pennsylvania
DEPARTMENT OF HUMAN SERVICES

AUG 1 1 2015

Ms. Sharon Ritsick, Administrator, Personal Care
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 Human Services' licensing inspection on April 28, 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.

Your regular license for the period August 15, 2015 to August 15, 2016 was issued on May 5, 2015. 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: WESLEY VILLAGE	License Number: 24188
Address: 215 ROBERTS ROAD, PITTSTON, PA 18640	County: Luzerne
Administrator: SHARON RITSICK	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
L&I

Staffing Hours

Resident Support: 0 | Total Daily Staff: 63 | Waking Staff: 47

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

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

04/28/2015: Harvey, Jason; Harvey, Jason

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 who:
Number of Residents Served: 63	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 63
Area:	Have Mental Illness: 0
Secured Dementia Unit Capacity, if Applicable:	Have an Intellectual Disabliity: 1
Number of Residents Served in Secured Dementia Care Unit, if applicable:	Have a Mobility Need: 0
Number of Current Hospice Residents: 1	Have a Physical Disability: 1
Number of Hospice Residents in past year: 1	

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.16(b) - The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

2a. DESCRIPTION OF VIOLATION

The home has not developed a written policy and procedure for immediate reporting and submission to the Department for a plan of supervision or notice of suspension of an affected staff person as required by regulation 2600.15(c) as it relates to an allegation of abuse of a resident involving a home's staff person.

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 # 5

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN/Admin

Date 6-18-2015

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

The above plan of correction is approved as of 7/27/15 (Date)

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

Plan of correction implementation status as of 7/27/15 (Date)

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

Attachment # 5

P24 of 10

Regulation 2600.16 (b)

Plan of Correction:

The current abuse policy was developed to be used in both the Skilled Nursing facility, and the Personal Care facility on the Wesley Village Campus. The current policy does not directly state that the "department" will be notified in the event of resident abuse. However, the facility does maintain a required policy pertaining to reportable incidents, 2600.16, which list abuse as a reportable incident in which the "department" would be notified. The current abuse policy had been in place in prior inspections, and was not questioned at the time. It was not indicated previously that the current abuse policy is not acceptable. The reportable incident policy, 2600.16, has also been in place in past inspections and has been approved.

Due to this violation and need for revision of the abuse policy, the United Methodist Homes corporate staff are in the process of developing and implementing a new abuse policy. Date of completion is unknown at this time, however, due to the violation received, the policy will be completed within 30 days of receipt of this plan of corrections. The policy will be forwarded to the department, to complete this plan of correction, in addition to a staff signature form indicative of provided education to staff of the new policy in place.

The Administrator will be responsible to assure the policy is completed, with the requirement of the notification of the "department", in the event of resident abuse within the home. The Administrator will also assure that staff are educated on the policy in place.

As per Adm, Completed Week of 7-20-15. CR. 7/27/15

Sharon Patrick RN / 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600--

2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION

By reviewing the readings in the glucometer machine belonging to resident #3 and documentation on the resident's MAR, it was determined that the glucometer machine belonging to resident #3 was used to measure the blood sugar level of the following residents on the stated dates and time:

4/23/15; Shift 12-8pm, resident #2

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 #1"

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon RitsickRN / Admin. Date 6-18-2015

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Plan of correction implementation status as of 7/23/15 (Date)

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

Attachment #1

page 3 Ag 10

1. Regulation 2600.85(a

Plan of Correction:

The facility maintains the practice of each Resident requiring a glucometer for blood glucose monitoring to have their own machine. Each residents' glucometer machine, and the required supplies, are kept in an individual labeled container. The containers are stored in the locked nurses' area.

The staff have been educated on the proper use of glucometer's in the facility, and the use of each residents machine not to be shared among the residents requiring blood glucose monitoring.

Currently the licensed nurse staff is performing the blood glucose monitoring. The goal of the facility is to have the PCA staff eventually be trained and certified to perform both the glucose testing and the insulin administration.

In regards to this violation, the nursing staff have been re-educated on the use of glucometers in the Personal Care facility. In addition, a policy and procedure has been implemented for all staff to be educated on in regards to glucometer use and maintenance of the machines. Enclosed is the policy and procedure (Attachment #2) which has been implemented and staff have been educated, and also the staff signature sheet of receipt of the policy and procedure. (Attachment # 3).

Due to this violation, the inspectors had informed the Administrator on the day of the inspection, April 28, 2015, that the residents whose glucometer was in question of have been used on another resident for blood glucose testing, would have to be provided with a new glucometer at the cost of the facility. The facility had notified the pharmacy, and a new glucometer was delivered to the facility on April 30, 2015. (Dated receipt enclosed, Attachment #4).

The Administrator will be responsible to assure staff adheres to the policy and procedures regarding glucometer use in the facility. As stated in the policy and procedure, the Administrator will be responsible to complete weekly random checks, and compare the results of the resident glucometer, with the results documented in the electronic resident chart. In addition to the current procedures in place, the staff will also be cleaning the machines with alcohol after each use, to assure sanitary conditions are maintained.

Anne Grasiano 7/23/15

Sharon Ritsick RN 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.132(a) - An unannounced fire drill shall be held at least once a month.

2a. DESCRIPTION OF VIOLATION
Wesley Village personal care home is constructed of two building which are connected to each other, Anderson personal care home and the Myers building. Both building have separate alarm systems and have been instructed by their fire safety expert to run a fire drill for each building monthly. During September 2014 the home did not run a fire drill in the Myers building. During October the home only conducted one fire drill and did not specified what building the fire drill was located in.

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 Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) SharonRitsick RN / Admin. Date 6-18-2015

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

Plan of correction implementation status as of 7/30/15 (Date)

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

Attachment# 6

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3. Regulation 2600.132(a)

Plan of Correction:

Prior to the current annual inspection conducted on 4/28/2015, concerns were noted in regards to the fire drill log, dates of fire drills conducted, and documentation of the drills.

The Administrator had brought the discovery of these concerns to the Executive Director, and then had met with other Corporate Management Staff of Wesley Village.

It was determined at this time that the Personal Care Facility would seek the assistance of an outside, recommended, fire safety expert, [redacted] has worked for many years in assisting Personal Care facilities in Pennsylvania to assure compliance with all fire safety regulations. He has extensive knowledge of the Regulatory Compliance Guide, and the requirements and needed provisions that a Personal Care facility requires to assure the safety of residents, providing adequate education to staff to perform fire drill evacuations, and proper documentation of these drills to satisfy the needed requirements. The Administrator has worked with [redacted] in the past, and had been satisfied with his ability to assist a Personal Care facility in need for proper fire safety requirements, and ability to explain and incorporate these requirements to facility management and staff, for adequate knowledge of compliance needs.

The Administrator, and the newly appointed Plant Operations Director, [redacted], met prior to [redacted] visit to discuss the areas of needed improvement in the conduction and documentation of fire drills, in addition, to a review of the current fire evacuation plan, within both buildings of the Personal Care facility, Anderson and Myers Manor. The Plant Operations Director had been responsible to conduct the monthly fire drills in the Personal Care, and maintain the documentation, and/or, assign a designated staff of Plant Operations, to complete the same. It was determined that the Plant Operations department would continue to be initially responsible to schedule and conduct drills, document all areas of fire safety within the Personal Care, and maintain the requirements of fire safety regulations, under the direction and supervision of the Administrator.

Anne Hagan 7/23/15 Sharon Ritsick RN 6-18-2015

P48 of 10

Recognizing the need to provide adequate documentation and proper scheduling of the fire drills, [redacted] was contacted initially via telephone, and the process began with providing the necessary information. [redacted] visited the Personal Care facility on June 4, 2015.

At the current time, [redacted] will be working closely with the Plant Operations Director, [redacted] in reviewing current processes in place, and making recommendations and revisions where necessary. The Administrator will be in direct contact with the Plant Operations Director, and available as needed, to work with [redacted] in assuring areas of violation will be corrected, and maintain compliance in all areas of fire safety within the Personal Care. [redacted] will be conducting and reviewing fire drills, with recommendations as needed, and assisting in developing, and completing, staff and resident education, with the implementation of any changes from the prior fire evacuation plan, drills, and staff documentation on the fire drill log. In regards to this specific violation, (2600.132(a), in conducting fire drills to assure all Personal Care residents participate in a monthly fire drill, both buildings, Myers Manor and Anderson, which both houses Personal Care residents, required their own fire drill monthly. This was not completed for the two months stated on the violation report, as recommended by the previous fire safety expert. It was determined by [redacted] that incorporating the alarm system currently in use, to alarm in both buildings at the same time, (which previously did not occur since they were considered two free standing buildings, although connected by adjoining floor structures), would allow one fire drill monthly. This will assure all residents in the Personal Care to be involved, and would not require two separate drills, thus, assuring the facility remains in compliance, and also assures resident safety and knowledge of the fire evacuation process, demonstrating proper evacuation for preparation in the event of an actual fire event.

[redacted] will also assist the Plant Operations Director in providing recommendation to assure dates vary throughout each month, and do not occur at the same time each month, varying routinely, in regards to days of the week, and weeks of the month.

The Administrator will be responsible to assure that a fire drill occurs monthly, varies throughout the month in regards to day of the week, and week of the month, and the documentation of these drills are correct, and compliance is maintained as per the Regulatory Compliance Guide, and the recommendations as provided by the fire safety expert, [redacted] The Administrator will work closely with the Plant Operations Director, [redacted] to assure this

[redacted] 7/23/15

Sharon Ritsick RN/ 6-18-2015

compliance. The Administrator will be responsible to observe and evaluate fire drills monthly, as often as available, in addition to reviewing the fire drill documentation at least quarterly, and as needed, to again, assure compliance is maintained, and any problems or concerns, are addressed in a timely manner. [redacted] will be contacted as needed for review or revisions when these concerns arise, in addition, to his contracted services.

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Anne Shagrue 7-23-15

Sharon Pitsick RN 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.132(c) - A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

2a. DESCRIPTION OF VIOLATION

The written fire drill record for the fire drill held on 6/26/2014 did not include the number of residents in the home.

The written fire drill record for the fire drill held on 7/28/14, 8/21/14, 9/16/14 and 10/23/14 did not indicated the correct number of residents in the home at the time of the fire drill. The home used the daily census not the actual number of resident in the building at the time the fire drill was held.

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 #7

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN / Admin. Date 6-18-2015

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The above plan of correction is approved as of 7/30/15 (Date)

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

Plan of correction implementation status as of 7/30/15 (Date)

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

Attachment # 7

P 5A 8 10

Regulation 2600.132(c)

Plan of Correction:

As stated in prior violation, the facility recognizing concerns prior to the annual inspection, had determined that fire safety expert, [redacted] would be notified to assist the Personal Care facility in correcting and maintaining adequate and appropriate fire drills, evacuation plan, and documentation. Specifics to contacting and implementing [redacted] assistance is specified in the previous violation plan of correction.

In regards to this specific violation, the documentation in the fire drill log regarding the number of residents in the home at the time of the drill was incorrect, and demonstrated in several of the drills conducted in the facility throughout the months.

The facility will utilize [redacted] expertise in educating and instructing the staff responsible to conduct the fire drills in the home proper documentation of resident participation during a fire drill. As stated, the Plant Operations Director, [redacted] will be responsible to conduct the fire drill and document, in addition to designating a staff in Plant Operations to also perform the drills, and be instructed on proper documentation in all areas of the fire drill log, and other areas required in the maintenance of fire safety.

The Administrator will be responsible to review the fire drill log quarterly, and as needed. The Administrator will work together with the Plant Operations Director to assure documentation of the fire drills in regards to resident participation is accurate, and staff designated to perform the fire drills, is also assuring accuracy with staff, and resident participation. The Administrator will be responsible that any problems or discrepancies are addressed in a timely and appropriate manner, and [redacted] is notified as needed, when additional assistance is required to assure compliance.

Anne Heazlewood 7-30-15

Sharon Petrick RN 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION

Wesley Village personal care home is constructed of two building which are connected to each other; Anderson personal care home and the Myers building. Both building have separate alarm systems and have been instructed by their fire safety expert to run a fire drill for each building monthly. The home's fire drill record indicates the home did not complete a fire drill during sleeping hours within the past 6 six months in each building.

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 #8

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN / Admin. Date 6-18-2015

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Plan of correction implementation status as of 7/30/15 (Date)

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

Attachment # 8

Regulation 2600.132(e)

Plan of Correction:

As stated in the previous two violation plan of corrections, the facility has acquired the assistance of fire safety expert, [redacted] to assist the Personal Care facility, in correcting the concerns recognized, and implement [redacted] expertise into the overall fire safety of the home, including fire evacuation plan, fire drills, documentation, and all other areas of regulatory compliance.

The Administrator will work closely with the Plant Operations Director, [redacted] in assuring the conduction of the overnight fire drills are occurring as required, and have been scheduled per the recommendations of the fire safety expert, [redacted] Plant Operation Staff designated by the Director to perform the fire drills will be educated on the regulation of the drills and the need to schedule the drills to assure compliance.

The Administrator will be responsible to review the fire drill log quarterly, and as needed, to assure compliance with the drills, and documentation of the drills, is maintained. The Administrator will be aware of the scheduling of over night fire drills and will assure that the drills occur as scheduled, and have been completed accurately and in a timely manner.

Anne Grazian
7-30-15

Sharon Petrick RN 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.183(f) - Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

2a. DESCRIPTION OF VIOLATION

Resident #5's medication of Ondansetron 4mg tab as need for nausea and vomiting was discontinued by the physician but maintained in the home's medication cart.

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 #9

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN / Admin. Date 6-18-2015

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

Plan of correction implementation status as of 7/23/15 (Date)

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

Attachment # 9

P7A 9 10

Regulation 2600.183 (f)

Plan of Correction:

The PCA and nurse staff were re- educated on the proper and immediate removal of medication from the medication cart upon the discontinuation of the medication by the residents physician, and/or the discharge of a resident from the home.

Printed memo of review provided. Attachment # 10

The staff was provided with an in service and review of the information memo. Enclosed is a staff signature form of attendance of the informative in service conducted by the Administrator. Attachment # 11

Medication cart audits are completed monthly. The audits are assigned by the Administrator to the nurse staff, who is responsible to complete a full medication cart audit, which includes the removal of any medication noted to be discontinued by a resident physician, and for some reason, was not removed initially upon receipt of the order.

The Administrator will be responsible to assure that the nurse staff complete the medication cart audits, which need to be signed off upon completion, t by the assigned staff.

The Administrator will also be responsible to assure that staff adhere to the procedure of removing medication promptly from the medication cart, for that medication which has been discontinued by the residents physician. The Administrator will complete random audits of the medication carts to assure medication documented as discontinued from a physician order, has been removed, and the facility is maintaining regulatory compliance.

Anne Graziano 7/23/15 Sharon Ritsick RN / 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.187(c) - If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

2a. DESCRIPTION OF VIOLATION

The home failed to contact resident #5's physician regarding the resident's refusal to take Colace 100mg on 4/1/15, 4/3/15, 4/5/15, 4/6/15, 4/16/15 and 4/20/15 and Miralax powder on 4/20/15.

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.

Attachment #12

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

Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN / Admin

Date 6-18-2015

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Plan of correction implementation status as of 7/23/15 (Date)

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

Attachment # 12

F84
8/0

Regulation 2600.187 (c)

Plan of Correction:

The nurse, and PCA staff, have been re- educated on the procedure when a resident refuses a medication. The importance of maintaining this procedure was reinforced to all staff, with an in service provided by the Administrator to review the procedure, and assure all staff had been provided with the required information.

A staff signature form of attendance of the in service is enclosed. Attachment # 13.

The PCA staff, certified to administer medications to the resident, is to document the resident refusal and reason, in the resident electronic MAR. The electronic resident MAR program, utilized by the home, allows staff to complete this process easily and accurately when documenting administered medications for the resident. The PCA staff must then notify the nurse on duty for that shift, of the resident refusal of the medication. The nurse is responsible to notify the resident physician of the refusal, and follow any new orders received from the information provided. Repeated refusal of a medication needs to be communicated to the residents' physician, and also request a possible discontinuation of the medication, should the refusal be continuous and recurrent. The physician will determine if the medication should be discontinued at that point, or the staff is to continue to offer the medication to the resident, and continue to document refusals as prior.

The Administrator will be responsible to assure that staff remain compliant with the procedure of resident refusal of medication. The Administrator will conduct random checks of the resident electronic

Anne Stagiano 7/23/15 Sharon Russell RN 6-18-2015

P8 & 9 D

MAR, reviewing administration records to assure that any refusals have been properly documented, initially by the PCA, in the resident electronic MAR, and then by the nurse, to the physician, with documentation that the nurse has communicated the refusal to the physician, and any orders received have been followed through. The Administrator will complete random checks in the resident record in addition to completing quarterly reviews of the staff medication administration records, to satisfy the requirements of the medication certification for the trained PCA staff. These two checks will provide the Administrator with two opportunities to assure staff is completing proper documentation of the resident refusals, and communication to the nurse for notification of the resident physician.

The Administrator will be responsible to assure compliance of this regulation.

Sharon Rusnak 6-18-2015

Anne Hagan 7/23/15

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

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

Resident #1 was admitted to the home on 2/26/2015. The initial assessment for resident #1 prepared on 3/12/2015 was incomplete. Section 1 was missing information and did not assess the resident's toileting, bladder management, bowel management needs and resident's ability to secure and use transportation. Section 3 of the assessment for medical diagnosis/psychological was not noted and was left blank.

Resident #2 was admitted to the home on 5/5/2014. The initial assessment for resident #2 was completed on 6/10/2014, and not within 15 days of admission. The resident participated in the assessment and signed the initial assessment on 6/10/2014.

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.

Attachment #14

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Signature of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sharon Ritsick RN/Admin

Date 6-18-2015

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Plan of correction implementation status as of 7/23/15 (Date)

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

Attachment # 14

P9A 8/5

Regulation 2600.225(a)

Plan of Correction:

The resident RASP forms are completed by the nursing staff. The initial RASP is completed by each nurse on a rotating basis. The home employs three full time nurses, and each will be responsible to complete a resident RASP, rotating assignment with each admission. This allows each nurse to have adequate time to complete a resident RASP on a newly admitted resident and provides a designated assignment and responsibility of this specific task.

The Administrator is responsible to review the resident chart within 30 days of admission. This allow the Administrator to assure all newly admitted residents have all the requirements completed within this time frame, such as the DME, and the RASP form. It also provides an opportunity to review the work completed on these required forms, as assigned to the nurse staff, to assure accuracy and completion of information on the forms. Needed corrections or revisions can occur at this time, while maintaining compliance with the time frames specified in the regulation

The Administrator conducted a meeting with the nurse staff, and reviewed the regulation specified for the RASP, and the assessment portion of the form. Emphasis was placed on completion of all information, and staff need to review their completed forms to assure accuracy. The Administrator also informed the nurse staff that t she too, would be reviewing the completed assessment portion of the RASP, to assure accuracy, and review for the staff to maintain compliance. This would be considered a team effort, and again, assist in assuring compliance with completion of the resident RASP.

Staff signature form of attendance of the meeting with the administrator is enclosed. Attachment # 15.

The Administrator will be responsible to assure that the nurse staff remain compliant in completing the information on the resident assessment portion of the RASP form, and the information is completed within the time frame specified in the regulation. The Administrator will assure this in completing reviews of the resident RASP, which will include the assessment portion within 15 days of admission, the support plan within 30 days of admission and also, annual resident RASP forms.

Anne Grazian 7/23/15 Sharon Ritsick RN / 6-18-2015

Violation Report: 24188 - 04/28/2015 - Harvey, Jason
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.227(a) - A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

2a. DESCRIPTION OF VIOLATION
Resident #2 was admitted to the home on 5/5/2014. The resident's initial support plan was prepared on 6/10/2014, more than 30 days after admission to the home. The resident participated in the development of the support plan and signed the support plan on 6/10/2014.

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.

Attachment #16

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Sharon Ritsick RN			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Sharon Ritsick RN / Admin	Date	6-18-2015	

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

The above plan of correction is approved as of 7/23/15 (Date)

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

Plan of correction implementation status as of 7/23/15 (Date)

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

Attachment # 16

P10 of 10

Regulation 2600.227 (a)

Plan of Correction:

The plan of correction for this violation will remain the same as the prior violation, in regards to the Administrator review of the resident RASP form completed by assigned staff.

The completion of the resident RASP form, including the assessment portion and the support portion, will be assigned to staff in a rotating basis. This will include both newly admitted residents, and also annual RASP forms. This rotation of assignment will allow adequate time for each staff to complete the forms, and for the Administrator to review the forms for accuracy, and any incomplete information. The resident participating in the development of his/her RASP form will sign the form on the date of completion.

The Administrator conducted a meeting with the nurse staff to review the above and assure continued compliance with completion of the RASP forms in a timely manner. Enclosed is the staff signature of attendance of the meeting. Attachment # 17

The Administrator will assure that all RASP forms are completed it their entirety, and resident signature is obtained upon completion of the form by the assigned staff. The Administrator will also utilize the assistance of the Assistant Administrator to assist in performing reviews of the resident RASP, in the instance of annual reviews of resident RASP forms. The newly admitted resident RASP forms will be reviewed by the Administrator for accuracy, and time compliance.

Sharon Patrick RN 8-18-2015

Anne Grozian 7-23-15