

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to MORRIS-PACE ASSISTED LIVING INC
LEGAL ENTITY

To operate MORRIS-PACE PERSONAL CARE
NAME OF FACILITY OR AGENCY

Located at 416 READING AVENUE, WEST READING, PA 19611
(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

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 63
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions: _____

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 September 10, 2013 until September 10, 2014,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 215900

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



SEP 10 2013

Mr. Nathaniel D. Pace, Administrator
Morris-Pace Assisted Living Inc.
Morris-Pace Personal Care
416 Reading Avenue
West Reading, Pennsylvania 19611

Dear Mr. Pace:

As a result of the Department of Public Welfare's licensing inspection on June 25, 2013, of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) 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.

A regular license is being issued based on the enclosed License Inspection Summary. Your license is enclosed.

Sincerely,

A handwritten signature in black ink, appearing to be "R. Melusky".

Ronald Melusky
Director

Enclosures
License
License Inspection Summary

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.25(c)(2) - The contract shall specify a fee schedule that lists the actual amount of allowable resident charges for each of the home's available services

2a. DESCRIPTION OF VIOLATION
 The home's contract in resident # 1's records was signed by the resident upon admission on 4/11/11 but does indicate a charge for room, meals or a bed hold. These areas on the contract are marked T.B.D. (to be determined).

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.

- (25C-2) Resident # 1's contract did not have an amount for rent: (TBD)
1. A residents record/contract must have the amount of the rent on it. A Resident needs to know how much is owed every month in order to pay the correct amount.
 2. When the resident moved in, she did not have any idea what her check was due to her mother was her payee and she was in the hospital/Nursing Home. Admin. did not go back when her rent was paid and correct the contract/record.
 3. It was an oversight on the part of the Administrator, even though we have been doing our chart checks to ensure that all documents have current dates on them, this was not on our list to check. Check list has been revised.
 4. New contract was created on 6/25/13, Resident was informed of why there needs to be a new contract and signed after Admin. went over the new contract with her.
 5. During our "chart review check list", the addition of "rent amount" will help remind Admin. of checking that as well.
 6. Administrator will be responsible for making sure that the contract is fully completed and checked within the first week of admission, this is the time when the assessment/support plan is completed. Records staff will assist while assessment/support plan is being completed.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Nathan E S Pace	8/5/13

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

The above plan of correction is approved as of <u>8-20-13</u> (Date)	Plan of correction implementation status as of <u>8-20-13</u> (Date)
The above plan of correction was approved by <u>oo</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21580 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600

2600.54(a) - Direct care staff persons shall have the following qualifications:

- (1) Be 18 years of age or older, except as permitted in § 2600.54(b).
- (2) Have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry.
- (3) Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

2a. DESCRIPTION OF VIOLATION

Primary care staff person "A" DOH 08-03-09 and staff person "B" DOH 03-18-13 did not have a copy of their high school diploma, GED or CNA certification

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.

(54A) Missing proof of High School Diploma for staff member "A & B":

1. All staff must have High School Diploma/GED in order to work for a Personal Care Home.
2. Morris-Pace was not able to find the needed documents at the time of inspection. Admin. did not make sure that these documents were in place at the time of employment or lost them.
3. No proof of education/GED/High School Diploma.
4. Morris-Pace is informing anyone who fills out a application that they must have a copy of GED/Diploma with a completed application in order to have an interview. **NO GED/DIPLOMA, NO INTERVIEW!!**
5. Diploma/GED will be attached/stapled to an applicants application when returned. This will assist Admin with all documents needed, and be ready for interview.
6. Administrator will be responsible to have all needed documents for employment. I will have a better view of who's applying and whether they can work here depending on these needed documents.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

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

Date

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8-20-13
 (Date)

Plan of correction implementation status as of

8-20-13
 (Date)

- Fully Implemented
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- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by

OR
 (Initials)

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.65(e) - Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

2a. DESCRIPTION OF VIOLATION
 Staff person "A" DOH 08-03-09 did not have a record that they had received all of the required hours of annual training for 2012. Staff person "A" was found to have 10.5 hours of annual training out of the required 12 hours for the training for 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.

(65E) Training incomplete for staff member "A":

1. 12 hours of training is mandatory for all direct care staff to keep them up to date on the current needs of the residents.
2. [REDACTED] only had 10.5 hrs. Morris-Pace, in 2013 has done a better job of getting the training done. Out sourcing some of the training will ensure the complete hours needed.
3. Required training wasn't complete for all staff.

8/5/13

4. To fix the problem is to increase the training, also, start earlier in the year. This is what we have done. I also check on-line for trainings for the direct care staff. (Geisinger Health System) attached
5. Continue my plan on early trainings, out source training, on-line trainings, as well as in house training.
6. The Administrator is responsible to make sure that training as done on time.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	12/14/2012	
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Matthew Pace

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Matthew Pace	8/5/13

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The above plan of correction was approved by <u><i>MP</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS FACE PERSONAL CARE

1. REGULATION 56 Pa.Code §2600
 2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION

Department Representatives observed the mattress located in resident # 2's room. The mattress had spotted reddish - brown stains at the top corner of the mattress as well as several other areas along the crease of the mattress.

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.

(85A) Soiled mattress of (L5):

1. Soiled/stained mattresses are a health problem to residents. Resident had dead bed bug eggs in the corner.
2. During weekly room checks, there was not any mention of this issue, or when linen is being changed on the weekend due to the sealed covers on this mattress. Staff did not notify office of this
3. The cover must have been ripped and came off of the mattress, this is what caused the violation. Almost all beds have a sealed cover to protect the resident and the mattresses from bed bugs.
4. Staff scrubbed mattress with bleaching agent to remove eggs, then the mattress was treated & sealed to protect resident. Staff will be inspecting the mattresses better, as well as, during the changing of the linen to ensure compliance.
5. Doing our room checks have been such a great help. We will continue to do our weekly checks to be pro-active in avoiding these violations.
6. Day staff will be conducting building checks and document, I (Admin) will be the person responsible to have the repairs done in a timely manner.


Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Nathan Ier S. Pace	Date 8/5/13
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 (Initials)

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- Not Implemented

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 65 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

Department Representatives observed the common bathroom across from bed room D2. The garbage can located in the bathroom contained soiled paper towels and tissues, however the garbage can did not have a cover to prevent the penetration of insects as well as prevent the spread of disease.

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

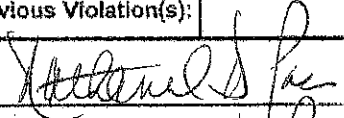
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

(85)"D" bathroom trashcan did not have a lid:

1. This is important because this cuts down on the flying insects/germs/smells.
 2. All public trashcans must have a covering/lid for health/sanitary reasons, our lid was missing from trashcan.
 3. Staff did not notice the missing lid during their shifts.
 4. While we continue to do our weekly checks, staffs is aware of this violation and have better aware of checking all public trashcans.
 5. Extra trashcan lids/covers are here and ready to replace any lids that come up missing. Weekly checks are still being done for compliance.
- ALL STAFF are responsible to meet this regulation. Admin. will oversee.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Nathaniel S Pace	8/5/13

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Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.92 - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Za. DESCRIPTION OF VIOLATION
 Department Representatives observed the window located in bedroom G3 open. The window did not have a screen in place to prevent insect or rodent infestation.

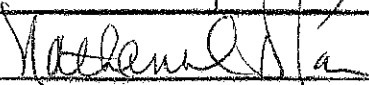
3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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(92) No screen in room. (G-3):
 The screen was in the window the whole time, resident just did not pull it down when he opened the window. The storm window was there as well, blocking your view of the screen. See attached photo.

1. Using the screen allows the resident to receive air from outside without allowing flying/crawling bugs & birds into the room. Safety is the reason for this regulation.
2. The violation happened when resident opened the window, raised the storm window and did not pull the screen down.
3. Violation was caused by staff not correcting the resident on the need of the screens and seeing to it that the screen is in place.
4. Check all windows for screens. If there are any that are not present, close window and document in communication book. Make sure that all air conditioners are installed properly, blocking the opening(s) with cardboard or Styrofoam.
5. During our building checks, be aware of the screens when you are entering or leaving the building. When/if you see any open window without a screen, close it or pull the screen down, inform the resident that they must have a screen to open the window. This is a great way to protect the integrity of the building.
6. ALL STAFF are responsible to make sure that there are NO open windows that don't have a screen. Then notify Admin. so that he can order/purchase needed screens.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	12/14/2012	
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Signature of Legal Entity Representative
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
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Nathaniel J. Pace

8/5/13

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Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS FACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION
 Department Representatives observed the refrigerator located in the common area of the J Wing. The refrigerator handle is loose and hanging from two loose screws attached to the top of the door. The bottom of the handle is completely detached from the bottom of the door. The sharp edges of the handle as well as the loose screws are a safety hazard to any resident utilizing the refrigerator.

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.

- (95) Refrigerator handle was attached at the top, however, loose at the bottom, all appliances must be in good operating condition.
1. All equipment/appliances must be in good operating condition for the safe use of the resident.
 2. The handle to the refrigerator was ajar/loose and needed to be repaired.
 3. Constant use of opening and refrigerator pulled the screw out of the handle and caused the violation.
 4. Administrator replaced the screw on the refrigerator in order to be compliant with this regulation.
 5. Continue making our weekly checks (building). Kitchenettes are on that list, this is a sure fire way to keep up on these incidents and also be pro-active in our repairs.
 6. All Staff are required/responsible to inform Admin. of any/all repairs that need to be completed asap. Administrator will oversee repairs & compliance.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	12/14/2012	
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Signature of Legal Entity Representative
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Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Date 8/5/13

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Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.100(a) - The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION
 Department Representatives observed the sidewalk directly in front of the main entrance of the home. The sidewalk has numerous areas where the concrete has cracked and been removed. The removal of the concrete has created several large areas where the surface of the sidewalk drops 3 inches causing an uneven walking surface. There are also areas where the concrete has cracked, however has not been removed. When stepped upon, these concrete pieces move and wobble also causing an unsafe walking area for residents of the home.

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.

(100-A) Sidewalk in need of repair:

1. The regulation protects the safety & welfare of all residents.
2. M-P had to wait for the funds to have the sidewalk repaired.
3. The age of the sidewalk & the salt used to remove the ice/snow during the winter caused the decaying of concrete.
4. M-P sent DPW all of the estimates for the repair, Borough was out 7/31/13 to show Patch-Man what needs to be repaired/cut/replaced. I should have the new estimate within a week, replacement by Oct. 31, 2013
5. How we have tried to prevent this violation was to have a repairman come out and repair as we find new decaying concrete, this is the only thing we can do to try and stay ahead of this.
6. Administrator is responsible for maintaining the integrity of the walkways.

Nathaniel S Pace
 8/5/13

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

Signature of Legal Entity Representative
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Date 8/5/13

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 (Date)

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

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

Violation Report: 21590 - 08/25/2013 - O'Haire, Anne
 PCH Name: MORRIS FACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.101(j)(7) - Each resident shall have the following in the bedroom: An operable lamp or other source of lighting that can be turned on at bedside.

2a. DESCRIPTION OF VIOLATION
 The bed located on the right side of resident room A7 does not have an operable source of bedside lighting.

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.

(107) Bedside lamp did not operate: Knob to turn on lamp was missing, however, if you screwed in the bulb, the light came on.

1. Residents need bedside lamp to navigate at night. (i.e. going to the bathroom, phone call, etc)
2. Lamp did not operate as it should, resident should be able to turn on & off lamp.
3. The knob was unscrewed and lost.
4. The lamp was replaced during the inspection, M-P has extra lamps on hand.
5. While we are doing our "Building Check list", we are also turning on and off lamps as we go through the rooms.
6. ALL STAFF are responsible for making sure that bedrooms have bedside lamps, Admin. will oversee and remind staff.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Maureen D. Face

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Maureen D. Face</i>	<i>8/5/13</i>

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

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- Not Implemented

The above plan of correction was approved by *[Signature]*
 (Initials)

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.105(g)(1) - To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

2a. DESCRIPTION OF VIOLATION
 Department Representatives observed a 1/2 inch thick coating on the lint box of the home's industrial size dryer. It was determined through staff interviews that the lint buildup was caused by staff not cleaning out the lint box when removing previous loads of laundry. Not regularly removing lint from the dryer greatly increases the risk of a fire within the personal care home.

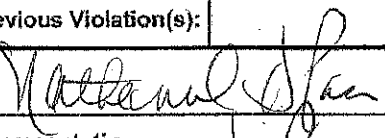
3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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(105) Dryer lent screen was full:

1. Dryer lent has been the cause of several fires in PCH's.
2. We as staff members must be aware to check and clean lent filter EVERY TIME we dry clothes
2. Staff did not clean the dryer lent screen after every load as required.
3. Administrator had a meeting and created a check list that hangs outside of the dryer room & in the Med Room on the top of the med cart for staff to initial when the lent screen is cleaned daily. Night staff check during their shift, day shift has to check first thing BEFORE passing any meds to ensure that we all are managing this.
4. Remind staff that we must clean these filters after every cycle and involve all staff so that there aren't any gaps in coverage of this.
5. As we move forward, M-P will be making every attempt to check & clean when we walk by the dryer room. Doing this will help us stay on top of issue.
6. ALL STAFF are responsible for this. Admin. will oversee, remind, check periodically.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page)



Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
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NATHANIEL PACE

8-5-13

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Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600

2600.143(a) - The home shall have a written emergency medical plan that includes the following:

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

2a. DESCRIPTION OF VIOLATION

The home's emergency medical plan did not contain all the required elements to comply with this regulation. The home did not state what emergency transportation it would utilize in the event of a medical emergency and if residents' had a choice in utilizing this service. The home did not have a staffing plan in place in the event of an emergency that required additional 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.

(143A) Emergency Medial Plan:

- 1. Residents/DPW needs to know that during an emergency, there are Policies in place at Morris-Pace to assist the residents in anyway possible. There safety must come first.
- 2. M-P did not have, in our Emergency Preparedness Plan/Policy, Emergency staffing listed, we have 2 of the 3 required. (see Emergency Preparedness)
- 3. There was not a staffing plan for emergencies, leaving a gap in this policy.
- 4. M-P has had Live-in Staff for such emergencies. In the event that my regular staff are not able to come in, my Live-in staff has agreed to step in until the regular staff are able to get in, this is in their contract.
- 5. Keep this "Emergency Medical Plan" in place and current with the needs of the resident. (see attached)
- 6. The Administrator will be responsible for this policy being in place and current.

Nathaniel Pace
 8/5/13

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Nathaniel Pace</i>	8/5/13

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The above plan of correction is approved as of <u>8-20-13</u> (Date)	Plan of correction implementation status as of <u>8-20-13</u> (Date)
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| The above plan of correction was approved by <u><i>[Signature]</i></u>
(Initials) | <ul style="list-style-type: none"> <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented |
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Violation Report: 21500 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION

The Humalog 75/25 mix Quick Pen prescribed for resident # 2 was not dated to indicate when it was opened.
 The Lantus Solostar 100u. Insulin pen prescribed for resident # 3 was not dated to indicate when it was opened.

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.

~~(b)(7)(C)~~ Some Insulin pens did not have the sticker on them indicating the "open & expiration date".

1. Regulations require that all insulin be dated to ensure the proper use.
2. Insulin was not dated as required.
3. Med staff (Nate) did not attach sticker to insulin pen when he put another pen inside of the zip lock bag.
4. M-P has attached yellow stickers to each pen, whether open or not. (see attached)
5. When Med cart has its weekly check, insulin is checked to ensure that the pens/boxes of insulin has a yellow sticker on it that informs when opened and expired.
6. Administrator will be responsible for making sure that pens/insulin are dated.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
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The above plan of correction was approved by <u>[Signature]</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

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

187a: Resident # 1 is prescribed Lopressor .5mg, take ½ tablet daily. The resident's Medication Administration Record incorrectly states the dose of the medication. The MAR documents Lopressor .5mg, take 1 tablet daily.

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 pages

Repeat Violation: Yes	Date(s) of Previous Violation(s):	12/14/2012	
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Nathan E. D. Pace*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Nathan E. D. Pace</i>	Date <i>8/5/13</i>
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The above plan of correction is approved as of 8-29-13
 (Date)

Plan of correction implementation status as of 8-29-13
 (Date)

The above plan of correction was approved by *EP*
 (Initials)

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

14a

9

17

(187A) Resident 1's med. was written incorrectly on MAR due to following the info on script. The script (see attached) is written 12.5mg tab when the tab only comes in 25mg tabs. This is an issue that we could not have known about. The Pharmacist informed us that there is no 12.5mg tab., even though the script says it, and staff followed the script except left off the (1) in the 12.5mg.

1. Medication administration is the MOST important service we do when trying to keep residents healthy.
2. When you document on the MAR's, there must be a unified charting on the Med & MAR when the Med. comes into the facility. This was not the case.
3. Lopressor was written on MAR differently (2.5mg) than on the Med sheet on the back of the planner from the Pharmacy (25mg).
4. Staff corrected the error on MAR during inspection. Staff will follow the EXACT writing on the script AND check to be sure that when the Med comes in, they match.
5. M-P will be doing our weekly check on the MAR's and what's in the Medi-planner. If there is an inaccurate count, the Medi-planner goes back for adjustment.
6. Med staff will be responsible for checking, Admin. will be checking the "Med Planner" check list for compliance.

Orlene Stinson
8/29/13

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600

2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION

The medication Benzotropine Mesylate 1mg, prescribed for resident # 3 (admitted 6/1/13) was listed in the Medication Administration Record and initialed by staff indicating it was administered to resident # 3 from 6/21/13 to 6/25/13 however the medication was not on hand for five days.

Department Representatives reviewed the Medication Administration Record (MAR) for resident # 4. On 6/21/13 resident # 4 was prescribed Nareglinide 60mg, take one tablet 3 times daily before meals for Diabetes. A review of the MAR's determined that the medication was initialed as administered from 6/21/13 through 6/25/13; however this medication has not been on hand at the facility for staff to administer this medication to resident # 4. This medication was not available for 5 days. Staff are not properly recording and documenting on the MAR when the medication is being administered as required.

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.

(187B&D) Resident # 3 & 4 did not have all meds in the planner. Pharmacy sent over their paper work for checking the planners. We will be using these Physicians orders to verify our count every week. Pharmacy has their count on the front page for us to follow, every month we will be getting these pages to ensure our count is the same as theirs.

1. All prescribed medications must be administered & documented correctly at there prescribed times.
2. Medication was not in planner when the Pharmacy delivered it, M-P did not check the count.
3. Any medication that is not administered is a med error.
4. Pharmacy picked up the planner (6/25/13, placed the med inside and returned it to the facility (6/25/13).
5. Now that M-P has a check list for the planners, we (Med staff) will be checking the planners as they come in. We have 2 different med staff checking every Friday for compliance.
6. Med staffs are responsible for preventing this violation. Admin. will be checking the Med-planner check list too.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Nathaniel S Pace

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

NATHANIEL S PACE

Date

8/5/13

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The above plan of correction is approved as of

8-29-13
 (Date)

Plan of correction implementation status as of

8/29/13
 (Date)

The above plan of correction was approved by

QP
 (Initials)

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

Violation Report: 21550 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

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

2a. DESCRIPTION OF VIOLATION

Benztropine Mesylate 1mg. prescribed for resident #3 (admitted 6/1/13) was not on hand. The medication was initialed by staff in the Medication Administration Record as being administered to resident # 3 from 6/2/13 to 6/25/13. The resident did not receive the medication as prescribed by the physician.

Resident #4 is prescribed Nareglinide 60mg, take 3 times daily before meals for Diabetes. It was determined that this medication has not been on hand at the facility since the original order date of 6/21/13 and therefore has not been administered to the resident as prescribed by the physician.

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.

(187B&D) Resident # 3 & 4 did not have all meds in the planner. Pharmacy sent over their paper work for checking the planners. We will be using these Physicians orders to verify our count every week. Pharmacy has their count on the front page for us to follow, every month we will be getting these pages to ensure our count is the same as theirs.

1. All prescribed medications must be administered & documented correctly at there prescribed times.
2. Medication was not in planner when the Pharmacy delivered it, M-P did not check the count.
3. Any medication that is not administered is a med error.
4. Pharmacy picked up the planner (6/25/13, placed the med inside and returned it to the facility (6/25/13).
5. Now that M-P has a check list for the planners, we (Med staff) will be checking the planners as they come in. We have 2 different med staff checking every Friday for compliance.
6. Med staffs are responsible for preventing this violation. Admin. will be checking the Med-planner check list too.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/12/2013	12/14/2012
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Signature of Legal Entity Representative
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Nathaniel S. Pace* Date *8/5/13*

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 (Date)

Plan of correction implementation status as of 8/29/13
 (Date)

The above plan of correction was approved by *OO*
 (Initials)

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

Violation Report: 21590 - 06/25/2013 - O'Haire, Anne
 PCH Name: MORRIS PACE PERSONAL CARE

1. REGULATION 55 Pa.Code §2600
 2600.190(c) - A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

2a. DESCRIPTION OF VIOLATION
 The home did not maintain ongoing medication training records pertaining to those staff persons who were medication trained. The home did not maintain the annual practicum worksheets for the 2 required medications pass observations and 4 MAR's reviews. No annual student certification forms were present in their training record.
 Staff person "A" received medication training 12/2008 and staff person "C" received medication training in 3/2010 their training record contained their original training record and only the annual summary sheets.

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.

(190C) Med. Cert. Training documents not done annually.

1. Med Cert training and documentation is important to show that Med staff is being trained properly and timely.
2. Nate (Admin. & Trainer) did not use the training documents need to show proof of training.
3. Nate (Admin. & Trainer) did not have the documents the inspector needed. I was told by the Train to Trainer that I did not need to keep any additional documents other than the Annual Training Practicum.
4. DPW Inspector gave me the needed documents to be compliant. I appreciated this assistance greatly.
5. When Admin./Med Trainer does the Annual practicum, that had to be completed on a quarterly basis, this will be done in order to be compliant.
6. Admin./Med Trainer will be responsible for compliance.

Repeat Violation: No	Date(s) of Previous Violation(s):	
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Nathaniel S Pace*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Nathaniel S Pace</i>	Date <i>8/5/13</i>
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The above plan of correction was approved by *NS*
 (Initials)