



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

APR 13 2015

Ms. Kim Salvo, Administrator  
Baptist Homes Society  
489 Castle Shannon Boulevard  
Pittsburgh, Pennsylvania 15234

RE: Providence Point  
200 Adams Avenue  
Pittsburgh, Pennsylvania 15243  
License #: 441430

Dear Ms. Salvo:

As a result of the Department of Human Services' licensing inspection on October 31, 2014 and November 7, 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 January 4, 2015 to January 4, 2016 was issued on October 2, 2014. Your regular license remains in good standing.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Jones".

Matthew J. Jones  
Director

Enclosure  
License Inspection Summary



Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

On 10/9/14, at approximately 9:00 a.m., a visitor reported an allegation of abuse to staff person D; however, staff person D did not immediately report this allegation to the local area agency on aging.

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

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

- Staff person D was educated on proper reporting procedures of abuse by using the 2600.00 Pennsylvania Code Title 55 and the Providence Point personal Care Policy 104 "Preventing Resident Abuse." This was completed in October 2014 for staff person D. Please see attached signature sheets. The education that was provided to staff person D was supervised by Jennifer Ward, Assistant Director of Nursing Healthcare.
- Formal ACT 13 training on "Mandatory Abuse Reporting Requirements" was conducted by [redacted] for all staff of Personal Care and Skilled Nursing on February 25, 2015. See attached information and staff signatures. Any staff member who was unable to attend this training will be given the annual training that is conducted in Personal Care for Older Adult Protective Services Act (see attached information). [redacted], Medication Aide, is responsible to distribute information and have staff sign off on education. Completion of education on OAPSA will be by March 15, 2015.
- Maintenance process is OAPSA information reviewed and provided to each employee as a handout (see attached) to all new hires during orientation and annually to comply with regulatory requirements of 65 f and g. confirmation of received education will be on DHS Record of Training. Responsible parties: [redacted] Medication Aide and [redacted] PCHA.

On 10/14/14 at 4:30 p.m., the allegation of abuse was reported to the local Area Agency on Aging.

SMP 3/11/15

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

Signature of Legal Entity Representative (Required on EVERY Page) *Kim Salvio, PCHA*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Kim Salvio, PCHA* Date *2/25/15*

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

The above plan of correction is approved as of 3-11-15 (Date)

Plan of correction implementation status as of 3-11-15 (Date)

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

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

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

MAR 03 2015

1. REGULATION 55 Pa.Code §2600

2600.15(b) - If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

WEST REGION FIELD OFFICE  
Human Services Licensing

2a. DESCRIPTION OF VIOLATION

On 10/13/14, an allegation of abuse against direct care staff person A was reported to staff person C, the home's administrator. Direct care staff person A was suspended on 10/14/14; however, returned on 10/27/14 and worked unsupervised from 1:00 p.m. to 6:00 p.m. Direct care staff person A returned to work prior to the conclusion of the Department's investigation.

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

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

- Staff person A's employment has been terminated as a result of the abuse investigation by Area Agency on Aging and Department of Human Services.
- Staff person A was terminated on: 10/27/14 <sup>SUP</sup> 5-11-15
- Prevention of further occurrence will be that all management at Providence Point Personal Care (██████████ PCHA, ██████████, RN Supervisor, ██████████, HR Coordinator) will not allow any employees who are on Administrative Leave pending investigation for abuse to return to work for any reason (including education) until Department of Human Services finalizes the investigation and makes a determination. See Providence Point Policy 104 "Preventing Resident Abuse" page 4/7 section V. (b).
- ██████████ PCHA: ██████████ RN Supervisor, and ██████████ HR Coordinator along with all Licensed Nursing staff in Personal Care education on Policy by March 15, 2015.

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

Signature of Legal Entity Representative (Required on EVERY Page) *Kim Salvio, PCHA*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Kim Salvio, PCHA*      Date *2/25/15*

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

The above plan of correction is approved as of 3-11-15 (Date)

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

Plan of correction implementation status as of 3-11-15 (Date)

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

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.65(f) - Training topics for the annual training for direct care staff persons shall include the following:

- (1) Medication self-administration training.
- (2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- (3) Care for residents with dementia and cognitive impairments.
- (4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
- (5) Personal care service needs of the resident.
- (6) Safe management techniques.
- (7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person B did not receive annual training in the following topics during training year 2013:

- \* Medication self-administration
- \* Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

3. PL

- Incl* 1. Current practice is that regulated training is conducted per schedule monthly. Any employee who is unable to attend training on date provided, will be identified by designee in charge of training, and be given another form of training such as a handout or video on the training needed. *completed*
- imm* 2. Added to the above practice will be that those unable to attend the training (which is conducted on the third Wednesday of every month) will have the training completed by the following month.
- 3. Direct care staff person B has been on FMLA since January 13, 2015. Prior to return, direct care staff person B will complete training on Medication Self Administration and Instructions on meeting the needs of residents as described in the pre admission screening form, assessment tool, medical evaluation and support plan. Her expected date of return to work is April 1, 2015 but may be extended. Will send follow up on if employee returns to work by 4-1-15. Responsible party: PCHA.
- 4. Maintenance and prevention: will audit training monthly to ensure all staff is up to date with training.
- 5. Responsible party: PCHA or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page)	Kim Salvio, PCHA
--	------------------

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Kim Salvio, PCHA	2/25/15

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

The above plan of correction is approved as of 3-11-15  
(Date)

Plan of correction implementation status as of 3-11-15  
(Date)

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

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

MAR 23 2015

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

WEST REGION FIELD OFFICE  
Human Services Licensing

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

2a. DESCRIPTION OF VIOLATION

On 10/31/14, there were multiple food particles splattered on the bottom and sides of the secured dementia care unit's (SDCU) kitchenette microwave.

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

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

The SDCU kitchenette microwave was cleaned at the time of inspection on 10/31/14.

*3/16/15*

1. Education for Personal Care Staff in cooperation with Dining Service staff will be conducted and completed by March 15, 2015 to institute the protocol that both departments are responsible to clean and ensure continued cleanliness of appliances after meals and use daily.
2. Maintenance of this process will be verified daily by LPN/Medication Aide on evening shift and documented on log that will be kept in Nursing Care Base.

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

Signature of Legal Entity Representative  
(Required on EVERY Page) *Kim Servio, PCHA*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Kim Servio, PCHA* Date *3/25/15*

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

The above plan of correction is approved as of 3-11-15  
(Date)

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

Plan of correction implementation status as of 3-11-15  
(Date)

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

Violation Report 44143 - 10/31/2014 - Rosol, Jennifer

PCH Name: PROVIDENCE POINT

WEST REGION FIELD OFFICE  
Human Services Licensing

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

On 10/31/14, at 11:20 a.m., the temperature in the freezer in the kitchenette off of the 1st floor dining room measured 8° Fahrenheit.  
On 10/31/14, at 11:47 a.m., the temperature in the ice cream freezer in the 3rd floor kitchenette measured 23° Fahrenheit.

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. Ice cream freezer thermometer was not correctly placed at time of inspection on 10-31-14.
2. Ice cream freezer thermometer was properly placed under ice cream shelf at time of survey on 10-31-14 by Dining Supervisor, [REDACTED]
3. Maintenance process is: temperatures of ice cream freezer and all other refrigeration appliances have temperatures checked and recorded twice daily by dining staff at open of shift (7am) and close of shift (7:30pm) and logged on a temperature log document which is located in the kitchenette on the side of the refrigeration appliances.
4. Log or documentation information is maintained by dining services.
5. If temperature is out of compliance, the dining staff notifies the dining manager.
6. Dining staff will be re-educated by Dining Supervisor, [REDACTED] on maintenance of proper temperatures on refrigeration appliances and procedures when temperatures are out of compliance.
7. Dining staff will be educated on regulation 2600.103 by [REDACTED]
8. Responsible party: [REDACTED] Dining Services Supervisor and [REDACTED] PCHA.
9. Date of completion: March 15, 2015.

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

Signature of Legal Entity Representative  
(Required on EVERY Page) *Kim Salvo, PCHA*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Kim Salvo, PCHA* Date *2/25/15*

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

The above plan of correction is approved as of <u>3-11-15</u> (Date)	Plan of correction implementation status as of <u>3-11-15</u> (Date)
The above plan of correction was approved by <u>Smp</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>SVP</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

MAR 23 2015  
WEST REGION FIELD OFFICE  
Human Services Licensing

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 10/31/14, at 11:55 a.m., the temperature on the front of the electric fireplace, in the sitting area, across from the 1st floor dining room measured 195.4° Fahrenheit. There was no protective guard in place to protect the residents from burns.

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 fireplaces in Personal Care (1<sup>st</sup> floor and 3<sup>rd</sup>) have had the heating element permanently disabled. No heat is emitted when the fireplace switch is activated.
2. This was completed by Environmental Services Supervisor, [REDACTED] on 12-20-14.
3. Prevention and Maintenance not necessary due to permanent change in equipment.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Kim Salviio, PCHA*

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

*Kim Salviio PCHA*

Date *2/25/15*

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

The above plan of correction is approved as of 3-11-15  
(Date)

Plan of correction implementation status as of 3-11-15  
(Date)

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

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

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

MAR 6 2015

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.133(a)(1) - If the home serves nine or more residents, signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

2a. DESCRIPTION OF VIOLATION

On 10/31/14, the home served 82 residents.

There are three doors leading from the SDCU to the enclosed courtyard. None of these doors are marked not an exit. According to the home's most recent fire safety inspection, dated 7/9/14, this enclosed courtyard is not a fire safe area.

The door leading from the 1st floor dining room to the enclosed courtyard is not marked not an exit. According to the home's most recent fire safety inspection, dated 7/9/14, this enclosed courtyard is not a fire safe 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.

1. On January 2, 2015 Enforcement Officer, [REDACTED] visited Providence Point Personal Care and Memory Support units to inspect the enclosed courtyard and doors that do not provide egress during evacuation or emergency.
2. Letter confirming ability to label doors as "NOT AND EXIT" was obtained and included with this plan of correction.
3. Doors were labeled on 1-2-15 as permitted by code enforcement officer.
4. See attached photos for confirmation.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCH

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCH Date 2/25/15

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

The above plan of correction is approved as of 3-11-15 (Date)

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

Plan of correction implementation status as of 3-11-15 (Date)

Fully Implemented SWP

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

MAR 03 2015

WEST REGION FIELD OFFICE  
Human Services Licensing

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 #2 is prescribed Novolog 100 u/ml-3 times daily per sliding scale as followed:

- \* 70-140= 0 U
- \* 141-180= 1 U
- \* 181-220= 2 U
- \* 221-260= 3 U
- \* 261-300= 4 U
- \* 301-340= 5 U
- \* 341-400= 6 U

<70 or > 400 call MD

However, the pharmacy label indicates Novolog 100 u/ml 4 times daily per sliding scale as followed:

- \* 70-140= U
- \* 141-180 1 U
- \* 181-220= 2 U
- \* 221-260= 3
- \* 41-400= 6 U

<70 or > 400

Resident #4 is prescribed Acetaminophen 325 mg-take 2 tablets by mouth every 6 hours as needed for pain or temperature; however, the pharmacy label indicates take 2 tablets by mouth every 4 hours as needed for pain or temperature.

Resident #5 is prescribed Acetaminophen 325 mg-take 2 tablets by mouth every 6 hours as needed for pain or temperature; however, the pharmacy label indicates take 2 tablets by mouth every 4 hours as needed for pain or temperature.

3. PLA *Inclu imm*
1. Resident #2 had a new insulin bottle with new label sent to her when this violation was discovered by Department of Welfare on 10-31-14.
  2. Resident #4 and resident #5 violation was corrected by using a change in direction label to comply with the physician order done 10-31-14. *if be completed*
  3. Medication cart audits using physician order sheets and comparing with contents and labeled medications in cart are conducted by designated staff weekly on Thursday's and forms of completion are submitted to RN Supervisor weekly.
  4. RN Supervisor maintains forms.
  5. RN Supervisor and designee are responsible parties for this regulation.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Kim Salvio, PCHA*

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

*Kim Salvio, PCHA*

Date *3/11/15*

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

The above plan of correction is approved as of 3-11-15  
(Date)

Plan of correction implementation status as of 3-11-15  
(Date)

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

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

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

MAR 03 2015

WEST REGION FIELD OFFICE  
Human Services 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

Resident #8, admitted 6/26/14, did not have a preadmission screening form completed.

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. Resident #8 preadmission screen completed "late" on date of survey 10-31-14. Incompletion was an oversight on Administrators part. Completed by [redacted] PCHA 10-31-14.
2. Preadmission screens will be completed at time of initial level of care assessment prior to physical admission to Personal Care Unit.
3. Chart audits are completed by RN Supervisor 1 week after admission to ensure compliance of all necessary documents and completion of admission paperwork.
4. Chart audits conducted regularly every 6 months by RN Supervisor to ensure documents are maintained properly in charts.
5. Responsible parties: RN Supervisor, PCHA or designee.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Kim Salvio, PCHA*

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

Kim Salvio, PCHA

Date 2/25/15

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

The above plan of correction is approved as of 3-11-15  
(Date)

Plan of correction implementation status as of 3-11-15  
(Date)

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

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

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer		MAR 9 8 2015	
PCH Name: PROVIDENCE POINT		WEST REGION FIELD OFFICE Human Services Licensing	
<p>1. REGULATION 55 Pa.Code §2600 2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.</p>			
<p>2a. DESCRIPTION OF VIOLATION Resident #4 participated in the development of his/her support plan on 10/13/14; however, the resident did not sign the support plan. Resident #7 participated in the development of his/her support plan on 10/9/14; however, the resident did not sign the support plan.</p>			
<p>3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) <i>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.</i></p> <ol style="list-style-type: none"> <li>1. Support plans for Resident #4 and Resident #7 have corrected been late as of 10-31-14 by RN Supervisor. See attached.</li> <li>2. Maintenance and prevention from further violation of regulation will be done by auditing Supporting Plans on admission and every six months.</li> <li>3. Responsible party is RN Supervisor.</li> </ol> <p>Immediately - All residents will be provided with the opportunity to participate in the development of their support plan. All persons participating in the development of the support plan will provided with the opportunity to sign the support plan. If the resident or designated person refuses or is unable to sign the support plan the staff person completing will indicate the reason for not signing, the date, time and staff person's initials.</p> <p>Within 30 days of receipt of plan of correction - All staff persons involved with the completion of support plans will be educated on the proper completion of support plans including the required signature of persons involved with the development of support plans.</p> <p style="margin-left: 200px;"><i>SMP</i> <i>3-11-15</i></p>			
Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/17/2013	
Signature of Legal Entity Representative (Required on EVERY Page)		<i>Kim Salvio, PCHA</i>	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)		Date	
<i>Kim Salvio, PCHA</i>		<i>2/25/15</i>	
<b>DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!</b>			
The above plan of correction is approved as of <u><i>3-11-15</i></u> (Date)		Plan of correction implementation status as of <u><i>3-11-15</i></u> (Date)	
The above plan of correction was approved by <u><i>SMP</i></u> (Initials)		<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>SMP</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented	

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer

MAR 23 2015

PCH Name: PROVIDENCE POINT

WEST REGION FIELD OFFICE  
Human Services Licensing

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

Resident #3, was admitted to the SDCU on 11/18/13; however, the medical evaluation was completed on 5/21/13.

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. Unable to change dates on DME, dates are incorrect. Note added to dme that dates are out of compliance.
2. PCHA has added note to denote that Providence Point is aware that the dates are incorrect.
3. Resident will not be admitted to SDU until DME is reviewed for proper documentation. Review will be conducted by RN Supervisor, PCHA, or designee.
4. Chart audits are conducted on admission and every six months to assess compliance.
5. Chart audits conducted by RN Supervisor or designee.
6. Responsible parties: RN Supervisor or designee.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Kim Salvio, PCHA*

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

Kim Salvio, PCHA

Date 3/25/15

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

The above plan of correction is approved as of 3-11-15  
(Date)

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

Plan of correction implementation status as of 3-11-15  
(Date)

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

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer  
PCH Name: PROVIDENCE POINT

MAR 23 2015

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.231(c) - A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION

Resident #2, admitted to the SDCU on 10/5/12, did not have a written cognitive preadmission screening completed.

Resident #3, admitted to the SDCU on 11/18/13, had a written cognitive preadmission screening completed; however, it was completed on 10/24/13.

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. Resident #2 had a cognitive screen completed "late" to maintain compliance with regulation 231(c) by RN Supervisor on 10-31-14.
2. Resident #3 had cognitive screen completed upon initial assessment in the home prior to admission to the unit which didn't take place until 11-18-13 by PCHA.
3. All residents coming to memory support will have cognitive screen completed in compliance with regulation 231(c) and responsible parties are Administrator, RN Supervisor or designee.
4. Chart audits monitor compliance are completed every 6 months by RN Supervisor.
5. Responsible parties: PCHA< RN Supervisor or designee.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Kim Salvio, PCHA*

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

Kim Salvio, PCHA

Date

2/25/15

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

The above plan of correction is approved as of

3-11-15  
(Date)

Plan of correction implementation status as of

3-11-15  
(Date)

Fully Implemented

Partially Implemented - Adequate Progress *SNP*

Partially Implemented - Inadequate Progress

Not Implemented

The above plan of correction was approved by

SNP  
(Initials)

Violation Report: 44143 - 10/31/2014 - Rosol, Jennifer

PCH Name: PROVIDENCE POINT

WEST REGION FIELD OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.231(e) - Each resident record shall have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

2a. DESCRIPTION OF VIOLATION

Resident #1 was admitted to the SDCU on 10/21/13. The home has no documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the SDCU.

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.

RECEIVED

MAR 12 2015  
WEST REGION FIELD OFFICE  
Human Services Licensing

1. Reviewed Regulation 231 (e) with both admissions coordinators, [redacted] and [redacted] see attached training page.
2. Gave admissions coordinators a checklist to complete with each admission and a copy of the regulation to ensure all necessary paperwork is completed upon admission.
3. Monthly audits are and will continue to be conducted as part of QI process to check 2 or more memory support charts to ensure compliance with regulation 231 (e).
4. Responsible parties: admissions coordinators and PCHA.

Resident #1's SDCU admission acknowledgement was signed on 11/3/14.

SVP  
3/11/15

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

Signature of Legal Entity Representative (Required on EVERY Page)	<i>Kim Salvio, PCHA</i>
--	-------------------------

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Kim Salvio, PCHA</i>	<i>3/11/15</i>

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

The above plan of correction is approved as of 3-11-15  
(Date)

Plan of correction implementation status as of 3-11-15  
(Date)

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

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