pennsylvania
DEPARTMENT OF HUMAN SERVICES

Ms. Annette Chickey, Acting Administrator
UMH PA CORP
209 Roberts Road
Pittston, Pennsylvania 18640

SEP 27 2016

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

Dear Ms. Chickey:

As a result of the Department of Human Services' annual licensing inspection on May 20, 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,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

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

PCH Name: WESLEY VILLAGE	**License Number:**
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
LABOR AND INDUSTRY

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 70 **Waking Staff:** 53

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

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

05/20/2016: Dumas, Gerald; Yellenic, Cindy; Valence, Duane

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: 69

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: 3

Number of Hospice Residents in past year: 3

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 64

Have Mental Illness: 0

Have an Intellectual Disability: 1

Have a Mobility Need: 1

Have a Physical Disability: 0

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.5(a)(1) - The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to: Agents of the Department.

2a. DESCRIPTION OF VIOLATION
On 5/20/16, Department Representatives were delayed in reviewing the resident's insulin checks and administration records in a timely manner. Several issues in the home's electronic, computerized system caused the delay which took from approximately 10:30 a.m. until the early afternoon to complete.

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 Ritsick RN

Date: 6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

Sharon Ritsick RN
6/27/2016

ATTACHMENT # 1 Page 3 of 18
(1 of 2)

Regulation 2600(a)(1)

The facility is currently utilizing the use of an electronic resident record. The company had implemented the new system in 2013. This was the second annual inspection by the department in using the electronic resident record for review of information.

The representatives of the department were supplied with (2) laptops upon their arrival in the facility, and the Administrative assistant began the process of contacting IT department to provide the inspectors with surveyor access and required passwords ,to access the program and resident information.

The representatives' ability to navigate through the system required some guidance by the facility staff due to the unfamiliar computer program. Guidance was provided as requested.

The Department Representative responsible to review the glucometers and insulin administration, and documentation of blood glucose results, required additional amount to time to navigate through the residents records to obtain the information she needed, and compare the numbers and administration amounts to the actual glucometer machine.

The representatives had also requested that staff provide copies of information in the resident record for review of forms, such as the DME, RASP, and resident-home contract. The available staff to assist the representatives were able to print off the forms and other requested information, however, this needed to be completed in the Administrators office, which the staff had access to two computers and also a printer. The staff attempted to obtain the information as quickly as possible, however, due to the amount of time to obtain the information by navigating through several resident records, printing, stapling, and then bringing the information to the room where the department representatives were stationed, was a flight of stairs above the office, did take some additional time to complete this request manually. The staff did continue to bring up information as it was completed, and did not wait until it was all available to bring up at once, which allowed the representatives to have some of the information quicker than others, and review some while waiting for others to arrive.

The facility recognizes that the department representatives need to work with many different computer programs in different facilities, utilizing the electronic record, and many of them are not similar, and will require additional assistance by the facility staff to navigate and obtain the information required in a timely manner on the day of inspection. In understanding the difficulty in needing to familiarize themselves with numerous computer programs, and more and more facilities will be implementing the use of the electronic record in the near future, the facility will adopt some additional practices to assist the department during inspections, and provide additional support and assistance with navigating the system, assuring the information requested is obtainable to all representatives.

ATTACHMENT #1
(2 of 2)

P2 Bg 18

The facility proposes to provide a centralized computer(s), which will be maintained in medical records, for the sole purpose of use by department representatives on the day of inspection. These computer(s) will be "on-call" for inspection use, and continuously updated and charged, in anticipation of an unannounced visit by the department. Access to the computer(s) will be readily available, and representatives will not have any additional wait time for the computer to be delivered to their area on the day.

The IT department will assure that upon notification by the facility, the response for the request for computer access and passwords for the representatives, will be priority.

The Administrator will provide assignments to delegated staff in the facility. These assignments will be prepared prior to the inspection date. Staff will have designated responsibilities to assist the Administrator, and other management staff, with supporting the Department Representatives with their request, and obtaining information as needed.

The facility will have a list of staff considered computer "super users", which will be available to assist the Department Representatives on the day of inspection with navigating through the computer system if needed. These staff persons will have extensive knowledge of the use of the computer program, and the required ability to generate the information, if not founded, by the representative, in a timely, appropriate manner, and produce the information requested. At least one staff will be available at all times to assist, and will be placed on a rotating schedule, to assure there is availability of proper staff, on any day that an unannounced visit by the department may occur.

ADM/Designee will also review BHSL Electronic Records Policy & provide staff training on same.
8-13-16

Sharon Ritsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.28(f)(2) - Refunds shall be made within 30 days of the resident's discharge.

2a. DESCRIPTION OF VIOLATION
Resident # 1 was discharged from the facility on [redacted]15. The resident did not receive his/her refund until 9-11-15.
Resident # 2 was discharged from the facility on [redacted]15. The resident did not receive his/her refund until 1-8-16.

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 #2

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

Date 6/27/2016

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Plan of correction implementation status as of 8-13-16 (Date)

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

ATTACHMENT# 2 P3 AB18

1. Regulation 2600.28(l)(2)

The resident date of discharge is placed in the computer system by the Personal Care Admissions Department, or the Personal Care Nurse Supervisor, depending on the circumstances of the discharge and time. For example, weekend discharges would be placed by the nurse staff, while a scheduled discharge, may be completed by Admissions.

The resident discharge date placed in our computer system is viewable by the business office. However, to assure the staff of the business office is informed of the date of discharge without delay, the Admissions Department, and/or the Nurse Supervisor will be responsible to generate an email to the business office on the day of the residents discharge. The Administrator will also be informed in this manner, to maintain discharge records, and information, which will be accurate, and remain up to date, again, with no delay.

The business office will communicate to the corporate office the resident discharge date. A refund due to the resident will be generated by the corporate staff, and sent out to the resident, and/or responsible party, within the thirty day timeline. The Administrator informed the corporate office staff responsible to generate the resident refund checks, of the violation received from the annual inspection, and the process that is stated above, and have been in place, was reviewed to assure the understanding of the need to maintain a thirty day refund of any resident funds due, after discharge. Any concerns, or possible delay in the refund, needs to be communicated to the Administrator, to assure there is a clear understanding of the process and an unnecessary or incorrect delay will not occur.

The corporate office sends a copy of the refund check to the Administrator prior to mailing. This allows the Administrator the ability to complete the discharge chart, have the accurate amount of the refund, and close the chart with all required and necessary information, and maintain her own discharge records of the resident discharges.

The Administrator will be responsible to assure all resident refunds due, are completed within the thirty day compliance time, in assuring the above procedure is maintained and the appropriate staff are alerted if the Administrator determines a refund has not been issued as required.

8-13-16

Sharon Ritsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.29a(b)(11) - Documentation of compliance with this section is to be kept in the fire drill record, as well as in the resident's record. The documentation is to include the following:
(i) A copy of the Department of Health license for the hospice agency.
(ii) Written certification by the physician as specified in § 2600.29a(b)(1).
(iii) Written informed consent as specified in § 2600.29a(b)(2).
(iv) Written documentation of the home's consideration of relocation of the resident's bedroom as specified in § 2600.29a(b)(3).

2a. DESCRIPTION OF VIOLATION

Resident # 3 is presently receiving Hospice services from Hospice of the Sacred Heart, Wilkes-Barre, Pa. The administrator did not have a copy of the current Pa. Department of Health Certificate of Licensure for Hospice of the Scared Heart. The only Certificate of Licensure provided for the above Hospice Agency was for an expired licensed period from February 1, 2014 until January 31, 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 Attachment #3

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 — Date 6/27/2016

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

ATTACHMENT# 3

Regulation 2600.29 (b)(11) Page 18

The facility maintains a policy and procedure for residents receiving hospice care which includes a Hospice booklet, which provides a listing of required information, including the forms and documents which are require when a resident is ordered on hospice services.

The facility had, as required, requested a copy of the hospice agency operating license, upon the start of the residents' hospice services in the home. The copy of the licenses received was expired. The Administrator and the other nursing staff did not noticed the expiration date on the license that was received by the facility.

A current copy of the agencies license was faxed to the facility on the day of inspection.

The copy was properly placed in the residents' electronic chart, a copy in the Administrators office, and also forwarded to the Plant Operations Department, to place in the fire safety information folder, which includes the forms and documentation on residents receiving hospice care in the facility, and their current status.

The nursing staff in the facility was made aware of this violation. They were instructed to inspect any requested license from home health or a hospice agency, to ensure the license is current, and no future expired licenses, if sent, will be accepted. All licenses will be inspected prior to placing in the residents' electronic record, and/or forwarding them to the Administrator, or Plant Operations, for proper filing of the information.

The Administrator will be responsible to inspect all licenses upon receipt, which are requested from a hospice agency, providing care to a resident in the facility, to assure it is current, and has not expired. The procedure of obtaining the license on the first day of a resident visit in the facility will be maintained.

Hospice License : Attachment # 4

8-13-16

Sharon Rutsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.82(a) - Poisonous materials shall be stored in their original, labeled containers.

2a. DESCRIPTION OF VIOLATION
A half filled 1/10 pint clear bottle labeled "alcohol" found in resident # 4's bedroom 101N, Myers Manor was not stored in its original, labeled container. The half-filled bottle is believed to be rubbing alcohol.

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 + #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) Sharon Ritsick RN

Date 6/27/2016

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

Plan of correction implementation status as of 8-23-16 (Date)

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

Sharon Rebuck RN
6/27/2016

ATTACHMENT # 5

Regulation 2600.82(a) p Sag 18

The resident involved with this violation resides in a one bedroom, private room, with its own bathroom. The resident requires the assist of family and friends to purchase and/or bring items for [redacted] use and/or request. The facility does not supply rubbing alcohol to residents in that form, and it is believed that the family brought in this item for the resident per [redacted] request for reasons unknown at this time.

The resident and family member, and/or responsible parties are instructed upon admissions that they are requested not to bring in over the counter medications for the residents own use, and must inform the nursing staff if they need a specific item, so a physician order can be obtained, and placed on the MAR and/or treatment log. Residents are not allowed to keep medications in their room per the facility policy and procedure. This is again explained and reviewed upon the admission process. Also, in regards to this incident, the resident and family are asked to not keep items in the room which are not stored in their original containers, as in the case of the rubbing alcohol.

The Personal Care Staff are educated on such situations as above, and will alert the nurse Supervisor, and/or Administrator, if they should discover any items in the resident room such as medications, or items such as the rubbing alcohol, which is not stored in their original container, and may be mistaken for another product, by the resident in the room or another resident in the facility, or possibly a staff. The Administrator and/or Nurse Supervisor will then communicate this to the resident, and remove the item in question to assure the safety of the resident and others.

The residents are also reminded of this very important rule over the course of their residency during the monthly resident house meetings. This is a common topic to discuss with the residents every several months. The importance of the rule is emphasized and the reason for the rule explained for the resident, and others safety. It is reviewed frequently to the residents during the meeting, and also individually, if necessary.

The activity department is also involved in enforcing this rule at times when resident scheduled activity trips out of the facility, involve shopping. Residents are reminded prior to leaving for the shopping trip, that they are not to purchase over the counter medications, and occasionally their shopping items will be inspected for items that may not be safe, or allowable, in the residents' room, or in-properly labeled items which may be a concern.

The Administrator will be responsible to review this rule with staff/housekeeping so it may be enforced, and staff can intercept items, such as in the case of the rubbing alcohol, in a residents room during

8-13-16

ATTACHMENT #6 p 5 of 18

Sharon Ritsick RN
6/27/2016

times of providing care and items such as this are discovered. The Administrator will also be responsible to review the rule with the residents during resident house meetings, intermittently, to assure all are aware, and can remember this important rule. The admission department will also be reminded to assure this is being reviewed upon admission with the resident and family members, as procedure and part of the admission process of information required at this time.

8-13-16

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.88(a) - Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION
Sections of the metal ceilings of the outside covered walkway leading to the Anderson Personal Care Home and the portico of the covered parking area had brown soffit panels loosely hanging which could potentially be hazardous to residents using these areas should they fall.

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 — Date 6/27/2016

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

Plan of correction implementation status as of 8-13-16 (Date)

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

Sharon Ritsick RN
6/27/2016

ATTACHMENT # 7

p6 of 18

Regulation 2600.88(a)

The above concern was repaired by the maintenance staff immediately upon report of the problem by the Department Inspector. The repair was completed quickly and easily by staff.

The Plant Operations Director had concluded upon inspection of the concern, some panels had loosen as a result of the winding weather conditions at that time. The entire area and ceiling was also inspected at this time for any other areas that may have required attention, to avoid potential problems in the future, or with changing weather conditions.

The Maintenance department maintains a routine inspection of all areas of the building and buildings on campus, which includes both the structures and the grounds. Routine inspections, in addition to immediate repairs are conducted to avoid potential problems and maintain the safety of resident, visitors and staff.

The Administrator will continue to communicate with the Plant Operations Director in regards to any area of concern in the building, and routine meetings concerning the maintenance of the building.

Staff have been, and continue to be, educated in communicating to maintenance any problems or known complaints voiced by the residents, for repair and further investigation of the problem. The facility utilizes work order forms, which are available to both the staff and residents, to report the areas of needed repair or need of concern. The work orders are collected daily and are completed on the basis of priority of need and severity of the repair.

Please emphasize Staff responsibilities QP 8/13/16

The Maintenance department has just recently implemented a new magnet system which provides the resident a magnet type card, which is placed in the residents' room, with number to call maintenance directly, if a problem or concern has arisen, which can be utilized in conjunction to the paper work orders available. The maintenance department will also provide a communicative door hanger, which informs the resident that maintenance has visited the resident room, and the repair was done, or not completed, and the reason, should the resident not be available in the room at the time of the maintenance arrival and repair of the problem voiced. The staff is also an excellent resource for the residents, if they have a complaint, or are in need of a repair in their room, they can simply inform a staff member, and maintenance can be notified directly by phone, and the repair, or concerned, addressed quickly, as necessary.

The Administrator will be responsible to assure that the maintenance department maintains a routine schedule of maintenance repair and up-keep of the facility, both inside and out, and also addresses resident complaints and concerns, in a timely, and priority of the need.

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.91 - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

2a. DESCRIPTION OF VIOLATION
There were no emergency phone numbers required by this regulation found posted on or by telephones with an outside line in the following resident rooms. Myers Manor room 101 near resident sofa and near resident's bed, Myers Manor room 108 near telephone near the window. Myers Manor room 210 near bedside telephone.

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	Date	6/27/2016	

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

The above plan of correction is approved as of 8-17-16 (Date)

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

Plan of correction implementation status as of 8-17-16 (Date)

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

ATTACHMENT # 8

Regulation 2600.91 page 1 of

Upon review of the resident rooms listed in this violation, on the day of inspection, the posted numbers were founded, however, were unfortunately not in view, and covered by the residents furniture, placed per their preference, and obstructing the view of the posted numbers.

The resident rooms are inspected on a routine basis for the required posted telephone numbers. All resident rooms have been recently renovated, and the placement of the posted numbers were a part of the itemized check list to assure were in place. The numbers have been placed in a permanent laminated covering, and placed conspicuously in each room, near the telephone jack, to assure compliance with every phone in the facility. The placement of furniture however, has caused the posted numbers to be obstructed from view and had resulted in this violation.

The housekeeping department and the maintenance staff have been educated in regards to this regulation and the need to assure the posted numbers are always in view. Both departments are actively involved with the placement of resident furniture, resident room moves, and the placement of furniture at admission. The departments were educated to avoid placement of resident furniture in the areas where the posted numbers may be installed. If a resident insist on having a large piece of furniture, such as a bookcase or large cabinet, placed in an area which would obstruct the view of the numbers, the Administrator will be notified, and an alternate placement of numbers will be provided for that resident in their room to maintain compliance.

The direct care staff were also educated on the regulation, and the need for the posted numbers to be in view in all resident rooms. The staff will inform the Administrator if they should notice any resident room which the numbers have been covered by furniture or other means. The Administrator will then be responsible to investigate the need to rearrange furniture and/or provide an alternate means for the numbers to be posted in an alternate location in the room, or directly on the phone, if necessary.

The housekeeping staff are assigned to monitor the telephone number postings in the resident rooms on a routine basis, and alert the Administrator of any missing, or needed postings, which the maintenance staff will provide when the need is communicated. The Administrator will be responsible to assure that the housekeeping staff continue to routinely inspect the resident rooms and common areas for the required posted numbers, conduct routine room inspections to assure numbers are visible, and continue to educate staff on this regulation, and the need to maintain the above procedures to assure compliance.

8-13-16

Sharon Ritsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.130(h) - The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

2a. DESCRIPTION OF VIOLATION
The home's inoperable smoke detector policy does not indicate who will conduct the fire watch, how often it will be conducted, and how residents and staff will be notified in the event of a fire emergency.

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 & # 10

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 | Date 6/27/2016

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Plan of correction implementation status as of 8-17-16 (Date)

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

ATTACHMENT # 9

Regulation 2600.130(h) P8a4j18

The policy for the homes inoperable smoke detectors was reviewed by both the Administrator and the Plant Operations Director. The information not available in the policy as stated in the violation, was included after discussion, on how to proceed with an effective method of alerting staff and residents in the facility, during an emergency situation, when the page system is not operating properly for adequate communication..

The continuation of (15) minutes checks by staff, throughout the facility will remain. In addition to the staff checks, the facility will now utilize the use of air horns, to alert both the staff, and residents, when communication is effected during these times. As stated in the policy (enclosed attachment#), the air horns will be located in a designated area on each floor for quick and easy access. The maintenance staff will be responsible to check the air horns monthly for placement and proper function, and will replace as necessary. Direct care staff will also be responsible to alert the maintenance staff if a horn is found to be missing, inoperable, or in need of visible repair, due to a break or other defect.

The Administrator will be responsible to maintain a copy of the updated version of the policy, and assure access for staff review as needed, as are all policies and procedures in the facility, and have the maintenance department monitor the location and proper functioning of the air horns.

Updated version of the policy is enclosed, attachment# 10

QR 8-13-16

Sharon Ritsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant, or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

2a. DESCRIPTION OF VIOLATION
The home did not have a completed medical evaluation (D.M.E.) for resident # 5. The resident was admitted to the home on [redacted]6.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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Attachment # 11 & #12

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

Date 6/27/2016

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ATTACHMENT # 11

Regulation 2600.141(a) P9a 8 18

The resident was seen by their physician for an evaluation in March, 2016. The information on the DME was completed by the facility staff, and sent to the MD for signature. However, the DME was not returned to the facility in a timely manner, and the staff failed to follow up on its return, and notify the physician of the need for it to be signed, and returned back to the facility as required.

The following procedure has been implemented to track and monitor resident DME's for date of evaluation, completion of the DME form, date sent, date to be returned, and follow up with resident physician as needed, to assure form is returned back to facility in an appropriate amount of time.

One nurse has been assigned to be responsible to complete the initial and annual DME form. A spread sheet was developed to provide the nurse assigned, and all nurse staff, with Administrator access, the resident information which again includes the resident name, date of required evaluation, date of last evaluation, (if applicable), date DME is due, date DME completed, date DME sent to physician, and the date returned, and then scanned into the resident electronic record. The spread sheet will allow the nurse to track all required DME's and assure all have been completed appropriately to maintain compliance. The spread sheet will be available to all nurses and Administrator who can also assist the assigned nurse in her absence, quickly and efficiently, without delay or confusion.

The Administrator will conduct monthly resident chart audits, on assigned designated days, to assure all DME's are completed at the appropriate date, and returned back to the facility to be filed in the resident chart as required. The Administrator will utilize the spread sheet monthly to monitor the completion of the DME, and all required DME's due, to again, assure compliance.

The facility has also adopted the use of peer reviews annually. The peer review allows other management staff to review the records and compliance of regulations in the Personal Care facility prior to a state survey. This provides another layer of audit check and balances, of all regulatory compliances within the facility, and an opportunity to have another set of eyes review the information needed and required by the home.

Q. 8-13-16 Sharon Ritsick RN 6/27/2016

p96818

The Administrator will be responsible to assure that all resident DME's are completed with appropriate dates of evaluation, signature of the physician, and filing in the resident record, by utilizing the procedures put in place, assuring the nurse assigned is accountable to complete and demonstrate compliance of the forms, conduct the monthly chart reviews, and assist and participate in the annual peer reviews to maintain compliance of this and all regulations in the guide.

Attachment #12

cc 8-13-16

Sharon Rutsch RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.141(a)(2) - The medical evaluation must include the following: (1) through (10)

2a. DESCRIPTION OF VIOLATION
Resident # 3 's medical evaluation, date 3-19-16, does not have the following sections completed: Section 1 - the resident's height, weight, pulse rate, blood pressure, and temperature; Section 6 – immunization history; and, Section 4 – needs addendum with special dietary and health needs

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 # 13

& #14 thru #19

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

Date 6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

Sharon Ritsick RN
6/27/2016

ATTACHMENT # 13 p10a 8 13

Regulation 2600.141(a)(2)

The plan of correction for this violation will be the same as the previous violation for regulation 2600.(a)(1).

The implementation of a procedure to complete the DME, utilizing a spread sheet, will be assigned to one nurse supervisor, the responsibility of assuring the completion and adequate dates of evaluation have been completed on the DME, in addition to all other appropriate dates and completion of the information on the form, as stated in this violation.

The facility staff, which is the assigned nurse, completes the allowable information on the DME form prior to obtaining the physicians signature after the resident has been evaluated, when it is applicable to do so. The information stated in this violation is standard information on the resident, which the facility has access to, and documentation of the physician visit to complete appropriately.

The Administrator has provided a DME guide for the nurses to reference the proper procedure for completion of the form, and maintaining compliance. (copy of the guide is enclosed, attachment# 14). The guide provides another tool for staff to utilize, and a reference if they are unsure of how to proceed, or need a question answered. (ABOVE, ATTACHMENT #14 THRU #19)

Staff have been instructed to review the completed DME form in its entirety, assuring all areas have been documented and not leaving any box unanswered, prior to scanning into the resident electronic record. Staff may assist each other in reviewing the form for each other, and have a second set of eyes view it prior to scanning to assure it has been completed.

The Administrator will be responsible to assure the DME form, completed by the nurse staff, has been completed in its entirety, and no areas have gone unanswered. The Administrator will view resident DME's upon completion, and prior to scanning, when possible. In addition, the Administrator will conduct monthly chart audits, and review all newly admitted residents DME's ,and all annual DME's completed by staff for the month. This is another check that has been implemented to maintain compliance with the required forms, and lessen the possibility of errors.

Q. 8-13-16

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
2600.185(b) - At a minimum, the procedures in § 2600.185(a) shall include:
(1) Documentation of the receipt of controlled substances and prescription medications.
(2) A process to investigate and account for missing medications and medication errors.
(3) Limited access to medication storage areas.
(4) Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply for a resident who self-administers medication without the assistance of a staff person and stores the medication in his/her room.

2a. DESCRIPTION OF VIOLATION
The home's medication policy for controlled substances requires two staff to count the controlled substances and both staff sign the controlled substance count record. The following dates and times the record was not signed: 5-14-16 at 4:00pm, 5-15-16 at 12:00am, 5-20-16 at 12:00am, and 5-20-16 at 4:00pm.

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.

Attachment #20

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 | Date 6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

ATTACHMENT # 20

Regulation 2600.185(b) p11 a g18

The policy and procedure for appropriate count of the controlled substances, from shift to shift, continues, and was reviewed with the staff due to the above violation. The direct care staff, and nurse staff, are aware that a count of the narcotic medication, in the medication cart, assigned to the staff for a scheduled shift, is required to be counted at the end of the shift, prior to the on- coming shift taking over responsibility of the cart and its contents. The narcotic count also occurs anytime one staff takes over responsibility of the medication cart, regardless of the time and/or shift change. Documentation and verification that the narcotic count has been completed, is the signature of both staff on the appropriate form.

The nurse supervisor is assigned to be responsible to review the narcotic signature sheets on her scheduled shift, to assure that the count has been completed correctly and satisfactorily, with signatures of both staff, on- coming and out- going, in place on the appropriate form. Non- compliance with this policy will result in disciplinary action on the staff not adhering to this important policy. A non -signature will also indicate that the narcotic count has not been completed, and/or is not correct, which will result in further investigation initially by the nurse supervisor, and then immediate notification of the Administrator if there is no resolution by the nurse supervisor.

The Administrator will be responsible to assure that staff are aware of this policy and they maintain compliance. The Administrator will conduct random, and intermittent checks of the narcotic books, to assure compliance by the staff, and the nurse staff completing their shift checks of appropriate signatures, and completion of the narcotic count, staff to staff, prior to the exchange of responsibility of the medication cart and its contents.

(Staff signature sheet of review of policy enclosed, attachment# 27)
& #30

CJ 4-13-16 Sharon Rikard RN 6/27/2016

Sharon Rusiecki RN 6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
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

The master key was missing staff person(s) signatures.

Resident # 6 has a physician's order for a blood glucose (BG) test to be administered 4 x day. On 5-16-16 at 11:30am,the resident's BG#260 was recorded in the MAR as 268.

Resident # 7 has a physician's order for a blood glucose (BG) test to be administered 2 x day. On 5-18-16 at 4:00pm, the resident's BG#323 was not recorded in the MAR.

Resident # 8 has a physician's order for a blood glucose (BG) test to be administered 3 x day. On 5-12-16 at 11:00pm,the resident's BG#96 was recorded in the MAR as 186, and on 5-19-16 at 11:00pm, the BG# 165 was not recorded in the MAR.

Resident # 9 has a physician's order for a blood glucose (BG) test to be administered 4 x day. On 5-13-16 at 7:30pm, the resident's BG#154 was recorded in the MAR as 158.

Resident # 10 has a physician's order for a blood glucose (BG) test to be administered 4 x day. On 5-13-16 at 5:00pm, the resident's BG#101 was not recorded in the MAR; 5-13-16 at 8:00pm, the BG# 197 was recorded in the MAR as 101; 5-18-16 at 8:00pm, the BG#203 was not recorded in the MAR; 5-19-16 at 5:00pm, the BG#211 was not recorded in the MAR; and, on 5-19-16 at 8:00pm the BG#215 was not recorded in the MAR.

Resident # 11 has a physician's order for a blood glucose (BG) test to be administered 3 x day. On 5-16-16 at 11:00pm, the resident's BG#211 was not recorded in the MAR, and on 5-19-16 at 5:00pm, the BG#124 was recorded in the MAR as 123.

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.

Please see p. 13

Violation Report: - 05/20/2016 - Dumas, Gerald
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.

See Attachment #21

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 Date 6/27/2016

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

The above plan of correction is approved as of 08-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

ATTACHMENT # 21

Regulation 2600.187(a) p13 of 18

The nurse staff is responsible to perform blood glucose monitoring per the physicians orders, record and document results of the testing, and administer appropriate doses of insulin as ordered by the resident physician, including both straight dose and sliding scale orders.

The facility has implemented a system to assist in preventing errors in recording blood glucose results in the resident record.

The nurse will perform the blood glucose testing as ordered, and upon completion of the testing, the results obtained on the glucometer machine will be directly recorded into the resident record via the electronic record, and will not document on paper, and then later place results in computer.

The facility has supplied the nurses with a cart which they place all required equipment such as the computer laptop, giving them direct access into each resident electronic record, glucometer machine and supplies to perform the testing, and also insulin and syringes for each resident, gloves, sharps containers, ect. The nurse can perform all necessary procedures in the privacy of the resident room and document immediately afterwards without interruption, or the need to remember results, and later documenting.

The Administrator will be responsible to review the resident glucometer readings on a monthly basis, and compare them to the results documented in the resident record. Discrepancies will be addressed immediately to identify problems of documentation, and determine methods to prevent future errors.

The Administrator will be responsible to assure the nurses maintain compliance with the proper procedure implemented to obtain blood glucose monitoring, and documentation.

8-13-16 Luann Ritsick RN 6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
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
Resident # 9 has physician's orders for a blood glucose (BG) test to be administered 4 x day and insulin coverage based on a sliding scale. On 5-13-16 at 8:00am, the resident required 2 units of insulin and received 0 units. On 5-14-16 at 8:00am, the resident did not require any insulin and received 2 units.
Resident # 10 has physician's orders for a blood glucose (BG) test to be administered 4 x day and insulin coverage based on a sliding scale. On 5-14-16 at 11:45am, the resident required 4 units of insulin and received 2 units. On 5-18-16 at 5:00pm, the resident required 10 units of insulin and received 7 units.
Resident # 11 has a physician's order for a blood glucose(BG) test to be administered 3 x day. On the following days and times the resident did not receive a BG test: 5-12-16 at 7:00am, 5-12-16 at 11:00am, 5-14-16 at 11:00am, 5-15-16 at 11:00am, 5-16-16 at 11:00am, 5-17-16 at 11:00am, 5-18-16 at 11:00am, 5-18-16 at 5:00pm, 5-19-16 at 7:00am, and 5-19-16 at 11:00am.
Resident # 12 has a physician's order for a blood glucose test to be administered 1 x day. On 5-16-16 the resident's blood glucose was not tested.

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 # 22

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

Date 6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

Plan of correction implementation status as of 8-13-16 (Date)

☐ Fully Implemented
☒ Partially Implemented - Adequate Progress

See next page please

Violation Report - 05/20/2016 - Dumas, Gerald PCH Name: WESLEY VILLAGE	
1. REGULATION 55 Pa.Code §2600 2600.187(d) - The home shall follow the directions of the prescriber.	
The above plan of correction was approved by _____ (initials)	☐ Partially Implemented - Inadequate Progress ☐ Not Implemented

Sharon Retsick RN
6/27/2016

Cont from page #14

(Attach MAR #22).

ATTACHMENT # 22

Regulation 2600.187(d) P15 a g 18

Upon review of the resident records are stated in this violation, it was noted that the errors noted were in regards to the individual nurses' documentation of the administration of both the straight dose and sliding scale dose of insulin ordered by the resident physician. Documentation of the units of insulin administered varies, and the nurses are not consistently documenting the amount of insulin administered correctly. Some nurses are documenting the straight dose on the record, if a sliding dose is not needed to be given, and another nurse is documenting the sliding scale dose of insulin only. There is no consistency, and it is very confusing in examining the amounts administered, which appear to have been correct, however, are documented incorrectly, in the wrong area on the electronic MAR.

The nurses received extensive training from the Education Department from our in-house Educator. Proper documentation of the insulin dose administered in addition to proper documentation of both straight order insulin, and sliding scale dose insulin coverage, was reviewed with the nurses. Consistency in documentation was emphasized, and the violation received reviewed, to assure a clear understanding of their errors to avoid repeating.

The Educator will continue to review the nurses' documentation intermittently to assure proper documentation and correct insulin doses are administered.

The Administrator will be responsible to review the documentation and administration of the residents insulin completed by the nurse staff. The Administrator will inform the educator of any incorrect or concerning documentation that is found, to assure the nurses are re- educated if needed, and the errors are corrected, and future errors can be avoided.

8-13-16

Sharon Ritsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
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
The home did not complete an assessment for resident # 5 (Date of Admission [redacted]16). The resident's assessment was due within 15 days of admission to the home.

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 #23

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/28/2015		

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 | Date 6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

ATTACHMENT # 23

Regulation 2600.225(a) p16 a 8/18

The Administrator has assigned a staff nurse the responsibility of completion of the resident RASP, both the initial and annual. This assignment for the RASP has been determined as the prior assignment, for the DME form.

The nurse will be responsible to assure the initial RASP has been completed within the first 15 days after admission. The use of a spread sheet, as utilized with the DME, will be implemented as a system to track the RASP forms, which are due both initially and annually.

The assessment portion of the RASP will be completed on the day of admission by the nurse who completed the resident admission. Completion of the RASP will then be done by RASP assignment nurse.

The Administrator will be responsible to complete the resident chart audits on designated days each month. The Administrator will be monitoring the completion of both the RASP and DME via the spread sheets.

The spread sheets and nurse assignment for each individual task are implemented to assure compliance with the required forms, and assure date of completion is maintained.

If Additional or updated info regarding the resident and their need(s) will be documented on the RASP in order to perform the most accurate, comprehensive and timely assessment possible while still complying w/ this regulation. CE 8-13-16

Sharon Rutsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:
(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

Resident # 13, who's date of admission was on [redacted] 2013, has an annual Resident Assessment and Support Plan that was completed on 2-18-15.

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 #24

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

Date 6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

ATTACHMENT # 24

Regulation 2600.225 (c) P 17 a g 18

A RASP was not completed for Resident #13 for 2016. Upon review of the resident record, the resident was hospitalized 2/01/2016, and then had a stay in rehabilitation prior to returning back to the Personal Care facility.

To avoid future non-compliance with both the RASP and DME forms, the following, as stated in previous violation plan of correction, the following has been put in place:

1. A staff nurse will be assigned to complete the resident RASP, both initial and annual.
2. A spread sheet has been developed to track the forms and supply the staff with the appropriate dates of required completion, and last completed, (for annual).
3. The Administrator will conduct resident chart audits on designated days of each month to review both newly admitted resident required forms, and annual required forms.
4. A peer review will be conducted in the facility annually. The review will include the assurance of completed forms and compliance of dates.

The Administrator will be responsible to assure the above plan is maintained, and staff follow through occurs, to assure compliance with all required state forms.

Alternative circumstances may be noted in the resident record, along w/corresponding dates. The RASP may then be completed upon resident's return to the PCH.

QP. 8-13-16

Sharon Retsick RN
6/27/2016

Violation Report: - 05/20/2016 - Dumas, Gerald
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 # 5 was admitted to the home on [redacted]2016. The home did not complete a support plan within 30 days of admission to the home.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Attachment # 25

Repeat Violation: Yes	Date(s) of Previous Violation(s): 04/28/2015		
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	Date	6/27/2016

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

The above plan of correction is approved as of 8-13-16 (Date)

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

Plan of correction implementation status as of 8-13-16 (Date)

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

ATTACHMENT # 25

Regulation 2600.277(a) p18 as 18

The Plan of Correction for this violation will be the same as the previous violation, Attachment # 24
.

The Administrator will be responsible to assure staff maintains the plan, and assure compliance with all required forms.

The spread sheet has been in place, and has currently been utilized since the date of the inspection. At this current date, the review of the spread sheet indicates that all DME and RASP resident forms are up to date on newly admitted residents, and also due annual forms.

Staff assigned to complete each form are maintaining compliance of the dates due. During the absences of a staff assigned to complete the forms, such as vacation, and time off due to illness, a third nurse staff is assigned to assist with any forms that are required to be competed, and the assigned nurse is unable to complete on the date due. * Extenuating circumstances may be noted along w/ corresponding dates. Resident Support Plan may be completed following the completion of the assessment.
The Administrator conducts a weekly meeting with the nurse supervisors. In addition to other topics, the review of the spread sheet for both the DME and RASP, are reviewed to assure compliance with dates, and to communicate any need for assistance to complete. The meetings are conducted every Wednesday afternoon, and provide an opportunity to discuss both facility events, concerns, problem solving and the compliance of state required materials. 8-13-16

The Administrator is responsible to assure the plan of correction for this violation is maintained, in maintaining updated spread sheets, conducting monthly chart audits, participating in the annual peer review, and conducting the weekly meetings, assuring they are productive for the staff and adequate communication is maintained for compliance in all areas of the facility.

Susan Rutsch RN
6/27/2016