pennsylvania
DEPARTMENT OF PUBLIC WELFARE

OCT 0 9 2014

Ms. Lisa Johnson, CEO
Bradford Ecumenical Home, Inc.
100 St. Francis Drive
Bradford, Pennsylvania 16701

RE: Chapel Ridge
200 St. Francis Drive
Bradford, Pennsylvania 16701
License #: 426420

Dear Ms. Johnson:

As a result of the Department of Public Welfare's licensing inspection on July 24, 2014 and July 25, 2014, 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 must be maintained.

Your regular license for the period November 10, 2014 to November 10, 2015 was issued on July 30, 2014. Your regular license remains in good standing.

Sincerely,

Matthew J. Jones
Director
JH

Enclosure
License Inspection Summary

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

PCH Name: CHAPEL RIDGE	License Number: 42642
Address: 200 ST FRANCIS DRIVE, BRADFORD, PA 16701	County: McKean
Administrator: Lisa Johnson	Region: WEST
Legal Entity Name: BRADFORD ECUMENICAL HOME INC	
Legal Entity Address: 100 ST. FRANCIS DRIVE, BRADFORD, PA 16701	

Certificate(s) of Occupancy

C-2 LP
09/19/1996
L&I

Staffing Hours

Resident Support: 0 | Total Daily Staff: 58 | Waking Staff: 44

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

Reason(s) for Inspection(s)

Renewal, Incident

On-Site Inspections Dates and Department Representatives On-Site

07/24/2014: Williams, Jason; McConnell, Deb
07/25/2014: Williams, Jason; McConnell, Deb

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: 112

Number of Residents Served: 58

Secured Dementia Care Unit in Home: No

Area:

Secured Dementia Unit Capacity, if Applicable:

Number of Residents Served in Secured Dementia Care Unit, if applicable:

Number of Current Hospice Residents: 0

Number of Hospice Residents in past year: 1

Number of Residents who:

Receive Supplemental Security Income: 6

Are 60 Years of Age or Older: 1

Have Mental Illness: 2

Have an Intellectual Disability: 0

Have a Mobility Need: 0

Have a Physical Disability: 0

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

1. REGULATION 55 Pa.Code §2600

2600.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure

2a. DESCRIPTION OF VIOLATION

On 7/24/14 at 9:20 AM, the records for Residents #1, #2, #3 and #4 were in an unlocked cupboard in the first floor Resident Care Station with no staff person present. There was also a clipboard on the wall of this station with the toileting schedules for Residents #1, #5 and #6.

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.

Immediate Correction: At the time of inspection and when brought to the attention of the Administrator, the unlocked cupboards containing Resident records #1, #2, #3, and #4 were immediately locked. Posted clipboard that contained the toileting schedule for Residents #1, #5, and #6 was also immediately removed and placed in locked cupboard.

Ongoing, step-by-step plan to assure continued compliance:

a. All authorized users were educated on Chapel Ridge's policy (see attached) regarding confidentiality, accessibility, security and storage of resident records.
b. The Health Information Management personnel created an audit log that will monitor and document record security at various times and days (i.e., resident record cupboards and medication cart closet is locked); Findings will be presented to the Administrator.
c. The Administrator will report audit findings at the next three (3) Quality Management meetings (meetings held quarterly).
d. Any findings of non-compliance will lead to employee discipline.

As an extra measure, locks on the cupboards containing resident records (i.e., medical records, clipboards, transfer sheets, etc.) were changed by a professional locksmith. New master keys were only issued to authorized users that are named within our policy.

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) Lisa Johnson, CEO

Date 9-11-2014

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

The above plan of correction is approved as of 9-17-14 (Date)

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

Plan of correction implementation status as of 9-17-14 (Date)

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

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

1. REGULATION 55 Pa.Code §2600
2600.129(a) - A fireplace must be securely screened or equipped with protective guards while in use.

2a. DESCRIPTION OF VIOLATION
On 7/24/14, the gas fireplace in the home's first floor sitting room was in use. During this time the metal frame of the fireplace measured 130.4 fahrenheit with no protective guard to prevent residents from coming in contact with the metal frame.

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

Immediately after discovering the gas fireplace was on, the unit was turned off; no longer generating heat. The fireplace guard was also immediately put in place. In the future, the secure fireplace guard will be left in place at all times to ensure that residents maintain a safe distance from heat source. Maintenance Department will monitor secure, proper placement of fireplace guard. All staff will be responsible for ensuring resident safety when fireplace unit is in use. Please see attached Fireplace Unit Policy and Procedure.

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

Signature of Legal Entity Representative (Required on EVERY Page) Lisa Johnson

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Lisa Johnson, CEO

Date 9-11-2014

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The above plan of correction is approved as of 9-17-14 (Date)

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

Plan of correction implementation status as of 9-17-14 (Date)

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

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

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
The home's consistently has only 2 staff working on the 10:30 PM to 6:30 AM shift. According to the fire drill log, the fire drills conducted on 6/29/14 at 11:50 PM and on 3/26/14 at 4:45 AM both had 4 staff persons participating. The fire drills conducted on 12/21/13 at 12:41 AM and on 8/17/13 at 11:51 PM both had 3 staff persons participating.

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

Environmental Services Supervisor recognizes that only staff scheduled to be on duty will be counted as staff participating. Anyone in facility that is monitoring fire drill will not be included in this count. Administrator will monitor fire drill log after each fire drill along with schedule to ensure we are in compliance with counting only staff scheduled.

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

Signature of Legal Entity Representative (Required on EVERY Page) Lisa Johnson

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

Date 9-11-2014

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

Plan of correction implementation status as of 9-17-14 (Date)

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

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

1. REGULATION 55 Pa.Code §2600
144(c)(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

2a. DESCRIPTION OF VIOLATION
The home's smoking area is located just outside the exit doors leading to the back patio. There are picnic tables directly outside of each exit door with ash trays on them. A sign on the wall directly outside these doors says "Designated Smoking Area".

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.

Smoking is prohibited inside the building at Chapel Ridge. Resident smoking is permitted outside the building only in designated safe distance smoking areas. Designated smoking area has been changed from the back patio to a gazebo located to the far right of the building. Director of Environmental Services and Administrator coordinated the purchase of a gazebo that is designed as the smoking area for residents. The gazebo is a safe distance from heat sources, hot water heaters, combustible or flammable material and away from common walkways and exits.

Non-combustible ashtrays and/or outposts are provided for smoking in designated smoking area.

An assessment will continue to be performed on all residents who wish to smoke to determine if they are capable of smoking without supervision. All smokers will be reassessed annually according to RASP schedule and as determined by a change or decline in health status to insure they remain safe to smoke independently. Residents who smoke must sign a Smoking Policy Agreement which is attached as an Addendum to their Admission Agreement. The Smoking Policy Agreement specifies the resident's acknowledgement and agreement of designated smoking area.

A copy of the facility Policy and Procedure regarding Smoking is posted for all residents, employees and visitors. Administrator will review facility Smoking Policy with residents during Resident's Meeting on October 7, 2014.

Attached is a copy of facility Smoking Policy and Procedure, Resident Smoking Assessment and Resident Smoking Policy Agreement.

Immediately: A designated staff member on each shift will monitor the home on a daily basis for 3 weeks then 14 a month afterwards to ensure residents are smoking in the designated smoking area and away from common walkways and exits. AJP 9-17-14

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) Lisa Johnson, CEO

Date 9-11-2014

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

Plan of correction implementation status as of 9-17-14 (Date)

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

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

1. REGULATION 55 Pa.Code §2600
2600.162(c) - Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

2a. DESCRIPTION OF VIOLATION
The home does not post the breakfast portion of its menu one week in advance. It is posted daily at the tables in the dining room.

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 the time of inspection, all menu cycles were updated to include the breakfast meal. In addition, residents continue to receive a daily menu at their table setting to incorporate restaurant style dining and provide menu options and personalized service. Chapel Ridge has menus posted and displayed, at minimum, one week in advance. Weekly menus are posted on the first floor bulletin board across from the Activity Room in addition to scrolling daily menus on the large screen telegenda that is in the Front Lobby.

Administrative Assistant is responsible to post menus on a weekly basis. To ensure similar violation will not reoccur, Administrator and/or Dietary Supervisor will confirm complete menus are posted by checking weekly for three (3) months. A log has been created to monitor the menu postings and will be reported at Quality Management Meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Lisa Johnson

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Lisa Johnson, CEO Date 9-11-2014

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The above plan of correction is approved as of 9-17-14 (Date)

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

Plan of correction implementation status as of 9-17-14 (Date)

- [X] Fully Implemented QMP
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

1. REGULATION 55 Pa.Code §2600
2600.171(b)(5) - If staff persons or volunteers of the home provide transportation for the residents, the vehicle must have a first aid kit with the contents in § 2600.96 (relating to first aid kit).

2a. DESCRIPTION OF VIOLATION
On 7/24/14, the first aid kit in the Mazda van used to transport residents did not contain eye coverings.

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

Eye coverings were immediately placed in First Aid kit located in the Mazda van. A First Aid kit checklist was developed and implemented August 2014 to ensure all required contents are in First Aid kit. Please see attached for sample of checklist. The Transportation Aide of the Mazda van will be responsible for completing checklist monthly. Completed forms will be kept in a folder and monitored by Administrator to ensure compliance.

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

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

Date 9-11-2014

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The above plan of correction is approved as of 9-17-14 (Date)

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

Plan of correction implementation status as of 9-17-14 (Date)

- [X] Fully Implemented GSP
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

1. REGULATION 55 Pa.Code §2600
2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
(1) The resident's name.
(2) The name of the medication.
(3) The date the prescription was issued.
(4) The prescribed dosage and instructions for administration.
(5) The name and title of the prescriber.

2a. DESCRIPTION OF VIOLATION
Resident #7 is ordered Natural Fiber Lax Powder, dissolve 10 ml in 8 ounces of water every morning as needed for constipation. The medication label indicates to dissolve 3/4 scoop in 8 ounces of water every morning.

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

In keeping within the Regulation Code 2600.184(A), if a medication comes into the facility with the wrong prescribed dosage on the label, it will be immediately returned to the Pharmacy for a corrected label. If we are unable to immediately obtain a correct label on that medication, a warning label will be placed over the incorrect order to alert staff of the change to prevent a med error from occurring until a replacement medication with correct dosage can be delivered.

☒ DIRECTIONS CHANGED REFER TO CHART

New labels were ordered from the Pharmacy.

Staff will monitor label on routine medications each shift to make sure warning label is attached. On PRN medication, staff will monitor daily until replacement med arrives.

Pharmerica will send a consultant to perform med cart audits each month and staff will perform a monthly audit. Medication in question was properly disposed of.

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

Date 9-11-2014

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Plan of correction implementation status as of 9-17-14 (Date)

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

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

SEP 24 2014

WEST REGION FIELD OFFICE
Human Service Licensing

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 preadmission screening form, dated 9/27/13, for Resident #7, admitted 10/28/13, was completed more than 30 days prior to the resident's admission date.

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.

It was recognized that Resident #7 had his preadmission screening 31 days prior to admission. A Preadmission Screening Policy and Procedure has been provided outlining that a preadmission screen will be done the day of or 30 days prior to admission. Chapel Ridge Administrator reviewed all resident records verifying compliance of preadmission screen dates. In the future, the Administrator will be responsible for monitoring preadmission screening documentation to ensure completion per 2600.24(a) guidelines.

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

Signature of Legal Entity Representative (Required on EVERY Page) Lisa Johnson

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

Date 9-11-2014

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

Plan of correction implementation status as of 9-17-14 (Date)

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

Violation Report: 42642 - 07/24/2014 - Williams, Jason
PCH Name: CHAPEL RIDGE

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 assessment, dated 9/4/13, for Resident #8, does not address the diagnoses of arteriosclerotic cardiovascular disease, intraluminal coronary artery stent, cerebral vascular accident, noninsulin-dependent diabetes mellitus, or atrial fibrillation from resident's #8's medical evaluation, dated 7/9/14.

-The assessment, dated 5/15/14, for Resident #9, does not address the diagnosis of prostate cancer from resident #9's medical evaluation, dated 5/1/14.

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.

To keep in compliance with Regulation 55 PA Code 2600.225(a), correction was made to Resident #8 assessment adding missing diagnosis and plan to meet and support that diagnosis.

For Resident #9, the missing diagnosis of prostate, CA was added to the assessment and the plan to meet and support that diagnosis.

To prevent similar incidents from occurring again, the assessment and support plan will be reviewed by both the Nurse Manager and Administrator upon completion. Routine chart audits will be done on a regular basis by Medical Records and a quarterly audit to be done by the Pharmacy consultant to monitor compliance.

Within 30 days of receipt of the approved plan of correction, the administrator or designated staff member will review all current resident assessments for accuracy and completion including use current diagnoses. JHP 9-17-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Lisa Johnson

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

Date 9-11-20[illegible]

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

The above plan of correction is approved as of 9.17.14 (Date)

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

Plan of correction implementation status as of 9-17-14 (Date)

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