



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 25 2016

Mr. Michael A. Barton, Executive Vice President
NHS Pennsylvania
4391 Sturbridge Drive
Harrisburg, Pennsylvania 17110

RE: NHS Capital Region
1071 Page Road
Harrisburg, Pennsylvania 17111
License #: 321000

Dear Mr. Barton:

As a result of the Department of Human Services' annual licensing inspection on April 15, 2016 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,


Jay Bausch
Deputy Secretary

Enclosure
License Inspection Summary

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

PCH Name: NHS CAPITAL REGION		License Number: 32100
Address: 1071 PAGE ROAD, HARRISBURG, PA 17111		County: Dauphin
Administrator: Max Zurat		Region: CENTRAL
Legal Entity Name: NHS PENNSYLVANIA		
Legal Entity Address: 4391 STURBRIDGE DRIVE, HARRISBURG, PA 17110		
Certificate(s) of Occupancy R-4 11/15/2006 Lower Paxton Twp		
Staffing Hours Resident Support: 0 Total Daily Staff: 8 Working Staff: 6		
Type of Inspection: Full BHA Docket Number: Notice: Unannounced		
Reason(s) for inspection(s) Renewal		
On-Site Inspections Dates and Department Representatives On-Site 04/15/2016: Heerner, Laura		
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: 8 Number of Residents Served: 8 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: 0 Number of Hospice Residents in past year: 0	Number of Residents who: Receive Supplemental Security Income: 8 Are 80 Years of Age or Older: 3 Have Mental Illness: 8 Have an Intellectual Disability: 1 Have a Mobility Need: 0 Have a Physical Disability: 0	

Violation Report: 32100 - 04/15/2016 - Heemer, Laura

PCH Name: NHS CAPITAL REGION

1. REGULATION 55 Pa.Code §2600

2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
- (3) Resident rights.
- (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
- (5) Falls and accident prevention.
- (6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION

During training year 2016, Ancillary staff member A did not receive training in:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
- (3) Resident rights (under these regulations).
- (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.5102).
- (5) Falls and accident prevention.
- (6) New population groups that are being served at the home that were not previously served, if applicable.

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.

Violation of regulation 2600.65(g) On April 27, 2016, the Assistant Program Director requested any 2016 training certificates from the NHS File Hub. If any of the needed trainings are noted as being completed in 2015; those trainings will be noted as completed. For any training which is not noted as being completed, the Assistant Program Director will inform the NHS Personal Care Staff supervisor. The NHS Personal Care Staff Supervisor will arrange to have Chris complete all of the needed trainings for 2015 by June 1, 2016. Chris will be monitored with the other staff regarding his training needs, being made aware of 2016 trainings by the Staff Supervisor. Going forward the RN Supervisor/Staff Trainer will give Chris a list of the required trainings that need to be completed by December 31st, 2016. The RN Supervisor / Staff Trainer will provide Chris with a training Calendar and will schedule the trainings with him.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Michael A. Barton

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

Michael A. Barton, Exec. V.P. of BA.

Date *5/4/16*

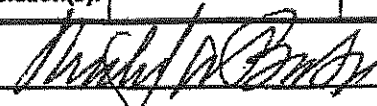
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/10/16
(Date)

Plan of correction implementation status as of 5/10/16
(Date)

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

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

Violation Report: 32100 - 04/15/2016 - Heemer, Laura	
PCH Name: NHS CAPITAL REGION	
1. REGULATION 55 Pa.Code §2600 2600.85(a) - Sanitary conditions shall be maintained.	
2a. DESCRIPTION OF VIOLATION On 4-15-16, the glucometers for Resident 1 and Resident 2 were stored in individual bins, however, there were no markings on the glucometers or the glucometer cases that specified to which resident each of the glucometers belonged. Readings logged in the glucometers did not match the home's April 2016 Glucometer Checks and Weekly Control log for either resident. During interviews, a staff member stated that it appeared the glucometers had been switched back and forth between the two residents.	
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>Violation of regulation 2600.85(a) As of April 18, 2016 two extra Glucometer's were purchased as back ups in case a glucometer is not functioning properly. All Glucometers are now properly labeled with the Residents initials. On April 22, 2015 the Program Director met with the nurses to discuss glucometer issue and explained the changes in protocol that would be taking place. As of May 1st, 2016 a new detailed Glucometer checks and Weekly Control Logs form is being used. The form allows for staff to sign off stating that they checked the initials on the Glucometer with the initials of the Resident they are assisting. The RN Supervisor or Program Administrators will monitor and sign off on the logs weekly for compliance. The RN Supervisor/Staff Trainer is developing a training for all staff on safe glucometer use. The training to be provided to all staff regardless of their ability to complete glucose monitoring so that they are aware of what the safe practices look like so they can identify and report any unsafe practices. The Training will be completed by all staff by June 30th, 2016. A sign off form was developed that all staff will sign stating that they understand the Glucometer protocols .A policy was created and added to the Personal Care Homes Policy and Procedure Manual regarding the use of Glucometers in the Personal Care Homes. A sign off area was added in the <u>TO BE COMPLETED WITHIN THE FIRST 40 SCHEDULED WORKING HOURS</u> section of the Orientation checklist. All new staff will be trained on the Glucometer protocols within the first 40 scheduled working hours. All signed forms will be kept in the Staff's HR file. As a precaution all residents will be offered laboratory testing as not to single any residents out.</p>	
Repeat Violation: No	Date(s) of Previous Violation(s):
Signature of Legal Entity Representative (Required on EVERY Page)	
	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Michael A. Barton, Exec. V.P. of B.H.	5/4/16
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!	
The above plan of correction is approved as of <u>5/10/16</u> (Date)	Plan of correction implementation status as of <u>5/10/16</u> (Date)
The above plan of correction was approved by <u>PAAS</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

Violation Report: 32100 - 04/15/2016 - Heemer, Laura
 PCH Name: NHS CAPITAL REGION

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

The home conducted a sleeping hours fire drill on 4/27/15 and did not hold another sleeping hours fire drill until 11/4/15.

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.

Violation of regulation 2600.132(e) Assistant Program Director will develop a Fire Drill Schedule by May 5, 2016, making certain that the overnight fire drills are scheduled within the 6 month time period. The Program Director will review the fire drill documentation by the 25th of each month to be certain the appropriate fire drill has been completed or is scheduled to be completed by the end of the month. Program Director will review the Fire Drill log for completion and will follow up with Assistant Director with any questions. In preparation for the 2017 Inspection the Program Director/Assistant Program Director will maintain the DHS PCH Fire Drill Record as fire drills are completed.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *[Handwritten Signature]*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Michael A. Barton, Exec. V.P. of B.H.</i>	Date <i>5/4/16</i>
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The above plan of correction is approved as of 5/10/16
 (Date)

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

Plan of correction implementation status as of 5/10/16
 (Date)

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