pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Sent via email to: [redacted]
MAILING DATE: June 10, 2015

Ms. Sharon Ritsick, Administrator
UMH PA Corp
209 Roberts Road
Pittston, Pennsylvania 18640

RE: Wesley Village
215 Roberts Road
Pittston, Pennsylvania 18640
License: #241880

Dear Ms. Ritsick:

As a result of the Department of Public Welfare's licensing inspection on April 8, 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,

Michele Moskalczyk
Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

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

PCH Name: WESLEY VILLAGE	**License Number:** 24188
Address: 215 ROBERTS ROAD, PITTSTON, PA 18640	**County:** Luzerne
Administrator: Sharon Ristick	**Region:** NORTHEAST

Legal Entity Name: UMH PA CORP

Legal Entity Address: 209 ROBERTS ROAD, PITTSTON, PA 18640

Certificate(s) of Occupancy

C-2 LP
08/01/1979
PA L&I

Staffing Hours

Resident Support: 0	**Total Daily Staff:** 62	**Waking Staff:** 47
Type of Inspection: Partial	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)

Incident

On-Site Inspections Dates and Department Representatives On-Site

04/08/2015: OHaire, Anne

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: 157

Number of Residents Served: 62

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: 1

Number of Hospice Residents in past year: 1

Number of Residents who:

- **Receive Supplemental Security Income:** 1
- **Are 60 Years of Age or Older:** 62
- **Have Mental Illness:** 0
- **Have an Intellectual Disablity:** 1
- **Have a Mobility Need:** 0
- **Have a Physical Disability:** 1

Violation Report: 24188 - 04/08/2015 - OHaire, Anne
PCH Name: WESLEY VILLAGE

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 #1's MAPAP 500 mg cap. ES to be taken for pain as needed had an expiration date of 03-2015.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

"See Attached 2nd page"

Attachment #1

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Bitsick RN / Admin.

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Bitsick RN / Admin — Date 6-1-2015

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

The above plan of correction is approved as of 6/9/15 (Date)

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

Plan of correction implementation status as of 6/9/15 (Date)

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

1. Regulation 2600.183(a) Cont (Attachment #1)

Plan of Correction:

The facility has policies and procedures in place to assist in assuring that all resident medication, in the medication carts are current, and have not expired. Medication cart audits are completed on a weekly basis by both the nursing staff, and also the trained medication administration certified PCA's. In addition to the weekly cart audits, medication in the carts are also inspected for any expired medications, when the PCA staff are responsible to re-order resident medications, which is assigned two times weekly, to the second and third shift PCA's. However, all PCA's, on all three shifts, are instructed that they are all responsible to assess the medications in the cart while administering medications, and any medication that is found to be expired, and/or, will be expired within the current month, is to follow up with the policy and remove \the medication, and notify the nurse supervisor to follow up.

The Administrator has also implemented a "Dot" policy, which has been in place for the past two years. In completing this procedure, all medications received within the facility, and prior to being placed into the medication carts, will have two white dots placed on the packaging of the medication. For example, on the bubble packs, the dots are placed in the upper left corner of the card, and where visible on other packaging, such as vials for eye drops. The expiration date of the medication is documented in red on the first dot, and then the second dot, will be used to mark the date the medication is re-ordered. This provides staff with accuracy, and a quick and easy system to monitor the expiration dates, without needing to examine the entire card, and look for dates which can vary in placement from pharmacy to pharmacy.

The staff have been instructed and reviewed on the policies , procedures and systems in place, to assist in monitoring the medication carts, expiration dates of medication, and maintaining overall compliance with the resident medications within the Personal Care setting. The Administrator maintains communication and instruction of medication policy and procedures with the PCA staff by utilizing memos, instruction guides, annual training, medication administration regulatory review requirements, in addition to one on one staff instruction as needed. The Administrator is also the Train the Trainer for the facility PCA staff, and implements both state regulatory compliance, and facility policy and procedure in her initial training requirements and quarterly reviews.

Sharon Rusick RN / Admin 6-1-2015

183(a) cont

The PCA and nursing staff of the facility were re-educated in regards to completion of medication cart audits, their responsibilities and follow up of the audits, and the importance of maintaining compliance with the policy and procedures in place to prevent a re-occurrence of the above violation.

Included, Attachment #2, signature of staff attendance and acknowledgment of information reviewed in regards to above violation.

The Administrator will be responsible to assure that the policies and procedures put in place to prevent a reoccurrence of the above violation, be maintained by all the staff. The staff will acknowledge the importance of maintaining these polices, and non- compliance of the set policies, procedures, and systems put in place can ultimately compromise resident care.

6/9/15

Sharon Rutowske RN / Admin 6-1-2015

Violation Report: 24188 - 04/08/2015 - OHaire, Anne
PCH Name: WESLEY VILLAGE

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

Resident #1's following medications were not entailed as being given on 04-07-15:
Balance Sytane eye drops DX dry eyes --9:00pm dose was not initialed as given.
Nystatin powder to be applied under each breast for a rash at 9:00am and 9:00pm was not initialed as being given on 04-07-15 at 9:00am & 9:00pm.
Resident #2's Lorazapam 0.5 mg tab. to be administered at 9:00am & 9:00pm for anxious mood was not initialed as being given on 04-07-15 at 9:00am or 9:00pm.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Attachment

"Attachment # 3

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Bitsick RN / Admin

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Bitsick RN / Admin Date 6-1-2015

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

Plan of correction implementation status as of 6/9/15 (Date)

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

2. Regulation 2600.187(a) Cont

Plan of Correction: (Attachment #3)

The facility is currently utilizing a computerized electronic resident record, which includes the MAR. The system in place does allow staff the ability to document, while administering medications, if the medication ordered was, or was not, administered, for a reason, as listed on the drop down provided. In the event a resident does not receive medication that has been ordered, the staff is responsible to complete the documentation as described above, and then notify the nurse supervisor for follow up. The nurse supervisor would then be responsible to notify the residents' physician of the medication not administered, and follow the orders as prescribed. Documentation in the resident record of the non- administration of medication, for the reason specified, would also need to occur, after notifying the physician, and receiving an order, if any.

Proper documentation, as stated in the violation did not occur by the staff administering the medications to Resident #1 and #2.

Upon review of this violation, the Administrator counseled the staff involved, who was an LPN, and was newly hired. The employee stated she was still leaning the system, and when reviewed the medications missed on the specific date, the employee stated that she had missed signing out the medications that were ordered for the specific times, and felt her error was due to her not be fully comfortable with the system. The employee stated, although she could not be totally certain, she was confident that she had given the medication as it was ordered, however, was hesitant to be 100% certain.

To assure that the staff was comfortable with the system and the possibility of minimizing any further mistakes, the employee was placed back on training of the computer system, and proper documentation of medication administration with other staff more familiar with the system. The employee herself stated she was more comfortable receiving more training at this time, and wanted to be assured that she was documenting correctly.

The Administrator reviewed prior administrations that the employee completed on her own over the prior week. No further errors were noted to be founded from her documentation.

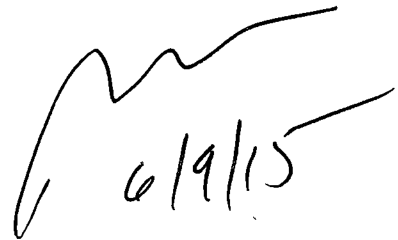
Sharon Russell RN/Admin 6-1-2015

187(a) Cont

The employee continued training on the computer system for one week, and then was supervised administering medications for another week. She completed her training on April 27, 2015, and then was administering medications unsupervised. This employee is currently working part time on the evening shift. She has been encouraged to request assist if needed, and has not had any medication errors since working independently.

Signature sheet of completion of additional training by above employee is included. (Attachment #4)

To provide additional training to all staff, Administrator also provided all current medication administration staff with review materials in regards to proper documentation in the electronic resident record, and policy and procedure for medication refusals and other situations when medications are not administered to residents as ordered. Staff signature of attendance (Attachment #5)



[signature] RN/Admin 6-1-2015

Violation Report: 24188 - 04/08/2015 - OHaire, Anne
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Staff person "A" failed to administer medications for their 5:00pm and 9:00pm medication pass for residents who reside on the third floor. Seven residents did not receive their 5pm and or 9pm medications on 03-17-2015.

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.

(Attachment #6)

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Bisick RN / Admin

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Bisick RN / Admin — Date 6-1-2015

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

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

Plan of correction implementation status as of 6/9/15 (Date)

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- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Regulation 2600.187(d)

Plan of Correction: (Attachment #6)

The employee found not to have administered seven residents medications on March 17, 2015, for the 5PM and 9PM scheduled medication administration times, was terminated from her position on March 19, 2015.

Full circumstances of this incident was completed in the reportable incident forwarded as required, on March 18, 2015, upon completion of a full investigation of the events leading up to, and involving the employee.

The Administrator had provided a mandatory in-service to all Personal Care staff, both the PCA's and Nurses, in regards to medication administration, proper documentation, regulatory compliance, and resident care and safety.

The Administrator will be responsible to conduct random medication cart audits, including random administration of medication to residents at designated times and shifts. The nurse supervisors have been instructed to also complete random audits on carts at unspecified times to assure compliance.

The Administrator also has the ability to review daily assignments of staff, and assure proper documentation is occurring as it should. The system provides for any missed documentation to be visualized, and staff will be held accountable for errors occurring, and non- compliance with medication administration and those responsibilities assigned.

Staff signature of attendance of Mandatory In-Service (Attachment # 7)

Sharon Russell RN / Admin 6-1-2015