



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [REDACTED]
MAILING DATE: March 10, 2015

Mr. Frank Minelli, Owner
Pittston Heavenly Manor Inc.
51 North Main Street
Pittston, Pennsylvania 18640

RE: Pittston Heavenly Manor
License # 218690

Dear Mr. Minelli:

As a result of the Department of Human Services' licensing inspection on January 22, 2015 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.

Sincerely,

A handwritten signature in black ink that reads "Michele Moskalczyk".

Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 21869 - 01/22/2015 - Foulkes, Kimberli
 PCH Name: PITTSTON HEAVENLY MANOR

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

2a. DESCRIPTION OF VIOLATION

According to the Centers for Disease Control, pen let devices should not be used for more than one resident. These precautions help to prevent the transmission of the Hepatitis B virus, and HIV. Each resident who is prescribed insulin must have his/her own lancets, testing strips, and glucometer.

On 1/5/15 at 4pm Resident #1's glucometer was used on Resident #2.
 On 1/6/15 at 8am Resident #3's glucometer was used on Resident #2.
 On 1/6/15 at 4pm Resident #4's glucometer was used on Resident #2.
 On 1/14/15 at 8am Resident #1's glucometer was used on Resident #5.

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

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

All of the above residents have received blood work that was received by the dept of health and CDC request for the possible cross contamination with glucometer sharing. Each resident has received a new machine due to possible contamination and the staff was inserviced about the importance of using the glucometer and tools for only the individual it was designated for. documentation on seperate sheet that the resident is receiving the appropriate machine and the resident signs that they see it is their machine. The supervisor will be responsible for checking daily to maintain the accuracy and the administrator or designee will check every couple of days at random to ensure that this is in compliance. there is a new policy in place for med techs that there is zero tolerance for sharing any accu check machines.

The administrator shall monitor and assure on going compliance. *M* 3/9/15

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Michelle Burke PCHA	Date 3/06/15
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The above plan of correction is approved as of 3/9/15
 (Date)

Plan of correction implementation status as of 3/9/15
 (Date)

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

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

Violation Report: 21869 - 01/22/2015 - Foulkes, Kimberli
 PCH Name: PITTSTON HEAVENLY MANOR

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

Resident #5 is prescribed Novolog insulin at bedtime. The resident's Novolog was opened 12/20/14. Per the manufacturer's instructions and the staff's training, this medication expires 28 days after the date it is opened. This medication was still in the home's medication cart and the resident continued to receive this medication at bedtime from 1/16/15 through 1/21/15.

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 staff will be inserviced on the start and expiration dates of insulin and the need of disposal of the medication when it is expired and the reordered will be there in its place. in the future the administrator will check randomly to ensure that there is no expired medication in the med cart. The inservice will occur within the next 2 weeks.

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Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle Burke*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Michelle Burke PCHA Date *03/06/15*

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Violation Report: 21869 - 01/22/2015 - Fouikes, Kimberli

PCH Name: PITTSTON HEAVENLY MANOR

1. REGULATION 55 Pa.Code §2600

2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

The home did not develop and implement procedures for the safe storage, access, security, distribution and use of medical equipment. The medical equipment was not stored in a manner that kept the equipment contained for only the resident for which it was prescribed.

In the home's medication cart they use plastic bins to store items. All of the pen let needles that are used with the pen like syringes are kept in one bin. There are 5 types of pen let needles in this bin. Per the home's staff the pen let needles can be used interchangeably with the pen like syringes. They do not use a specific pen let needle for a specific resident even though the residents have specific pen let needles prescribed by the physician for them. The staff report that each pen let needle is used only one time and disposed of. Resident's #1 and #4 are prescribed Autosield Duo Pen Needle .30mm, Resident #6 is prescribed NovoFine 30 and BD AutoShield needle 8mm, Resident #2 is prescribed Unifine Pentips 8mm needle, and Resident #7 is prescribed BD UltraFine pen ndl 5mm.

All of the syringes that are used with insulin vials are kept in bins. There were two bins. One bin contained BD Insulin syringe with ultrafine needle capacity ½ ml cc, length 12.7mm gauge 30. The home had a pharmacy label kept in a different location indicating these were the type prescribed for resident #8. One bin contained Monoject 1/2ml insulin safety syringe, 29 gauge x ½". The home had a pharmacy label kept in a different location indicating that these were the type prescribed for resident #9. According to the home's staff residents #5 and #10 both also use the Monoject syringes; however there was no order for these needles and no pharmacy labels for these residents.

The home also has a bin in the medication cart that contained different types of single use safety lancets. Per the home's staff they interchangeably use the different types of single use safety lancets one time on the resident and dispose of them. They do not use the specific box/specific type of single use lancets that are prescribed for the resident. They all get mixed in one bin. Residents #11 and #5 utilize the VA and are not prescribed single use safety lancets however the home uses the other resident's stock of single use safety lancets for these residents.

Violation Report: 21869 - 01/22/2015 - Foulkes, Kimberli
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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 pen let syringe style lancets were removed and all residents received orders for safety lancets. They are to ensure they are being used once and reduces risk to staff for accidental injury. The residents equipment will be kept seperately and in the individual accu check cases all other equipment will remain in the drawer to be refilled as needed by the resident. In the future the supervisor will ensure that the appropriate tools are used per person. There is a new procedure to be developed to ensure proper storage is maintained. the administrator is check to make sure that the appropriate procedure is followed and appropriate training is given

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Michelle Burke

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

Michelle burke PCHA

Date 03/06/15

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 (Initials)

Violation Report: 21869 - 01/22/2015 - Foulkes, Kimberli
PCH Name: PITTSTON HEAVENLY MANOR

1. REGULATION 55 Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

- (1) Resident's name.
- (2) Drug allergies.
- (3) Name of medication.
- (4) Strength.
- (5) Dosage form.
- (6) Dose.
- (7) Route of administration.
- (8) Frequency of administration.
- (9) Administration times.
- (10) Duration of therapy, if applicable.
- (11) Special precautions, if applicable.
- (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
- (13) Date and time of medication administration.
- (14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION

-The medication administration record for resident #10 has an incorrect blood sugar reading documented. On 1/9/15 at 12 noon the resident's glucometer had a blood sugar reading of 281. Staff recorded 251 on the medication administration record.

-The medication administration record for resident #1 has incorrect blood sugar readings documented. On 1/1/15 at 7am the resident's glucometer had a blood sugar reading of 124. Staff recorded 148 on the medication administration record. On 1/3/15 at 4pm the resident's glucometer had a blood sugar reading of 136. Staff recorded 132 on the medication administration record. On 1/6/15 at 7am the resident's glucometer had a blood sugar reading of 123. Staff recorded 138 on the medication administration record.

-The medication administration record for resident #7 has incorrect blood sugar readings documented. On 1/7/15 at 8am the resident's glucometer had a blood sugar reading of 226. Staff recorded 235 on the medication administration record. On 1/11/15 at 8am the resident's glucometer had a blood sugar reading of 184. Staff recorded 178 on the medication administration record. On 1/21/15 at 8am the resident's glucometer had a blood sugar reading of 175. Staff recorded 177 on the medication administration record. On 1/22/15 at 8am the resident's glucometer had a blood sugar reading of 230. Staff recorded 240 on the medication administration record.

-The medication administration record for resident #5 had incorrect blood sugar readings documented. On 1/18/15 at 12 noon the resident's glucometer had a blood sugar reading of 133. Staff recorded 101 on the medication administration record. On 1/18/15 at 8pm the resident's glucometer had a blood sugar reading of 101. Staff recorded 133 on the medication administration record. On 1/19/15 at 12 noon the resident's glucometer had a blood sugar reading of 147. Staff recorded 220 on the medication administration record. On 1/19/15 at 8pm the resident's glucometer had a blood sugar reading of 220. Staff recorded 147 on the medication administration record.

-The medication administration record for resident #4 had incorrect blood sugar readings documented. On 1/16/15 at 11am the resident's glucometer had a blood sugar reading of 243. Staff recorded 171 on the medication administration record. On 1/17/15 at 8pm the resident's glucometer had a blood sugar reading of 243. Staff recorded 245 on the medication administration record. Also the resident's glucometer had only one blood sugar recording of 146 on 1/6/15. The resident's medication administration record has 146 recorded for 8am and 11am on this date.

-The medication administration records for residents #10, #5 and #4 with sliding scale insulin orders have under the medication section the times of day that the accuchecks are to be completed and the medication name with the sliding scale doses are below that. At each time the accucheck is to be completed the staff put their initials and the glucometer reading on the medication administration record in the blocks. They do not indicate on the medication administration record the number of units that are being administered on the particular date according to the sliding scale doses.

-The medication administration record for resident #3 does not include the date and time the accucheck was completed, the blood sugar reading, or the name of the staff person performing the accucheck for 1/5/15 at 3:40pm.

-The medication administration record for resident #7 does not include the date and time the accucheck was completed, the blood sugar reading, or the name of the staff person performing the accucheck for 1/1/15 at 8am, 12 noon, and 4pm.

-The medication administration record for resident #4 does not include the date and time the accucheck was completed, the blood sugar reading, or the name of the staff performing the accucheck for 1/8/15 at 8am.

-Staff performed an accucheck on resident #3 on 1/5/15 at 3:40pm and did not record the date and time the accucheck was completed, the blood sugar reading, or the name of the staff person performing the accucheck in the medication administration record.

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

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- (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.

The staff has been recently inserviced on the proper documentation of accuchecks and will be reinserviced within the week. The glucometers are checked by supervisor daily and the administrator and designee check at random throughout the week. There is new implementation that the staff write the number and the resident signs that they have seen it and also their picture to ensure that it is the right machine to be used, in

The administrator shall monitor and assure ongoing compliance.
M
3/9/15

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Michelle Burke PCHA	Date <i>03/06/15</i>
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 (Date)

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 (Initials)

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- Not Implemented

Violation Report: 21869 - 01/22/2015 - Foulkes, Kimberli
PCH Name: PITTSTON HEAVENLY MANOR

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

2a. DESCRIPTION OF VIOLATION

- Resident #2 has a physician's order for accuchecks at 8am and 4pm. Accuchecks were not performed on 1/1/15 at 8am and 1/5/15 at 8am.
- Resident #8 has a physician's order for accuchecks at 6am, 11am, 4pm, and 8pm. An accucheck was not performed on 1/7/15 at 11am.
- Resident #5 has a physician's order for accuchecks at 8am, 12 noon, and 8pm. Accuchecks were not performed on 1/6/15 at noon and 1/9/15 at 8pm.
- Resident #4 has a physician's order for accuchecks at 8am, 11am, 4pm, and 8pm. An accucheck was not performed on 1/7/15 at 11am.
- Resident #12 has a physician's order for accuchecks at 8am and 8pm. An accucheck was not performed on 1/20/15 at 8pm.
- Resident #9 has a physician's order for accuchecks at 8am, 12 noon, and 4pm. Accuchecks were no performed on 1/5/15 at 4pm, 1/6/15 at noon and 1/7/15 at noon.
- Resident #5 has a physician's order for accuchecks at 8am, 12 noon, and 8pm. An accucheck was not performed on 1/21/15 at 8pm.
- Resident #6 has a physician's order for accuchecks at 6am, 11am, 4pm, and 8pm. Accuchecks were not performed on 1/4/15 at 11am and 8pm, and 1/5/15 at 4pm and 8pm.

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 med tech must follow the prescribers orders if there is a reason that the accu check was not done it needs to be documented and the prescriber needs to be notified there will be overall training within the next week to ensure the staff is aware and follows all necessary steps to document and notify the prescriber.

The administrator shall monitor and assume ongoing compliance in 3/9/15

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>michelle Burke PCHA</i>	Date <i>03/06/15</i>
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The above plan of correction was approved by <u>M</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