sure that residents are not using common towels.
The Administrator will monitor for compliance.
The Administrator will report her findings to the Quality Management Team.

Continued - see pg. 12A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

2600.102(k)

Residents have been advised that they are to put the wash cloths after use in the hamper provided to them in the bathroom.

Staff will regularly monitor for compliance and will report their findings to the Administrator.

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.132(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 home 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.

2a. DESCRIPTION OF VIOLATION
During staff interviews, it was reported that the fire drill record for the drill conducted on 6/6/12 does not include the correct number of residents evacuated. The record indicates 25 residents evacuated to fire safe areas; however only 22 residents evacuated and 3 remained in their bedrooms.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

A written fire drill record will include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating and problems encountered and whether the fire alarm or smoke detector was operative. The Administrator, prior to completing the fire drill record, will make her rounds of the resident rooms, common rooms, bathrooms, and dining room to make sure all of the residents have evacuated based on the days census. A head count will be taken.

The Administrator will monitor for compliance.

The Administrator will report her findings to the Quality Management Team.

Continued - See attached pg. 13A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction Implementation status as of 10/10/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

2600.132(c)

A fire drill will be conducted by the Administrator once a month rotating between Day/Evening/Night shifts.

The Administrator will call the Fire Alarm Company to take the alarm off line in order to conduct a fire drill.

The Administrator activates the fire alarm and begins timing the drill on her stop watch. When all residents have been evacuated to a fire safe area by the staff and the Administrator is notified by the staff that all residents have been evacuated to a fire safe area the Administrator then stops the clock and notes the time. The Administrator then asks the staff to do a head count to verify that all residents have been evacuated.

An evacuation time will be documented after accounting for all the residents.

The Fire Alarm Company is then called to put the alarm back on line.

The Administrator will monitor for compliance.

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
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.

2a. DESCRIPTION OF VIOLATION
According to staff, during the fire drill of 6/6/12, Residents #7, #8 and #10 remained in their bedrooms and did not evacuate to a public thoroughfare or a fire safe area. Staff person K confirmed that a head count is not taken to confirm the number of residents evacuated. On 6/6/12, Staff Person K determined an evacuation time before accounting for all residents. Resident #7 and #8 require physical assistance to evacuate during an emergency. The evacuation time for the fire drill of 6/6/12 was determined before staff could provide the assistance needed to evacuate Residents #7, #8 and #10.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Residents will 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.
During a fire drill, all residents will be evacuated to a fire safe area designated by a fire safety expert. A head count will be taken to confirm the number of residents evacuated. The evacuation time will be determined after all residents have been evacuated to a fire safe area.
The Administrator will monitor for compliance.
The Administrator will report her findings to the Quality Management Team.

Continued - See attached pg. 14A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☑ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

2600.132(d)

A fire drill will be conducted by the Administrator once a month rotating between Day/Evening/Night shifts.

The Administrator will call the Fire Alarm Company to take the alarm off line in order to conduct a fire drill.

The Administrator activates the fire alarm and begins timing the drill on her stop watch. When all residents have been evacuated to a fire safe area by the staff and the Administrator is notified by the staff that all residents have been evacuated to a fire safe area the Administrator then stops the clock and notes the time. The Administrator then asks the staff to do a head count to verify that all residents have been evacuated.

Residents who refuse to participate in the fire drill will be notified that in order for them to continue to stay at the home they will have to participate in the fire drill and after notifying them and they still refuse then they will be given a thirty day notice to find another home. This will be noted on the Fire Drill record.

An evacuation time will be documented after accounting for all the residents.

The Fire Alarm Company is then called to put the alarm back on line.

The Administrator will monitor for compliance.

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.142(a) - The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
Resident #15, admitted 6/22/12, was found laying face down on the outside deck ramp at 3:30pm on 6/24/12. Resident #15 was sent to the emergency room with right shoulder and left knee pain. At 6:51pm, on 6/24/12, Resident #15 was released from the hospital with care instructions for a fractured shoulder and contusion of the lower extremity. An orthopedic referral was suggested with special advice for the home to follow up with an orthopedic surgeon the following day, 6/25/12. The home did not contact an orthopedic surgeon until 7/11/12, 17 days later. The home did not document the resident's need for medical care upon return from the hospital, including updating the resident's assessment and support plan.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The home will assist the resident to secure medical care if a residents health status declines. The home will document the residents need for medical care, including updating the residents assessment and support plan.

The Administrator will monitor the health status of all residents, and upon noticing a decline, the Administrator will assist the resident to secure medical care. The Administrator will document the resident's need for medical care, and the resident's assessment and support plan will be updated accordingly.
The Administrator will thoroughly read care instructions returned with residents discharged from the hospital and carry out the follow up instructions as noted. All documentation will be made.
The Administrator will monitor for compliance.
The Administrator will report her findings to the Quality Management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☑ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.221(a) - The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

2a. DESCRIPTION OF VIOLATION
The home does not have a program of activities designed to promote the active involvement of residents with families and the community. The home has an acitivity calendar posted; however the staff stated that activities are not being initiated due to not enough staff to conduct the activities.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Administrator has developed a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

Attached is a revised activity calendar. A staff person has been designated as an Activity Coordinator to conduct the activities.

The Administrator will monitor for compliance.
The Administrator will report her findings to the Quality Management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.224(a) - A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

2a. DESCRIPTION OF VIOLATION
The pre-admission screening form for Resident #3, admitted 6/22/12, does not include a determination that the home can meet the service needs of the the resident.

The pre-admission screening form for Resident #9, admitted 6/25/12, does not include a determination that the home can meet the service needs of the resident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

A determination will be made within 30 days prior to admission and documented on the Departments preadmission screening form that the needs of the resident can be met by the services provided by the home.
The Administrator will complete a preadmission screening within 30 days prior to admission and document on the Department's preadmission screening form the service needs of the potential resident and the determination of whether or not the needs of the resident can be met by the services provided by our home.
Resident #9 has moved on and is no longer a resident here.
The Administrator will monitor for compliance.
The Administrator will report her findings to the Quality Management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/15/12 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.225(a) - A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

2a. DESCRIPTION OF VIOLATION
The home has not completed an initial assessment for Residents #6, #12 and #17, admitted 6/22/12.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

A resident will have a written initial assessment that is documented on the Department's assessment form within 15 days of admission.

Within 15 days of admission, the administrator or designee will complete an initial assessment. The assessment will be updated as necessary after the first 15 days as new care needs may be identified through continuous assessment of the resident.

The Administrator will monitor for compliance. The Administrator will report any findings to the Quality Review Team.

Continued - See pg. 18A

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/24/2011		

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/15/12 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

2600.225(a)

The Administrator has put a system in place whereby all residents will have an initial written assessment in place within fifteen days of being admitted to the facility.

The Administrator or designee will periodically review all resident charts to monitor for compliance.

The Director of Staff will randomly do audits to ensure for compliance.

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:
(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

The 5/22/12 assessment for Resident #4, admitted 11/16/09, indicates the resident requires some supervision in the home due to dementia and is independent with toileting and bowl and bladder managment. During staff interviews, it was discovered that Resident #4 has been wandering for several months into other resident rooms and having bowel movements on the floor. The home has not completed a new assessment of the resident's needs to reflect these changes.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The resident will have additional assessments as follows: (1) Annually, (2) If the condition of the resident significantly changes prior to the annual assessment, (3) At the request of the Department upon cause to believe that an update is required.
The Administrator will continuously assess the mental and physical status of all residents. If a significant change is noted, an additional assessment will be completed. An additional assessment will also be completed annually and at the request of the Department.
Resident #4 has moved on and no longer lives in the home.
The resident's assessments will be done and updated in a timely manner.
The Administrator will monitor for compliance.
The Administrator will report any findings to the Quality Management Team.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/7/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
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.

2a. DESCRIPTION OF VIOLATION
Upon Resident #15's return from the hosptial on 6/24/12, the support plan was not updated to provide care instructions for staff to evaluate the use of the arm sling, evaluate for swelling and pain, elevation of leg, pain medication effectiveness and medical care.

Resident #15's mobility status changed from mobile with the use of a walker to immobile with the assistance of staff to transfer. The resident's support plan does not document how this need will be met.

The 5/22/12 assessment for Resident #4, admitted 11/16/09, indicates the resident requires some supervision in the home due to dementia and is independent with toileting and bowl and bladder managment. During staff interviews, it was discovered that Resident #4 has been wandering for several months into other resident rooms and having bowel movements on the floor. The resident's support plan does not document how this need will be met.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The home will 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 residents physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.
The Administrator will document in the resident's support plan the medical, dental, vision, hearing, mental health or behavioral care services available to the resident, or referrals for the resident to outside services if deemed necessary by the residents physician, physicians assistant or certified registered nurse practioner.
The Administrator will monitor for compliance.
The Administrator will report any findings to the Quality Management Team. cont. - see attached pg. 20A.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/08/2012		

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator — Date 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSL (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

2600.227(d)

The Administrator has put a system in place whereby all residents will have their support plans updated whenever there is a change in condition.

Care instructions will be provided to the staff on the resident change of condition and how to provide care to the resident.

The Administrator or designee will periodically review all resident charts to monitor for compliance.

The Director of Staff will randomly do audits to ensure for compliance.

Violation Report: 32736 - 07/09/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.252 - Each resident's record must include the following information: (1) through (26)

2a. DESCRIPTION OF VIOLATION
Resident #15, admitted 6/22/12, record does not include weight, color of hair, color of eyes, religious affiliation, identifying marks and a photograph of the resident.

Resident #16, admitted 6/22/12, record does not include color of hair, color of eyes, language spoken and a photograph of the resident.

Residents #3, #6, #12, #17 and #18, admitted 6/22/12, records do not include a photograph of the resident.

Residents #9, #11 and #14, admitted 6/25/12, records do not include a photograph of the resident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Each residents record will include all information from (1) through (26).
Upon admission, the Administrator will take and print a picture of the new resident and place it in their record. A face sheet containing the required information under regulation 2600.252 (1) through (26) will be completed and kept with resident record.
The Administrator will monitor for compliance.
The Administrator will report any findings to the Quality management Team.

Continued - see attached pg. 21A

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — **Date** 08/17/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 9/25/12 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 10/16/12 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

2600.252

The Administrator has put a system in place whereby all residents will have a face sheet that will include weight, color of hair, color of eyes, religious affiliation, language spoken and identifying marks.

The chart will also have a photograph of the resident.

Care instructions will be provided to the staff on the resident change of condition and how to provide care to the resident.

The Administrator or designee will periodically review all resident charts to monitor for compliance.

The Director of Staff will randomly do audits to ensure for compliance.

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: ST STEPHEN S LIVING CENTER	**License Number:** 327360
Address: 1075 CHESTNUT STREET, NANTY GLO, PA 15943	**County:** Cambria
Administrator: Deborah Gabor	**Region:** CENTRAL

Legal Entity Name: ST STEPHEN'S LIVING CENTER LLC

Legal Entity Address: 1075 CHESTNUT STREET, NANTY GLO, PA 15943

Certificate(s) of Occupancy

C-2 LP
01/26/1989
L&I

Staffing Hours

Resident Support: 0	**Total Daily Staff:** 36	**Waking Staff:** 27
Type of Inspection: Partial	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)

Complaint

On-Site Inspections Dates and Department Representatives On-Site

10/15/2012: Erb, Jaime; Loudenslager, Lynn
10/16/2012: Erb, Jaime; Loudenslager, Lynn

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers:

Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 44

Number of Residents Served: 34

Secured Dementia Care Unit in Home: No

Area:

Secured Dementia Unit Capacity, If Applicable:

Number of Residents who:

Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION
On 10/3/2012, at approximately 6:30pm, an alleged incident of verbal abuse occurred between Staff Person A and Resident #1. The home did not report the allegation to the local area agency on aging or the State Department of Aging until 10/4/2012 at 4:15pm.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) *Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

All incidents of suspected abuse shall be reported immediately in accordance with the Older Adults Protective Services Act and 6 Pa. Code Sections 15.21-15.27.

Direct Care Staff and Ancillary Staff Persons have been instructed to report abuse immediately to the local Area Agency on Aging and to the Administrator.

ALL STAFF PERSONS WILL RECEIVE TRAINING IN THE DEFINITION OF ABUSE AND THE PROCEDURES TO FOLLOW WHEN ABUSE IS IDENTIFIED FROM THE AREA AGENCY ON AGING. -NSC

— COMPLETED BY 4/1/13

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator

Date 12/27/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 1/22/13 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 1/22/13 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.15(c) - The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

2a. DESCRIPTION OF VIOLATION
On 10/3/2012, an allegation of abuse was made against Staff Person A regarding Resident #1. The home did not submit a plan of supervision or notice of suspension of the staff person to the Department.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

A reportable incident form was faxed to the regional office on 10/4/2012 notifying the Department that Staff Person A had been suspended. (See attached).
A final report was submitted to the Department on 10/9/2012.

Going forward, the Department shall be notified immediately of an allegation of abuse and the action taken.

THE ADMINISTRATOR WILL BE RESPONSIBLE TO ENSURE THAT A STAFF PERSON WHO IS ACCUSED OF ABUSE IS SUSPENDED OR SUPERVISED.
— NSC

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator **Date** 12/27/2012

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Plan of correction implementation status as of 1/22/13 (Date)

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- ☒ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 32736 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.16(d) - The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

2a. DESCRIPTION OF VIOLATION
On 10/3/2012, the home received a report of suspected abuse involving Resident #1. The home did not notify the resident's designated person of the incident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Going forward, the resident's designated person shall be notified of an incident of suspected abuse.

THE ADMINISTRATOR WILL BE RESPONSIBLE FOR REQUIRED NOTIFICATIONS AND WILL RECEIVE ABUSE TRAINING IN 2013 FROM THE AREA AGENCY ON AGING. — NSC

— COMPLETED BY 4/1/13

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 12/27/2012

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- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600

2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 10/3/2012, Resident #2 was admitted to the hospital with a diagnosis of septic hypovolemic shock secondary to dehydration. Resident #2 passed away on 10/8/12. The home did not submit an incident report to the Department.

On 10/9/2012, Resident #4 was transferred by ambulance to the hospital and admitted for cardiac consultation. The home did not submit an incident report to the Department.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

An incident report shall be submitted to the Department when a resident is transferred and admitted to the hospital based on the resident's condition.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 12/27/2012

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Plan of correction implementation status as of 1/22/13 (Date)

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- ☒ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 32736 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.20(b)(3) - The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

2a. DESCRIPTION OF VIOLATION
The home maintains several residents' personal checking accounts. Inspectors interviewed one of the residents who stated he/she signs the checks as requested by the administrator, but the administrator does not provide any written receipts or bills for the payments. For example, Resident #3 signed a check payable to the resident for $80 on 10/3/2012. The resident received $30 and was told by the administrator that the remaining $50 cash goes to the home for cable TV, telephone and medications. The resident has never seen bills or invoices for any of those items. The checkbook shows disbursements to the home for beauty shop services. The resident does not see a bill for those services. The resident does not see a bank statement for the checking account.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Administrator shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.
A statement of charges due shall be provided to the resident for services provided.

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator **Date** 12/27/2012

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Violation Report: 32736 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION
On 10/3/2012, at 6:30pm, Staff person A yelled at Resident #1 and used inappropriate language.

Between August and October 2012, Resident #2 experienced incidents of skin breakdown. The resident was diabetic and at greater risk for complications related to wounds. On approximately 8/7/12, the home contacted the doctor to obtain medication for a bed sore. Staff Person B stated it was a Stage 2 bed sore at the time the doctor was contacted. The doctor prescribed a topical medication, but did not see the resident. The resident was seen by the doctor on 8/28/12, but Staff Persons B and C did not know if the doctor looked at the bed sore. The doctor's standard examination form completed on 8/28/12 for Resident #2 does not indicate decubiti, ulcers, bed sores or wounds. There appeared to be no change in the resident's medication or treatment instructions to the home after the doctor's visit.

At or around 9/20/12, the bed sore started bleeding after the wound was cleaned and the resident had developed two more bedsores in the same area and a wound on the side of the heel. The resident was seen by the doctor on 9/28/12. Staff Person C was present during the doctor's visit and he/she reported that doctor looked at the bed sores, but there was no change in the medication or instructions. Staff Person C did not mention to the doctor the wound on the resident's heel because he/she thought it was healing, although this Staff Person C reported during interview by inspectors that the last time he/she saw the wound on the foot was 9/23/12, therefore, it's not clear why he/she thought it was healing. Staff Person B did not see the bed sores between 9/27/12 and 10/3/12. On 10/3/12, Staff Person B saw drainage from the heel wound.

According to the doctor's notes on from the 9/28/12 visitation, the physician ordered wound care and hospice for Resident #2. These services were not arranged or provided for the resident before the resident's admission to the hospital on 10/3/2012.

On 10/3/12, the resident was admitted to the hospital. The Physician Attestation Statement indicates Septic Shock Present on Admission, Severe Sepsis Present on Admission, Pressure Ulcer, lower back, Present on Admission. The Medicare Diagnosis Related Group is Septicemia or Severe Sepsis. The resident passed away on 10/9/2012.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

staff person A was suspended and his employment was terminated. No form of abuse shall be tolerated and the rights of the resident shall be upheld.
wound care was be carried out on resident #2. A written order for Hospice services had not been received from the physician prior to the resident's admission to the hospital. The Administrator shall provide interim assessments monthly that a resident's needs can continue to met.

Repeat Violation: Yes	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator — **Date** 12/27/2012

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Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600

2600.63(a) - At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

2a. DESCRIPTION OF VIOLATION

On 9/23/12 through 9/26/12, between the hours of 2:00pm and 10:30pm, no CPR and first aid trained staff was present in the home. On 9/25/12, 9/26/12 and 10/2/2012 between the hours of 10:30pm and 7am, no CPR and first aid trained staff was present in the home. The owner resides in private quarters in the home and reported he/she is certified in CPR and first aid. However, Staff Person B stated that staff have not been informed that the owner is available to provide emergency services. During interviews, staff confirmed they were not aware and had not been informed that the owner was available to provide CPR and first aid if needed.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

An inservice on CPR and First Aid and obstructed airways techniques was held on 10/3/2012 for staff persons who required certification. (See attached).

A staff schedule shall be maintained that will assure that at least 1 staff person shall be present at all times who is trained in first aid and certified in CPR and obstructed airway techniques.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 12/27/2012

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- ☐ Not Implemented

Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.103(j) - Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa.Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

2a. DESCRIPTION OF VIOLATION
All eating equipment was being washed with Ajax dish detergent and staff were drying the equipment with a cloth towel. The home is not using a santizing process.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The dishwasher has been repaired and the Department was notified on 10/26/2012. The machine is currently operational and in good working order.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator — Date 12/27/2012

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Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.132(g) - Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

2a. DESCRIPTION OF VIOLATION
During the fire drill on 7/16/2012 at 6:09am, five staff participated in the drill. During the fire drill on 9/24/2012 at 5:35am, four staff participated in the drill. According to staff records, the average number of staff on duty at this time of day is two. The home has not demonstrated successful drills with the least number of staff.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Fire drills are held on different days of the week rotating between the day, pm, and Noc shifts. The last 2 drills were held with 2 staff persons participating. (See attached).

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 12/27/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

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Plan of correction implementation status as of 1/22/13 (Date)

- ☐ Fully Implemented
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- ☐ Not Implemented

Violation Report: 32738 - 10/16/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.142(a) - The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
Between August and October 2012, Resident #2 experienced incidents of skin breakdown. The resident was diabetic and at greater risk for complications related to wounds. On approximately 8/7/12, the home contacted the doctor to obtain medication for a bed sore. Staff Person B stated it was a Stage 2 bed sore at the time the doctor was contacted. The doctor prescribed a topical medication, but did not see the resident. The resident was seen by the doctor on 8/28/12, but Staff Persons B and C did not know if the doctor looked at the bed sore. The doctor's standard examination form completed on 8/28/12 for Resident #2 does not indicate decubiti, ulcers, bed sores or wounds. There appeared to be no change in the resident's medication or treatment instructions to the home after the doctor's visit.

At or around 9/20/12, the bed sore started bleeding after the wound was cleaned and the resident had developed two more bedsores in the same area and a wound on the side of the heel. The resident was seen by the doctor on 9/26/12. Staff Person C was present during the doctor's visit and he/she reported that doctor looked at the bed sores, but there was no change in the medication or instructions. Staff Person C did not mention to the doctor the wound on the resident's heel because he/she thought it was healing, although this Staff Person C reported during interview by inpsectors that the last time he/she saw the wound on the foot was 9/23/12, therefore, it's not clear why he/she thought it was healing. Staff Person B did not see the bed sores between 9/27/12 and 10/3/12. On 10/3/12, Staff Person B saw drainage from the heel wound.

According to the doctor's notes on from the 9/26/12 visitation, the physician ordered wound care and hospice for Resident #2. These services were not arranged or provided for the resident before the resident's admission to the hospital on 10/3/2012.

On 10/3/12, the resident was admitted to the hospital. The Physician Attestation Statement indicates Septic Shock Present on Admission, Severe Sepsis Present on Admission, Pressure Ulcer, lower back, Present on Admission. The Medicare Diagnosis Related Group is Septicemia or Severe Sepsis. The resident passed away on 10/9/2012.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Assistance shall be provided to a resident to secure medical care if a resident's health status declines. The Administrator shall monitor for changes in a resident's condition, document the need for medical care, and update the resident's assessment and support plan accordingly.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator **Date** 12/27/2012

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Plan of correction implementation status as of 1/22/13 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32736 - 10/16/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600

2600.182(c) - Medication administration includes the following activities, based on the needs of the resident:

(1) Identify the correct resident.
(2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
(3) Remove the medication from the original container.
(4) Crush or split the medication as ordered by the prescriber.
(5) Place the medication in a medication cup or other appropriate container, or in the resident's hand.
(6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in § 2600.182(b)(4).
(7) Complete documentation in accordance with § 2600.187 (relating to medication records).

2a. DESCRIPTION OF VIOLATION

On 10/15/2012, at 12:00pm, while talking to residents in the dining room, an inspector observed Staff Person D approach the table with two plastic containers. Each container had small medicine cups with resident names written on them. Staff Person D administered medications from one of the plastic containers to two residents at the table and administered medications from the second plastic container to a third resident. Staff Person D was interviewed by inspectors, he/she reported that he/she removes the pills from the original pharmacy packages and puts them in the medicine cups. At that time, he/she places a dot by the medication on the medication administration record (MAR). He/she then places the medicine cup in the plastic container. This procedure is followed for 3 or 4 residents. Then Staff Person D takes the plastic containers to the dining room and administers the medications to the identified residents. After the administration of all the medication in the plastic containers, Staff Person D returns to the medication cart and initials the MAR.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Regulation 2600.182(c) (1) through (7) reviewed with med. trained staff. Med. trained staff to perform the medication administration activities based on the needs of the resident. ALL STAFF WILL RECEIVE TRAINING ON PROPER MEDICATION ADMINISTRATION AND THE GUIDELINES IN THE REGULATORY COMPLIANCE GUIDE. THIS WILL BE COMPLETED BY 4/1/13.

The Administrator will monitor for compliance.

-NSC

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator **Date** 12/27/2012

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- [x] Not Implemented

Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.187(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.

2a. DESCRIPTION OF VIOLATION
The October medication administration record for Resident #4 does not include the diagnoses for Avodart, Lisinopril, Lorazepam, Metoclopramide, Risperidone and Tamsulosin.

The October medication administration record for Resident #2 does not include the diagnoses for Trazodone, Warfarin, Ferrous Glucon, Glipizide, Namenda, Exelon patch and Bacitracin.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Administrator shall monitor the medication administration records monthly for any missing elements as specified in 2600.187(a) (1) through (14) and emend them as necessary.

ALL RESIDENT RECORDS WILL BE AUDITED FOR MISSING INFO ON THE MAR. -NSC

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Deborah Gabor Administrator — Date 12/27/2012

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Plan of correction implementation status as of 1/22/13 (Date)

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- ☐ Not Implemented

Violation Report: 32736 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION
On 9/26/2012, Resident #2 was seen by a physician. The physician's form to document the visit indicates "Decubiti--open for hospice and wound care". As of 10/3/2012 when the resident was transferred to the hospital, the home had not arranged for hospice or wound care. The admission diagnoses was septicemia.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The home does follow the directions of the prescriber. Wound care was being provided to resident #2. At the time that resident #2 was transferred to the hospital, the home had not received a written order from the prescriber as of yet to open for hospice services.

The Administrator met with the prescriber this afternoon, 12/27/2012, and both agreed that orders must be received in a timely manner.

The Administrator shall, on receipt of a written order from the provider, follow the directions of the prescriber.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator

Date 12/27/2012

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- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 32738 - 10/15/2012 - Erb, Jaime
PCH Name: ST STEPHEN S LIVING CENTER

1. REGULATION 55 Pa.Code §2600
2600.225(c) - The resident shall have additional assessments as follows:
(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION
Resident #2 was admitted to the home on 6/22/2012. The home completed an assessment on 7/4/2012. No wounds or skin breakdowns were noted. The assessment was updated 8/7/2012 to indicate a skin breakdown, but the type of wound was not indicated. The assessment was not updated to include the additional bed sores and heel wound that developed around 9/20/2012.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Additional assessments shall be done as outlined in 2600.225(c) (1) through (3).

Interim assessments shall be done monthly by the Administrator to determine if the needs of a resident can continue to be met. If a need is identified, the written assessment shall be updated as required.

Repeat Violation: Yes	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deborah Gabor Administrator — **Date** 12/27/2012

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 1/22/13 (Date)

The above plan of correction was approved by NSC (Initials)

Plan of correction implementation status as of 1/22/13 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☒ Partially Implemented - Inadequate Progress
- ☐ Not Implemented