pennsylvania
DEPARTMENT OF HUMAN SERVICES

DEC 0 9 2014

Ms. Caroline DeAugustine, Executive Director
Shenango Presbyterian Seniorcare
238 South Market Street
New Wilmington, Pennsylvania 16142

RE: Shenango Presbyterian Home
License #: 440340

Dear Ms. DeAugustine:

As a result of the Department of Human Services' licensing inspection on October 2, 2014 and October 3, 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 3, 2014 to November 3, 2015 was issued on August 29, 2014. Your regular license remains in good standing.

Sincerely,

Matthew J. Jones
Director

Enclosure
License Inspection Summary

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

PCH Name: SHENANGO PRESBYTERIAN HOME	License Number: 44034
Address: 238 SOUTH MARKET STREET, NEW WILMINGTON, PA 16142	County: Lawrence
Administrator: Shawna Bostaph	Region: WEST
Legal Entity Name: SHENANGO PRESBYTERIAN SENIORCARE	
Legal Entity Address: 238 SOUTH MARKET STREET, NEW WILMINGTON, PA 16142	

Certificate(s) of Occupancy

C-1
04/12/2014
Labor and Industry

Staffing Hours

Resident Support: 0	Total Daily Staff: 58	Waking Staff: 44
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

10/02/2014: Cutter, Jan; McConnell, Deb
10/03/2014: Cutter, Jan; 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: 54	Number of Residents who:
Number of Residents Served: 44	Receive Supplemental Security Income: 2
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 44
Area: first floor	Have Mental Illness: 0
Secured Dementia Unit Capacity, if Applicable: 14	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, if applicable: 13	Have a Mobility Need: 14
Number of Current Hospice Residents: 3	Have a Physical Disability: 0
Number of Hospice Residents in past year: 13	

RECEIVED
NOV - 2014
Human Services Licensing

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

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 10/2/2014 at 12:05 PM the medication administration record (MAR) was sitting on top of the second floor medication cart unlocked and unattended.

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.

1. A cover for the medication carts has been ordered by maintenance so the Medication Administration Record will be covered and locked for privacy at all times. See attachment for picture.
2. Until the cover is installed, MAR will be placed in a secured area or carried by staff.
3. Audit will be done by doing random checks weekly by Personal Care Administrator or designee to ensure that MAR is always covered and locked when not in current use by staff.
4. The personal care home administrator or designee will report at quarterly QA meetings.

Within 30 days of receipt of the approved plan of correction, all staff persons will be educated on the confidentiality of resident records and the procedures for maintaining resident records in a secure location. JKP 11-20-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl, Dir. of Personal Care

Date 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

RECEIVED
NOV

Violation Report: 44034 - 10/02/2014 - Cutler, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

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 provides assistance with financial management for residents #1, #2, #3 and #4. The residents did not sign for disbursements of their funds on the following dates:

* Resident #1 on June 20, 2014.
* Resident #2 on July 2 and July 28, 2014.
* Resident #3 on July 21 and July 28, 2014.
* Resident #4 on July 2, 2014.

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.

1. For October and moving forward, all fund disbursement slips will be signed by resident at the time of disbursement and coordinated by activities staff or designee.
2. All fund disbursement slips will be audited by the financial director or designee each quarter for completion and results will be reported at quarterly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

RECEIVED
NOV

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

2600.84 - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120°F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

2a. DESCRIPTION OF VIOLATION

The water in the steam table in the secure dementia care unit measured 196.5 degrees Fahrenheit at 11:49 AM on 10/2/2014. The steam table and coffee pot were accessible to residents in the kitchen area. Staff do not remain in this area at all times.

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.

1. The coffee pot in the secure dementia unit was removed on 10-6-14.
2. A cabinet maker, [redacted] from Wilmington Case Works, was consulted on 11-4-14 and came to evaluate the steam table and area.
3. The cabinet maker and maintenance director are researching possible material options for building a locked cover to ensure that residents do not have access to the steam table. The goal is to have the cover made by 12-31-14.
4. Until a cover is made, the steam table will be monitored by a staff member while it is on and being used, until a more permanent solution is completed and the steam table will be turned off, covered and monitored by staff as soon as the food is done being served.
5. A line has been added, as of November 4, 2014, to the Woodside monthly safety audit for safety committee member to ensure that heat sources exceeding 120 degrees F are not accessible to residents or are equipped with protective guards or insulation to prevent the resident from coming into contact with the heat source.
6. The audit will be reviewed at monthly safety meetings by the committee beginning in November 2014.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutler, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.89(b) - Hot water temperature in areas accessible to the resident may not exceed 120°F.

2a. DESCRIPTION OF VIOLATION

On 10/2/2014, the water temperature at the sink in the men's common bathroom on the first floor measured 126.5 degrees Fahrenheit at 11:23 AM and 123.9 degrees Fahrenheit at 2:08 PM.

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.

1. The water temperature was adjusted on 10-3-14 by maintenance supervisor.
2. The water temperatures are recorded daily automatically by a computer system.
3. The maintenance director replaced the mixing valve on 11-5-14 to help adjust the water temperatures.
4. The maintenance staff will be doing daily monitoring and recording of the water temperatures with a thermometer, particularly in the first floor men's common bathroom, daily for two weeks beginning on November 3, 2014. They will continue to monitor and record weekly for 6 weeks after. They will then begin monitoring and recording monthly with a thermometer beginning January 1, 2015.
5. Water temperature audits/records will be reviewed at quarterly QA meetings.

Within 30 days of receipt of the approved plan of correction, the staff persons need be educated on safe water temperatures and the risk to residents. Documentation of the education will be kept QMP 11-20-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostph, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.103(f) - Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

2a. DESCRIPTION OF VIOLATION

There was no thermometer in the ice cream freezer in the first floor pantry.

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.

1. A thermometer was placed in the pantry ice cream freezer immediately after inspection on 10-2-14.
2. Dietary staff will do an audit twice a day until the next DPW survey to ensure there is a thermometer in the pantry ice cream freezer.
3. Dietary Supervisor or designee will report at quarterly QA meeting the results of audit.

Within 30 days of receipt of the approved plan of correction, all staff persons involved in food storage and preparation will be educated on proper food storage and safe food storage temperatures. Documentation of education will be kept. JSP (1-30-15)

Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/16/2013		

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostpal

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostpal, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11/30/14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

2600.123(a) - Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

2a. DESCRIPTION OF VIOLATION

The exit gate in the enclosed courtyard of the secure dementia care unit is equipped with a key locking device.

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.

1. The exit gate in the enclosed courtyard was equipped with a keypad and the code was posted on 11-4-14.
2. A line has been added, as of November 4, 2014, to the Woodside monthly safety audit for safety committee member to ensure that the keypad on the exit gate in the courtyard is in good working order and the code is posted.
3. The audit will be reviewed at monthly safety meetings by the committee beginning in November 2014.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph, Dir of Personal Care

Date 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.123(b) - Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

2a. DESCRIPTION OF VIOLATION

The home's and the municipality's emergency preparedness plans were not posted in a conspicuous and public place in 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.

1. The home and the municipality's emergency plans were posted in a public place (in a binder in the front lobby) immediately after the inspection on 10-3-14.
2. Director of Personal Care or designee will do a monthly audit to ensure the home and municipality's emergency plans are posted in a public place and report at quarterly QA meeting the results of the audit.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph, Dir of Personal Care — **Date** 11-18-14

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The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

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 #5 is prescribed 12 units of Novolin N 100u/ml subcutaneously every morning; however, the medication label states 14 units of Novolin N 100u/ml subcutaneously every morning.

Resident #5 is prescribed Novolin R 100u/ml vial sliding scale with each accucheck before meals, inject 10 units subcutaneously every AM and every PM prior to dinner, 5 units subcutaneously at noon hold if blood sugar is below 100; however, the label states Novolin R 100u/ml vial sliding scale with each accucheck before meals.

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.

1. The Veteran's Association was notified that the current order on the resident's insulin was not correct. A new order for insulin was received on 10/30/14 and faxed to the VA to order the resident new insulin with the proper label.
2. Medications received from the various pharmacies will be reviewed upon receipt to ensure the label matches the physician order. If a discrepancy is noted, a sticker titled, "Directions Changed. Refer to Chart" will be placed on the label to notify staff that the directions are not correct and the Pharmacy will be notified of the correct order.
3. Staff to receive education at the 11/13/14 staff meeting to review medication labels to the physician order of any medications received from pharmacies.
4. Audit will be done monthly by Personal Care Administrator or designee to ensure that medication labels match the physician's order.
5. The personal care home administrator or designee will report at quarterly QA meetings.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Rastyph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Rastyph, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutler, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

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 7/1/2014, for resident #1, does not include the physical therapy services which were provided to the resident from 6/23/2014 to 7/29/2014.

The assessment, dated 1/6/2014, for resident #2, does not include that the resident has bilateral lower extremity cellulitis or the need for Jobst stockings.

The assessment, dated 6/30/2014, for resident #4, does not include the physical therapy services which were provided to the resident from 6/19/2014 to 7/15/2014.

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.

1. All current assessments were updated to include therapies, compression stockings and hospice.
2. A Resident Assessment and Support Plan Update form will be added to each resident's current RASP so that space is available to add any updates throughout the year. See attachment.
3. Staff to be educated at the 11/13/14 staff meeting on the form with education given about making updates to assessments and RASPs as orders are received and resident's conditions change.
4. Audit will be done monthly by Personal Care Administrator or designee to ensure that orders are being added to the assessments and RASPs appropriately.
5. The personal care home administrator or designee will report at quarterly QA meetings.

Within 30 days receipt of the approved plan of correction, the Administrator or designee will review all current resident assessments to ensure compression and necessary, including any diagnoses, and Special Services received. GHP 11-20-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bottegal

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bottegal, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.226(a) - The resident shall be assessed for mobility needs as part of the resident's assessment.

2a. DESCRIPTION OF VIOLATION

The assessment, dated 7/1/2014, for resident #1, indicates that the resident requires limited physical or oral assistance to evacuate in an emergency (mobile); however, the medical evaluation, dated 6/5/2014, indicates that the resident requires moderate physical or oral assistance to evacuate in an emergency (immobile).

The assessment, dated 1/6/2014, for resident #2, indicates that the resident requires limited physical or oral assistance to evacuate in an emergency (mobile); however, the medical evaluation, dated 12/16/2013, indicates that the resident requires moderate physical or oral assistance to evacuate in an emergency and is appropriate for admission to the secure dementia care unit (immobile).

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.

1. The medical evaluation for resident #1 was corrected on 11-3-14 by the nurse practitioner. See attachment.
2. The assessment for resident #2 was corrected on 11-2-14 by personal care home administrator.
3. The personal care home administrator or designee will complete an audit quarterly to ensure the DME and assessment correspond.
4. The personal care home administrator or designee will report at quarterly QA meetings.

Within 30 days of receipt of the approved plan of correction, the administrator or designee will review the current resident assessments for accuracy including mobility assessment matching the current medical examination. JSP 11-20-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph, Dir of Personal Care

Date 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutter, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

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

The support plan, dated 7/1/2014, for resident #1, does not include the physical therapy services which were provided to the resident from 6/23/2014 to 7/29/2014.

The support plan, dated 1/6/2014, for resident #2, does not indicate how the staff will assist the resident with bilateral lower extremity cellulitis or with donning Jobst stockings. In addition, the support plan does not include the physical therapy services which were provided to the resident from 4/16/2014 to 4/30/2014.

The support plan, dated 6/30/2014, for resident #4, does not include the physical therapy services which were provided to the resident from 6/19/2014 to 7/15/2014.

The support plan, dated 7/29/2014, for resident #6, does not indicate what services and how often the services of Family Hospice will be provided.

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.

1. All current RASPs have been reviewed with updates made regarding therapies, compression stockings and hospice.
2. A Resident Assessment and Support Plan Update form will be added to each resident's current RASP so that space is available to add any updates throughout the year. See attachment.
3. Staff to be educated at the 11/13/14 staff meeting on the form with education given about making updates to RASPs as orders are received and resident condition's change.
4. Audit will be done monthly by Personal Care Administrator or designee to ensure that orders are being added to the RASPs appropriately.
5. The personal care home administrator or designee will report at quarterly QA meetings.

within 30 days of receipt of plan approved plan of correction, the administrator or designee will review assessment, resident support plans to ensure completion date accuracy, including each resident's care needs and services GHP 11-20-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bistopl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bistopl, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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

Violation Report: 44034 - 10/02/2014 - Cutler, Jan
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.231(b) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION

The medical evaluation, dated 3/14/2014, for resident #3, did not document the resident's need to be served in a secured dementia care unit.

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.

1. Medical evaluation for resident #3 corrected on 11-3-14 by nurse practitioner. See attachment.
2. Personal care home administrator or designee will complete an audit quarterly of all new admissions to ensure the DME accurately reflects resident's need for secured dementia unit.
3. Personal care home administrator or designee will report at quarterly QA meetings.

Within 30 days of receipt of the approved plan of correction, the administrator or designee will review the current resident's medical evaluation to ensure the resident's need to be served in a secured dementia care unit is documented. JHP 11-20-14

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M. Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M. Bostaph, Dir of Personal Care — **Date** 11-18-14

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

The above plan of correction is approved as of 11-20-14 (Date)

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

Plan of correction implementation status as of 11-20-14 (Date)

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