



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to COUNTRY MANOR PCH LP
LEGAL ENTITY

To operate COUNTRY MANOR
NAME OF FACILITY OR AGENCY

Located at 111 ALTMAYER DRIVE, KITTANNING, PA 16201
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE _____ ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE _____ ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE _____ ADDRESS OF SATELLITE SITE

To provide Personal Care Homes
TYPE OF SERVICES TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 40
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from February 13, 2017 until August 13, 2017,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **446291**

Robert E. Robinson
ISSUING OFFICER

[Signature]
DIRECTOR

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE FEB 13 2017

Mr. Ben Willner, Owner
Country Manor, PCH LP
111 Altmeyer Drive
Kittanning, Pennsylvania 16201

RE: Country Manor
License #: 446291

Dear Mr. Willner:

As a result of the Department of Human Services' (Department) licensing inspections on July 1, 2016, July 6, 2016, October 25, 2016 and November 21, 2016 of the above facility, the violations specified on the enclosed Licensing Inspection Summary were found.

Based on violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes), your current license #446290 dated October 30, 2016 to October 30, 2017 is REVOKED. A FIRST PROVISIONAL license is being issued based on your plan to correct the violations as specified on the Licensing Inspection Summary. This first provisional license replaces all previously issued licenses and is effective for six months from the date of issuance. The license dated October 30, 2016 to October 30, 2017 is NOT reinstated upon expiration of this first provisional license. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation.) Your first provisional license is enclosed.

All violations specified on the Licensing Inspection Summary must be corrected by the dates specified on the Licensing Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Pursuant to 62 P.S. 1085-1087 and 55 Pa.Code §§ 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violations unless fully corrected on or before the mandated correction date.

55 Pa.Code Chapter 2600 Section no.	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
187b	II	30	\$5	\$150	5 calendar days from mailing date of this letter

A fine will be assessed on a daily basis beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a provisional license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa.Code Part II, Chs. 31-35. If you decide to appeal your provisional license, a written request for an appeal must be received within 10 days of the date of this letter by:

Kevin Brumbach, Enforcement Manager
Bureau of Human Services Licensing
Department of Human Services
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Jacqueline L. Rowe
Director

Enclosures
License
Licensing Inspection Summary

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

PCH Name: COUNTRY MANOR		License Number: 44629
Address: 111 ALTMAYER DRIVE, KITTANNING, PA 16201		County: Armstrong
Administrator: Tammy Branen		Region: WEST
Legal Entity Name: COUNTRY MANOR PCH LP		RECEIVED
Legal Entity Address: 111 ALTMAYER DRIVE, KITTANNING, PA 16201		
Certificate(s) of Occupancy C-2 LP 06/20/1998 Dept. of L & I		OCT 19 2016 WEST REGION FIELD OFFICE Human Services Licensing
Staffing Hours		
Resident Support: 0	Total Daily Staff: 46	Working Staff: 35
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Renewal, Complaint, Incident		
On-Site Inspections Dates and Department Representatives On-Site 07/01/2016: Cutler, Jan; Park, Beth 07/06/2016: Cutler, Jan; Park, Beth		
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: 40 Number of Residents Served: 34 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: 5 Number of Hospice Residents in past year: 11		Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 32 Have Mental Illness: 12 Have an Intellectual Disability: 0 Have a Mobility Need: 12 Have a Physical Disability: 3

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OCT 19 2016

Violation Report: 44828 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10226.701 - 10226.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION

On 5/23/2016, resident #1 gave his/her debit card and personal identification number to staff person A and requested that the staff person withdraw \$10 to purchase lemons for the resident. The resident made several attempts to get the debit card back, but the staff person failed to give it back to the resident until 5/31/16. Upon checking the online banking statement, resident #1 realized that money was missing and that the account was overdrawn. On 5/31/2016, the resident notified staff person C and staff person C notified the bank. The bank representative canceled the debit card and turned the items over to fraud protection authorities. The state police were also called and began an investigation into the theft. Direct care staff person A was suspended at the time that the theft was disclosed by the resident and ultimately terminated from employment. The total amount of the theft is \$1,141.62, not including \$144.00 in overdraft fees that will not be forgiven by the bank because the resident gave his/her debit card and personal identification number to staff person A. This allegation of abuse was not reported to the local area agency on aging until 7/1/2016.

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.

On 7-1-2016 an oral report was made to the Area Agency on Aging with a written report the next day 7-2-2016. All Staff were re-educated on the requirements of reporting abuse. They were all given a copy of regulation 2600.15 with the training. Going forward, any and all abuse reportable incidents will be reported to the Area Agency on Aging in a timely manner. All incident reports are being reviewed weekly by the Administrator or Executive Director to ensure if they are reportable that they are reported and reported in a timely manner. Each DCS was individually trained on regulation 2600.15 (d) and was given a copy of the regulation to keep. All new DCS receive the training and a copy of the regulation upon hire. Documentation attached.

Immediately - The administrator will take action to ensure the home places an increased emphasis on this licensing violation and plans of correction during each quality management plan review and evaluation in 2017. BB 1/26/17

Repeat Violation: Yes Date(s) of Previous Violation(s): 11/23/2015

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *10-18-2016*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

RECEIVED

OCT 19 2016

Violation Report: 44620 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Premises Services Licenses

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On 5/23/2016, resident #1 gave his/her debit card and personal identification number to staff person A and requested that the staff person withdraw \$10 to purchase lemons for the resident. The resident made several attempts to get the debit card back, but the staff person failed to give it back to the resident until 5/31/16. Upon checking the online banking statement, resident #1 realized that money was missing and that the account was overdrawn. On 5/31/2016, the resident notified staff person C and staff person C notified the bank. The bank representative canceled the debit card and turned the items over to fraud protection authorities. The state police were also called and began an investigation into the theft. Direct care staff person A was suspended at the time that the theft was disclosed by the resident and ultimately terminated from employment. The total amount of the theft is \$1,141.62, not including \$144.00 in overdraft fees that will not be forgiven by the bank because the resident gave his/her debit card and personal identification number to staff person A.

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.

Immediately on [redacted] 2016 Staff member A was terminated and also mandated to not enter the Facility. The incident was reported to DHS on 6-2-2016 within the 24 hour time period. The incident was reported to the Area Agency on Aging. All Staff were re-educated concerning Facility policy of not accepting any Resident funds for any reason at any time. All Staff were educated and also given a copy of regulation 2600.42, with emphasis on 42 (b). All new Staff are educated upon hire regarding this Facility policy. They are also given a copy of regulation 2600.42 with emphasis on 42 (b). All Residents were educated on the proper way to attain funds from their accounts. They signed a statement acknowledging the proper procedures for getting funds. They also were reminded that they will get reports quarterly or as requested. Administrator or Designee will continue to ensure compliance by doing Staff trainings and regular Staff meetings. The topic of Resident funds will be brought up at all Staff meetings. The Staff are all aware that any funds from Residents for any items must be directed to the Administrator or Executive Director using a Record of Financial Transactions reporting form. If a Resident needs help with getting items, the Administration will take the proper steps and record properly on the Record of financial transactions sheet with the Residents signature. A list of every Resident that is assisted with financial transactions is kept and updated as needed. The home's staff meetings will occur at least monthly.

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 10/6/17 (Date)

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

Plan of correction implementation status as of 10/6/17 (Date)

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

BS 10/6/17

RECEIVED

OCT 19 2016

Violation Report: 44029 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.53(a) - The administrator shall have one of the following qualifications:

- (1) A license as a registered nurse from the Department of State.
- (2) An associate's degree or 60 credit hours from an accredited college or university.
- (3) A license as a licensed practical nurse from the Department of State and 1 year of work experience in a related field.
- (4) A license as a nursing home administrator from the Department of State.
- (5) For a home serving 8 or fewer residents, a general education development (GED) diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

2a. DESCRIPTION OF VIOLATION

On 7/1/2016, the home was serving 34 residents. Staff person D, the administrator, did not have a license from the Pennsylvania Department of State as a registered nurse, as a nursing home administrator, or as a licensed practical nurse with one year of work experience in a related field, or an associate's degree or 60 credit hours from an accredited college or university.

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.

On 7-1-2016 Staff Person D was given the opportunity to continue her College education to become licensed. A waiver was sent on 7-5-2016. The waiver is attached to this report. Staff Member D decided to quit and the waiver was rescinded. Going forward the CEO or Executive Director will review and audit any Administrator hiring before Employment to ensure all qualifications of 2600.53 (a) are met.

7/18/16 - The home hired a qualified administrator in accordance with this regulation. *BB 10/6/17*

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 10/6/17
(Date)

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

Plan of correction Implementation status as of 10/6/17
(Date)

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

RECEIVED

OCT 19 2016

Violation Report: 44829 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 65 Pa.Code §2600
2600.58 - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

2a. DESCRIPTION OF VIOLATION
There was not a qualified administrator in the home during the month of June 2016.

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.

Staff Member D was hired on [redacted] 2016 in the capacity of Administrator. Staff Member D had completed the 100 hour course and passed the licensing exam. However Staff member D failed to disclose when applying for the Administrator position that she had not completed the required college credits. She disclosed in her interview with the CEO and Executive Director that she only needed to take the exam that week to become Administrator. During the inspection on 7-1-2016, upon review of Staff Member D's file, it was brought to the attention of the Executive Director that Staff Member D did not meet the Administrator qualifications. Immediately the Executive Director contracted a licensed Administrator to work in the Facility a minimum of 20 hours per week for the calendar month. On [redacted] a qualified Administrator was hired. She presented with all of the required qualifications. The CEO or Executive Director will ensure that a qualified Administrator is present in the Facility a minimum of 20 hours per week per calendar month. Time sheets will be kept for proof. In order to be sure that an Administrator has the qualifications, every document will be requested at the time of hire and if the qualifications are not there in writing, the person will not be hired.

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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The above plan of correction is approved as of 10/6/17
(Date)

Plan of correction implementation status as of 10/6/17
(Date)

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

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

RECEIVED

OCT 19 2016

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Violation Report: 44629 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Family Services Licensing

1. REGULATION 56 Pa.Code §2600

2600.86(f) - Training topics for the annual training for direct care staff persons shall include the following:

- (1) Medication self-administration training.
- (2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- (3) Care for residents with dementia and cognitive impairments.
- (4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
- (5) Personal care service needs of the resident.
- (6) Safe management techniques.
- (7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

2a. DESCRIPTION OF VIOLATION

The home's staff training year is 1/1-12/31. Direct care staff person E did not receive the following required training in 2016:

- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
- Care for residents with mental illness

The home served 12 residents whom have mental illness on 7/1/16.

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

Immediately an audit of the Employee record for DCS Person E was done to see what trainings she had. It was found that some of the trainings for 2015 are missing. Moving forward, all of the trainings for 2016 are accounted for and documentation attached. All other DCS records have been audited to be sure they are all in compliance with the training requirements. A Med Tech Record book with Observations and MAR reviews was created. This book includes all trainings for each DCS with a list of the trainings as a cover sheet for each DCS. Each new DCS will have a page for their trainings also. Administrator or Designee will audit this book monthly with documentation to be sure that all Staff are in compliance. Forms used are attached.

ring again. If steps cannot be completed
 Immediately - The administrator will implement procedures to ensure Agents of the Department are provided records immediately upon request. *BB 1/26/17*

on 10/19/16, the home submitted We are disputing this Violation for the following reasons:
 documentation indicating that Proof was found that DCS person E had the following trainings:

- Staff person E was trained on instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan on 10/21/16 and on 8/27/15. *BB 1/26/17*
 - Care for Residents with mental illness.
- Proof of trainings is attached.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction Implementation status as of 1/26/17 (Date)

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

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

RECEIVED

OCT 19 2016

Page 8 of 28

Violation Report: 44820 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Home Services Licensing

1. REGULATION 56 Pa.Code §2600

2600.85(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. §§ 10226.101-10226.5102).
- (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

The home's staff training year is 1/1-12/31. Direct care staff person E did not receive the following required training in 2016:

- Fire safety completed by a fire safety expert
- Resident rights
- The Older Adult Protective Services Act

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.

Immediately an audit of the Employee record for DCS Person E was done to see what trainings she had. It was found that some of the trainings for 2015 are missing. Moving forward, all of the trainings for 2016 are accounted for and documentation attached. All other DCS records have been audited to be sure they are all in compliance with the training requirements. A Med Tech Record book with Observations and MAR reviews was created. This book includes all trainings for each DCS with a list of the trainings as a cover sheet for each DCS. Each new DCS will have a page for their trainings also. Administrator or Designee will audit this book monthly to be sure that all Staff are in compliance. Forms are attached.

Immediately - The administrator will implement procedures to ensure Agents of the Department are provided records immediately upon request. *BB*
1/26/17

On 10/19/16, the home submitted documentation indicating that staff person E was trained on fire safety on 9/16/15 and 10/8/15 and resident rights and the Older Adult Protective Services Act on 10/22/15. *BB* 1/26/17

We are disputing this violation for the following reasons:

Proof was found that DCS person E had the following trainings:

- Fire safety completed by a fire safety expert
- Resident Rights
- The Older Adult Protective Services Act

Proof of trainings is attached.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Dunn

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

Caroline Dunn Executive Director

Date

10-18-16

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

The above plan of correction is approved as of

1/26/17
(Date)

Plan of correction implementation status as of

1/26/17
(Date)

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

The above plan of correction was approved by

BB
(Initials)

RECEIVED

OCT 19 2016

Page 9 of 26

Violation Report: 44629 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.89(b) - Hot water temperature in areas accessible to the resident may not exceed 120°F.

2a. DESCRIPTION OF VIOLATION

The water temperature at the sink in the bathroom between bedrooms #7 and #8 measured 127 degrees Fahrenheit on 7/1/2016 at 10:45 a.m.

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.

Immediately on 7/1/2016- the day of inspection, the temperature of the hot water tank that supports rooms 7 & 8 was lowered to be in compliance with a water temperature in running water at or below 120 degrees Fahrenheit. All other hot water tanks were also checked.

Administrator or Designee will do monthly checks on running water in 2 different areas of the Home to ensure that the temperature is in compliance at a temperature of 120 degrees Fahrenheit or below. The hot water tank will be adjusted if needed. Documentation will be kept and reviewed to ensure the temperature stays where it should. Form is attached.

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn - Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 10/6/17
(Date)

Plan of correction implementation status as of 10/6/17
(Date)

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

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

RECEIVED

OCT 19 2016

Page 10 of 26

Violation Report: 44829 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
HUMAN SERVICES LICENSING

1. REGULATION 55 Pa.Code §2600
2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION

Two nickel-sized holes on the arm rest of the love seat in the front sitting room had stuffing coming out and some of the stuffing was on the floor.

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.

Immediately On 7/1/2016- the day of inspection, the holes on the arm rest of the love seat in the front sitting room were repaired by sewing them shut. All stuffing was either put back in or discarded with it being in good repair when finished. The Designee walked throughout the rest of the Home to check for any other issues. A memo was also posted on the Staff bulletin board reminding them to let the Administration know of any items in need of repair.

The Administrator or Designee will do monthly rounds to check that all furniture or equipment is in good repair, clean and free from hazards. Any items found will be taken care of immediately to ensure the safety of all Residents. Copy of the memo is attached.

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn Executive Director*

Date *10-18-16*

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

The above plan of correction is approved as of 10/6/17
(Date)

Plan of correction implementation status as of 10/6/17
(Date)

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

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

RECEIVED

OCT 19 2016

Violation Report: 44628 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Liaison

1. REGULATION 65 Pa.Code §2600

2600.98(a) - The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

2a. DESCRIPTION OF VIOLATION

The home's first aid kit did not include adhesive bandages, gauze pads, gloves, and antiseptic.

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.

Immediately on 7/1/2016- the day of inspection, the Homes first aid kit was replenished with the items missing (adhesive bandages, gauze pads, gloves and antiseptic). An inventory sheet with the regulation with the items to be in the first aid kit was also placed in the kit.

All Staff will be educated on the importance of replacing the items after using them. All Staff will make a note on the inventory sheet of any item used and be sure it gets replaced as soon as possible. Documentation will be kept with signatures showing that the Staff are aware of this regulation. The inventory will be checked monthly going forward. Documentation will be kept with the first aid kit along with the reviewed monthly inventory list. New form attached.

Immediately and weekly thereafter- The administrator or designee will check the first aid kit for all of the required contents in accordance with Chapter 2600.96(a). BB 1/26/17

Immediately - A designated staff person will check the first aid kit daily for all of the requirements in accordance with Chapter 2600.96(a). BB 1/26/17

Immediate action will be taken to replenish any items missing from the first aid kit upon any of the checks. BB 1/26/17

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 1/26/17
(Date)

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

Plan of correction implementation status as of 1/26/17
(Date)

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

RECEIVED

OCT 19 2016

Violation Report: 44629 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Nursing Services Licensing

1. REGULATION 55 Pa.Code §2600
2800.101(j)(2) - Each resident shall have the following in the bedroom: A chair for each resident that meets the resident's needs.

2a. DESCRIPTION OF VIOLATION

There was only one chair available for resident #4 and resident #7 in bedroom # [redacted] on 7/1/2016.

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.

Immediately on 7/1/2016- the day of inspection, an extra chair was placed in room # [redacted]

All other rooms were checked to be sure that there was a chair per person in each room.

The Administrator or Designee made sure that each room has the required chair per person. Staff was educated on the regulation and it was explained that all chairs need to stay in the rooms at all times. A check list has been put in each room to be checked each day and initial that DCS checked the room for the correct amount of chairs. The Administrator or Designee will make monthly checks of the rooms to be sure that the correct amount of chairs are present and DCS is checking the room. Documentation will be kept. New checklist is attached.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 1/16/17 (Date)

Plan of correction implementation status as of 1/16/17 (Date)

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

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

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OCT 19 2016

Page 13 of 26

Violation Report: 44829 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 65 Pa.Code §2600
2600.101(r)(1) - There must be drapes, shades, curtains, blinds or shutters on the bedroom windows.

2a. DESCRIPTION OF VIOLATION

There were sheer curtains and no blinds for the window of resident #1's bedroom # [redacted]

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.

Immediately on 7/1/2016- the day of inspection, a blind was put in room # [redacted] for Resident #1. The Resident had refused to have anything on [redacted] window, but the Inspectors were able to convince [redacted] that in order for the Home to be in compliance, [redacted] had to allow a blind to be put up for [redacted] privacy. [redacted] was in agreement with the condition that the blind would be pulled up as far as possible.

A Designee checked all other rooms to be sure that the windows were in compliance with the privacy regulation 2600.101 (r). We would like to note that we wanted to put something on the window as all of the other rooms in the Home have. The Resident was very convinced that we would be violating [redacted] rights if we put anything up for privacy, as [redacted] wanted all the window exposed. In the future if this should happen, we will show the Resident the regulation and explain that we need to be in compliance.

Any resident education will be documented. BB 11/26/17

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of <u>10/6/17</u> (Date)	Plan of correction Implementation status as of <u>10/6/17</u> (Date)
The above plan of correction was approved by <u>BB</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>BB</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

RECEIVED

OCT 19 2016

Violation Report: 44629 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 68 Pa.Code §2600
2600.103(d) - Food shall be stored off the floor.

2a. DESCRIPTION OF VIOLATION

On 7/1/2016 at 10:40 a.m. there were boxes of potatoes, apples, bananas, single serve crackers, and bread crumbs stored directly on the floor in the pantry.

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.

Immediately on 7/1/2016- the day of inspection, the food was moved in the storage area to a shelf.

All Staff will be educated on regulation 2600.103 (d). Food shall be stored off of the floor. The Administrator or Designated Person will check the food storage area on the day of delivery (every 2 weeks) to be sure that everything is properly stored. An accountability chart was also put in the storage area to remind Staff to not let any food items to be directly on the floor. It will be signed each time a new order comes in to be put away. Copy of chart is attached.

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 10/6/17
(Date)

Plan of correction implementation status as of 10/6/17
(Date)

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

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

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OCT 19 2016

Violation Report: 44829 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2800

2600.103(f) - Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

2a. DESCRIPTION OF VIOLATION

On 7/1/2016, the temperature in the refrigerator on the right upon entry of the kitchen was 50 degrees Fahrenheit at 9:40 a.m. and 54 degrees Fahrenheit at 3:17 p.m. The temperature in the freezer on the right upon entry of the kitchen was 3 degrees Fahrenheit at 9:40 a.m. and 5 degrees Fahrenheit at 3:17 p.m.

On 7/1/2016, the temperature in the refrigerator on the left upon entry of the kitchen was 55 degrees Fahrenheit at 9:40 a.m. and 52 degrees Fahrenheit at 3:17 p.m. The temperature in the freezer on the left upon entry of the kitchen was 15 degrees Fahrenheit at 9:40 a.m. and 8 degrees Fahrenheit at 3:17 p.m.

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.

On 7/1/2016- the day of inspection, new thermometers were put in the 2 refrigerators in question. The refrigerator to the right upon entry to the kitchen was monitored and proved to be in compliance. The refrigerator to the left upon entry to the kitchen, did not meet requirements. All food was removed. A new refrigerator was ordered immediately. The new refrigerator was delivered on 7/5/2016. Receipt attached.

Staff was educated on Safe temperatures for the refrigerator and freezers. A Daily chart is on the front of all refrigerators and freezers and the temperatures are recorded daily. The Staff were made aware during their training that if the temperature does not meet the 40 or below for refrigerator, and at or below 0 for the refrigerator, that it needs to be immediately reported to the Administration. The charts on all refrigerators will be reviewed by the Administrator or Designee Monthly.

Immediately and weekly thereafter - The administrator or designee will check each refrigerator and freezer to ensure thermometers are present and temperatures are compliant with this regulation. If any refrigerator or freezer is observed with noncompliant temperatures then temperatures will be rechecked within 1 hour and documented. If temperatures remain non compliant then food will be immediately removed and stored in refrigerators and freezers with compliant temperatures. *BB 1/26/17*

Repeat Violation: No	Date(s) of Previous Violation(s):	
Signature of Legal Entity Representative (Required on EVERY Page) <i>Caroline Dunn</i>		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Caroline Dunn Executive Director</i>		Date <i>10-18-16</i>

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

The above plan of correction is approved as of 1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

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

document the temperatures *BB 1/26/17*

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OCT 19 2016

Page 16 of 26

Violation Report: 44629 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
PHILADELPHIA, PA 19103

1. REGULATION 65 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 fire drill record for the drill conducted on 4/28/2016 does not include the following:

- a.m. or p.m. for time
- the exit route used
- the number of residents in the home at the time of the alarm
- the number of residents evacuated
- whether the fire alarm or smoke detector was operative

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.

Immediately all fire drill records were reviewed for accuracy. All new Administration will be trained on the correct way to do a fire drill and the correct way to account for the drill. The Fire Drill in question was the first and only fire drill done by that Administrator. A copy of the current log is attached to this report. Each fire drill record will be audited by the Administrator or Designee for accuracy each month after the drill. Documentation will be recorded on the drill itself in the Planned Corrective Action column. The Administrator or Designee will sign in that column to note that it was reviewed for accuracy.

On 10/19/16, the home submitted fire drill records indicating the home conducted fire drills on 7/18/16 at 3:30 p.m., 8/25/16 at 11:10 a.m., and 9/30/16 at 8:22 a.m. and the records included all of the requirements in accordance with Chapter 2600.132(c). *BB*

1/26/17

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>Caroline Dunn</i>
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Caroline Dunn Executive Director</i>	<i>10-18-16</i>

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

The above plan of correction is approved as of <u>1/26/17</u> (Date)	Plan of correction implementation status as of <u>1/26/17</u> (Date)
The above plan of correction was approved by <u><i>BB</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>BB</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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OCT 19 2016

Page 17 of 26

Violation Report: 44629 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Firearm Services Licensing

1. REGULATION 65 Pa.Code §2600

2800.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

2a. DESCRIPTION OF VIOLATION

According to the fire drill log on April 28, 2016, "a resident was left in the bathroom" and did not exit to a fire-safe area or outside of the building during the fire drill.

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.

During the fire drill on 4-28-2016 a Resident was left in the bathroom due to [redacted] refusal to participate in the unannounced fire drill. [redacted] was in the middle of going to the bathroom and refused to exit. Staff reminded [redacted] of the importance of participating in the drill, but [redacted] would not comply. [redacted] was told it was a requirement, but [redacted] still refused.

Resident was reminded that the monthly fire drill participation is part of the requirement listed in [redacted] contract. A new part of the fire drills is for the Administrator Designee to thank the Residents for their participation and remind them that it would be a breach of contract for them to refuse to participate. Resident in question was told this and has participated in all drills since that time. A copy of the House rules was given to all Staff on 8-14-2016. A signed copy is in each chart. All new Residents will have the house rules explained to them upon admittance. Enclosed is the part of the house rules stating that Fire Drill Participation in Mandatory.

Immediately - Any resident who refuses to evacuate during any 2017 fire drill will be educated on the home's evacuation procedures and designated meeting place away from the building. Documentation of resident education shall be kept. *BB 1/26/17*

Immediately - The administrator will review fire drill records monthly to ensure all residents evacuate. *BB*
If the home does not evacuate a hospice resident who is actively dying then all of the requirements will be met in accordance with CHAPTER 2600.29a(b)(1)-(17) 8/1/2015

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Duan*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Duan Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

RECEIVED

OCT 19 2016

Page 18 of 26

Violation Report: 44629 - 07/01/2016 - Cutter, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
PENNSYLVANIA LICENSING

1. REGULATION 65 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

Resident #1, admitted [redacted] 2016, had a preadmission medical evaluation completed on 5/21/2016.

Resident #2, admitted [redacted] 2016, had an initial medical evaluation completed on 5/6/2016.

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.

Immediately following inspection on 7/1/2016 the Resident charts in question were reviewed. Since it is not possible to go back and correct the charts in question, we can only move on from here.

The previous Administration is no longer here to train, but all current and future Administrators and Designees in charge of any screenings will be trained on the time frames for completion. In addition a charting system was made with a calendar of dates due for annual DME's and RASPS. All Resident files have been recently reviewed by the Administrator and or Executive Director to determine if the dates are what they should be. If they can be corrected they have been. If it was with the previous Administration and can't be changed, it has been noted accordingly and we are moving on from here with the correct time frames. Each new Resident that is admitted to the Home will have the correct time frames applied. A Resident checklist is now in each file and will be added to all new files to be sure that everything is correct. Files will be reviewed by Administrator or Designee ^{monthly 2x / 26/17} periodically to be sure that everything is up to date. Copies of forms are attached.

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of <u>1/26/17</u> (Date)	Plan of correction implementation status as of <u>1/26/17</u> (Date)
The above plan of correction was approved by <u>BB</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>BB</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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OCT 19 2016

Violation Report: 44829 - 07/01/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

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

2a. DESCRIPTION OF VIOLATION

The medical evaluation for resident #3, dated 4/20/2016, did not include the resident's blood pressure, weight, or pulse rate.

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.

Immediately the medical evaluation for Resident #3 was updated to include the proper information. The Administrator and Executive Director reviewed all the current DME's to be sure that they were complete.

The Administrator or Designee will review any additional DME's for any missing information. ^{Approval to placing the form in the resident record as 1/26/17} Training for any new Designees responsible for filling out any of the required information will be done before permitting them to be responsible for any of the forms. The new forms for RASP & DME dates and the Resident checklist will be used to avoid this problem with dates in the future. Forms attached.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Dunn

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

Caroline Dunn Executive Director

Date

10-18-16

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

The above plan of correction is approved as of

1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

The above plan of correction was approved by

BB
(Initials)

RECEIVED

OCT 19 2016

Page 20 of 26

Violation Report: 44629 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR WEST REGION FIELD OFFICE

1. REGULATION 65 Pa.Code §2800
144(c)(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

2a. DESCRIPTION OF VIOLATION
On 7/1/2016 at 10:20 a.m., resident #2 was smoking directly outside of the back door. The designated smoking area is in the back of the 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.

Immediately Resident #2 was informed of the violation of where [redacted] was smoking. Large Bold signs were made and put on the inside of the building to direct Residents to the proper approved area. Another sign is posted when they go out the door to direct them away from the entrance. An addendum was added to each contract and included in all new contracts explaining the smoking policy. Each Resident signed the addendum dated 8-14-2016. They were also given a copy to keep. All new Residents and Employees that smoke will be educated on the smoking policy and area. A copy of the addendum is attached. Documentation of the resident and staff education will be kept.

The Administrator or Designee will check the smoking area on their daily rounds of the Home to ensure compliance.

BB
1/26/17

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

RECEIVED

OCT 19 2016

Violation Report: 44829 - 07/01/2016 - Guller, Jan
PCH Name: COUNTRY MANOR WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.183(b) - Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

2a. DESCRIPTION OF VIOLATION
On 7/1/2016 at 9:15 a.m., a bottle of Nystatin topical powder was accessible to residents in the unlocked staff break room.

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.

Immediately on 7/1/2016- the day of inspection, the powder was disposed of properly. A med cart audit was done to ensure that all prescription and OTC items were kept in a proper locked area. All med trained Staff were re-educated and trained on proper storage of all medications. Administrator or Designee will ensure all med trained Staff are properly storing all medications by doing periodic med cart audits. The House Pharmacy also comes in to do med cart audits. The Executive Director has been doing weekly observations on all med trained Staff with documentation.

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Duan*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Duan 10-18-16* Date *Executive Director*

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

The above plan of correction is approved as of 10/6/17 (Date)

Plan of correction implementation status as of 10/6/17 (Date)

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

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

RECEIVED

OCT 19 2016

Page 22 of 28

Violation Report: 44829 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2800.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

Resident #5 is prescribed blood glucose testing to be completed before every meal and before bedtime. The readings on the resident's accucheck machine did not match the numbers transcribed on the June and July medication administration record (MAR) on the following dates and times:

DATE	TIME	METER READING	MAR RECORDED
6/16/2016	7:12 a.m.	580	65
6/17/2016	6:56 a.m.	70	77
6/19/2016	7:11 p.m.	414	515
8/24/2016	7:38 p.m.	375	276
6/25/2016	3:56 p.m.	398	298
7/04/2016	6:56 a.m.	117	105
7/06/2016	6:53 a.m.	218	216

Resident #8 is prescribed blood glucose testing to be completed twice a day (7:00 a.m. and 4:00 p.m.). The readings on the resident's accucheck machine did not match the numbers transcribed on the June MAR on the following dates and times:

DATE	TIME	METER READING	MAR RECORDED
6/08/2016	7:02 a.m.	120	142
6/07/2016	4:08 p.m.	175	165
6/07/2016	7:05 a.m.	117	145
6/08/2016	7:08 a.m.	71	134
6/09/2016	7:03 a.m.	101	134
7/10/2016	7:08 a.m.	74	143
7/20/2016	8:30 a.m.	106	102

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.

Plan of Correction Attached ^{See} Page 22 A of 26

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Dunn

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

Caroline Dunn Executive Director

Date 10-18-16

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

The above plan of correction is approved as of 10/17
(Date)

Plan of correction implementation status as of 10/17
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress

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

- Partially Implemented - Inadequate Progress BB
- Not Implemented

Page 22 of 26

Immediately all med trained Staff were re-educated and trained on the importance and proper usage of the glucometer in glucose testing. They were educated and trained on the importance of using only the glucometer prescribed for each Resident for that Resident. Each med trained Staff was instructed to be sure that when they do the testing they use the correct number when recording in the EMAR. . Staff were re-educated at the recent diabetic trainings also.

In order to be sure of compliance, effective immediately, the Administrator or Designee will audit the glucometer readings within the week. They will be matched with the EMAR to ensure proper safety and ensure proper management of Diabetes. Documentation will be kept for each person that has a glucometer. Each med trained Staff that uses the glucometer will be observed to be sure they are using the correct glucometer for that person and recording correct readings. They will be observed weekly for a period of one month, which will be done with their weekly med pass observances. At that point the regular audits of glucometers will be done every other month with documentation. A copy of the form to be used is attached.

Immediately - The administrator or designee will observe each staff person qualified to administer medications take blood glucose tests and record the results on the medication administration records at least 2 times per week and then monthly for 6 months. Documentation of the observations will be kept.

BB
1/26/17

22A
Caroline Dunn
10-18-16

BB 1/26/17

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OCT 19 2016

Page 23 of 26

Violation Report: 44829 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.190(a) - A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

2a. DESCRIPTION OF VIOLATION

Direct care staff person E has not completed any annual medication administration practicum since initial medication training on 10/10/2014; however, this staff person administered several medications to include the following for resident #8:

- Atenolol 50 mg 8:00 a.m. on 8/20/2016, 8/21/2016, 8/22/2016, 8/23/2016, 8/24/2016
- Esomeprazole 40 mg 8:00 a.m. on 8/20/2016, 8/21/2016, 8/22/2016, 8/23/2016, 8/24/2016
- Furosemide 20 mg 8:00 a.m. on 8/20/2016, 8/21/2016, 8/22/2016, 8/23/2016, 8/24/2016
- Meloxicam 7.5 mg 8:00 a.m. on 8/20/2016, 8/21/2016, 8/22/2016, 8/23/2016, 8/24/2016
- Potassium Chloride 20 meq 8:00 a.m. on 8/20/2016, 8/21/2016, 8/22/2016, 8/23/2016, 8/24/2016

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.

Immediately DCS person E is no longer passing medications. DCS person E will need to have all medication training done before being able to do med passes again. DCS person E is off with health problems at the time, so she will do her med training when she returns. All other DCS records have been audited to be sure they are all in compliance with the med training requirements. A Med Tech Record book with Observations and MAR reviews was also created with every med trained Staff included. The record book has a list of when each person will need the next training required. The Administrator or Designee will do an audit monthly to be sure that no trainings are missed. All new med trained Staff will be added to the book and audited monthly also by the Administrator or Designee. The Executive Director is still trying to find proof that DCS person E had the annual practicums and MAR reviews. Some records from the previous Administration are still surfacing. A copy of the form for recording each person is attached. Staff person E did have an annual practicum in November of 2015 ^{and 2016 8/12/17} Proof Attached

Immediately - The administrator will implement procedures to ensure Agents of the Department are provided records immediately upon request. BB 10/6/17

Repeat Violation: Yes Date(s) of Previous Violation(s): 11/23/2015

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *10-18-16*

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

The above plan of correction is approved as of 10/6/17 (Date)

Plan of correction implementation status as of 10/6/17 (Date)

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

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

RECEIVED

OCT 19 2016

Page 24 of 26

Violation Report: 44629 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Home Care Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.225(e) - 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 #3's assessment was completed on 8/20/2016 and the previous assessment was completed on 3/26/2015.

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.

Since it is not possible to go back and correct the charts in question from the previous Administration, we can only move on from here.

The previous Administration is no longer here to train, but all current and future Administrators and Designees in charge of any Assessments will be trained on the time frames for completion. In addition a charting system was made with a calendar of dates due for annual DME's and RASPS. All Resident files have been recently reviewed by the Administrator and or Executive Director to determine if the dates are what they should be. If they can be corrected they have been. If it was with the previous Administration and can't be changed, it has been noted accordingly and we are moving on from here with the correct time frames. Each new Resident that is admitted to the Home will have the correct time frames applied. A Resident checklist is now in each file and will be added to all new files to be sure that everything is correct. Files will be reviewed periodically to be sure that everything is up to date. A copy of the forms is attached.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	11/23/2015		
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>Caroline Dunn</i>
--	----------------------

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Caroline Dunn Executive Director</i>	<i>10-18-16</i>

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

The above plan of correction is approved as of 1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

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

RECEIVED

OCT 19 2016

Page 25 of 28

Violation Report: 44829 - 07/01/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST BETHLEHEM FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.227(c) - The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

2a. DESCRIPTION OF VIOLATION

Resident #3's support plan was completed on 8/20/2016 and the previous support plan was completed on 3/26/2016.

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.

Since it is not possible to go back and correct the charts in question, we can only move on from here.

The previous Administration is no longer here to train, but all current and future Administrators and Designees in charge of any Support Plans will be trained on the time frames for completion. In addition a charting system was made with a calendar of dates due for annual DME's and RASPS. All Resident files have been recently reviewed by the Administrator and or Executive Director to determine if the dates are what they should be. If they can be corrected they have been. If it was with the previous Administration and can't be changed, it has been noted accordingly and we are moving on from here with the correct time frames. Each new Resident that is admitted to the Home will have the correct time frames applied. A Resident checklist is now in each file and will be added to all new files to be sure that everything is correct. Files will be reviewed ^{monthly as of 1/24/17} periodically to be sure that everything is up to date. Copies of the forms are attached.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Dunn

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

Caroline Dunn Executive Director

Date

10-18-16

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE

The above plan of correction is approved as of

1/26/17
(Date)

Plan of correction implementation status as of

1/26/17
(Date)

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

The above plan of correction was approved by

BB
(Initials)

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OCT 19 2016

Page 26 of 26

Violation Report: 44829 - 07/01/2016 - Culler, Jan

PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE

PHYSICAL SERVICES LICENSING

1. REGULATION 55 Pa.Code §2800

2600.251(b) - The entries in a resident's record shall be permanent, legible, dated and signed by the staff person making the entry.

2a. DESCRIPTION OF VIOLATION

There was "white-out" used on resident #1's contract on the first page to change the amount charged and to change the first name on the contract.

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

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

The Resident #1 was well enough to go home, so therefore her contract could not be redone. Her contract was done with previous Administration, therefore that person could not be trained on the importance of not using white out. All Administration and Staff were educated on the importance of not using white out on any Resident records. As Administrator and Executive Director have been auditing files, they have been looking for any other files that may have white out used on them. Any that are found will be corrected and initialed and if needed the Resident will sign again. Moving on, all new Administration and Staff will be educated on not using white out on any records.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Dunn

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

Caroline Dunn Executive Director

Date *10-18-16*

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

The above plan of correction is approved as of 1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

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

RECEIVED

Violation Report: 44629 - 10/25/2016 - Georgoulis, Karen
PCH Name: COUNTRY MANOR

JAN 06 2017

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

WEST REGION FIELD OFFICE
Human Services Licensing

2a. DESCRIPTION OF VIOLATION

At 10:00 a.m., there was a very pungent odor of urine and feces in the east wing hallway.

At 3:15 p.m., resident #2's glucometer was used to measure resident # 3's blood glucose level. Resident #3's blood glucose reading was 100.

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

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

The Inspectors determined that the pungent odor was coming from the mop bucket outside of the bathroom that had just been scrubbed by the Housekeeper. The mop was thrown away on the day of inspection 10-25-2016. Several new mops were purchased for the Facility. The Housekeeper was informed to let the Administration know if more supplies are needed in order to keep sanitary conditions maintained.

Immediately - The administrator or designee will observe each staff person qualified to administer medications take blood glucose tests and record the results on the medication administration records at least 2 times per week and then monthly for 6 months. Documentation of the observations will be kept. BB 1/26/17

Immediately on 10-25-2016 the glucometer in question for Resident # 2 was disposed of and a new one was acquired to use from this point on. All med trained DCS were re-trained on the importance of not using glucometers on anyone other than the intended Resident. On 11-21-2016 new glucometers were obtained for all diabetics. The new glucometers were marked with each person's name on the front and in addition their picture was added to the back of the glucometer. This is to ensure that the glucometer is only used for that person. In addition, most of the diabetics use the same brand of glucometer and testing strips. There is also a house stock supply of testing strips to ensure that the diabetics do not run out of strips. All med tech DCS were trained on the importance of not using any glucometer for anyone other than the intended Resident. Monthly printouts with documentation of glucose readings will be done for each diabetic Resident monitoring the glucometer with the EMAR for a period of one week.

Attachment
2A

Immediately - Soiled mops will be sanitized prior to reuse. BB 1/26/17

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

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

RECEIVED

JAN 06 2017

Violation Report: 44629 - 10/25/2016 - Georgoulis, Karen
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.103(j) - Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa.Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

2a. DESCRIPTION OF VIOLATION

The first compartment of the kitchen sink used to wash the pots, pans bowls and cooking utensils was 1/2 full of water that was not hot, dirty and greasy. Direct care staff and cook B, indicated they wash the cooking equipment and bowls in the first sink. They rinse and sanitize in the other side of the sink; however, the water that had some food residue in it and was cold and then air dry. The home's cooking equipment and utensils are not being washed rinsed and sanitized after each use by the method specified in 7 Pa. Code Chapter 46 Subchapter D.

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.

Immediately all eating, drinking and cooking utensils that do not go through the electric dishwasher will be washed, rinsed and sanitized after each use by using the 3-sink sanitation method. The proper procedure for this process has been posted in the kitchen for anyone working in the kitchen to refer to. All DCS have been informed of this regulation and have been trained on the proper way to meet this regulation. Each DCS has signed on the training poster that they are aware of the proper procedures for this regulation.

Immediately - A designated staff person will monitor manual ware washing of eating, drinking and cooking utensils at least twice daily to ensure they are washed, rinsed and sanitized after each use. Part of the monitoring process will include checking the temperature of the washing water and ensuring soiled water is not used to wash cooking equipment and utensils. BB 1/26/17

Attachment 3A
Immediately - The administrator or designee will monitor manual ware washing at least weekly to ensure the procedures outlined in regulation 2600.103j are followed. BB 1/26/17

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

RECEIVED

JAN 03 2017

Violation Report: 44629 - 10/25/2016 - Georgoulis, Karen
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

Resident #4 is prescribed Oxycodone HCL 5 mg, take one tablet every 8 hours as needed for pain; however, the medication was not available in the home.

Resident #5 is prescribed the following medications to be administered as needed, to include:

*Hydrocodone W/APAP 7.5/325mg take one tablet once a day as needed for pain; however, the medication was not available in the home from 10/8/16 through 10/11/16.

*Tramadol 50mg tablet, take on tablet daily as needed; however, the medication was not available in the home on 10/11/16 through 10/25/16.

Resident #6 was prescribed Oxycodone HCL 5mg take one tablet every 4 hours as needed for pain. The original order, dated 8/24/16, to take one tablet every 12 hours as needed for pain. The card contained 30 tablets. The order was changed to every 4 hours as needed on 9/9/16, delivery of 90 tablets. None of the medication was administered in the months of August, September and October. The medication was reported not available in the home on 10/11/16.

Resident #7 is prescribed Oxycodone HCL 5mg tablet take one tablet every 4 hours as needed for pain; however the medication was not available in the home on 10/8/16 to 10/11/15.

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.

Attached as 4A due to length

Also Attached 4B, 4C, 4D, 4E

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Dunn

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

Caroline Dunn - Executive Director

Date

12-30-16

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE

The above plan of correction is approved as of

1/26/17
(Date)

Plan of correction implementation status as of

1/26/17
(Date)

Fully Implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

The above plan of correction was approved by

BB
(Initials)

BB

RECEIVED

JAN 06 2017

WEST REGION FIELD OFFICE
Human Services Licensing

On 10-11-2016 it was discovered by the Administration that narcotics were missing. The incident was reported to DHS and the State Police. Through an investigation by the PA State Police, it was discovered that 2 Employees from the Facility had stolen many narcotics from the Facility. One of the Employees was a long-time Employee that had been trusted to do the med ordering. Both Employees were dismissed immediately and the State Police were left to press charges against them. All of the medications listed in this violation were the medications that were stolen, which is why they were not in the Facility for administration to the Residents. During the week of October 20, a new plan for narcotic counting was started. The new system is making each DCS and Administration more accountable for all medications with extra emphasis on narcotics. The House Pharmacy has done a training with the Administration and is working closely with the Home to ensure that all medications are properly stored, secured and distributed properly. All medications are counted as required. The Administration is working closely with all Med Techs to use this plan to the best benefit of all Residents. All new DCS Med Techs will be trained as part of their med training before passing any medications. All Med Techs were observed weekly with documentation to ensure that they were following the directions of the prescriber. MAR reviews have been being done by the Administration since October of 2016. The Administration will continue to do MAR reviews with documentation monthly. They had been done weekly for 2 months. The Administration will look for any holes and missed medications and address each issue as warranted. As each prescription is delivered, the bottle will be checked with the EMAR to ensure the directions are written & followed properly. The Administration will approve all medications through the EMAR. DCS will also be informed of any new medication and how it is to be administered to be sure the Physician orders are followed correctly.

Within 7 days of receipt of these plans of correction and twice monthly thereafter - The administrator or designee will check all, current prescriber's orders, medication storage areas, and medication administration records to ensure each resident's medications are available for administration per the orders, including for residents #4, #5, #6, and #7. *BB*

1/26/17

Caroline Dunn
Caroline Dunn - Executive Director 4A

1-6-17

Within 7 days of receipt of these plans of correction - The home will develop and implement written policies and procedures for a system regarding narcotic accountability. The system will include at least 2 staff persons counting all narcotics per shift. *BB 1/26/17*

BB 1/26/17
documentation will be kept.

Within 15 days of receipt of these plans of correction - All staff persons will be trained on the narcotics system policies and procedures. *BB 1/26/17*

RECEIVED

JAN 06 2017

Violation Report: 44629 - 10/25/2016 - Georgoulis, Karen
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION

Resident #5 is prescribed the following medications; however, on 10/7/16, the following medications were not indicated as administered in the October MAR, to include:

*At 9:00 a.m. - Aspirin 325mg EC tablet, Fenofibrate, 145mg tablet, Lamotrigine 100 mg, tablet, Losartan Potassium 50mg tablet, Metformin 1000mg tablet, Quetiapine 25mg tablet, Vitamin B-1 100mg tablet.

*At 8:00 a.m., Duloxetine HCL DR 30 mg capsule, Gabapentin 600mg tablet, Hydrocodone W/APAP7.5/325mg tablet

Resident #5 is prescribed Novolog insulin two times a day at 7:00 a.m. and 4:00 p.m.; however, there is no documentation indicating a blood glucose reading, the amount of insulin given, the site administered and who administered the insulin in the October MAR at 7:00 a.m.

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.

In October, 2016 all DCS Med Techs were retrained on the importance of recording medications that are administered at the time it is actually administered. All Med Techs were observed weekly with documentation to ensure that they were properly passing medications. MAR reviews have been being done by the Administration since October of 2016. The Administration will continue to do MAR reviews with documentation monthly. They had been done weekly for 2 months. The Administration will look for any holes and missed medications and address each issue as warranted.

The administration's medication administration records reviews will include checks on documented narcotic counts. *BB 1/26/17*
within 7 days of receipt of these plans of correction and twice monthly thereafter - The administrator or designee will review each resident's medication administration records to ensure they are compliant with this regulation. *BB 1/26/17*
Immediately - A designated staff person will review medication administration records on each shift for the information in Chapter 2600.187(a)(13) and Chapter 2600.187(a)(14). *BB 1/26/17*

Repeat Violation: Yes Date(s) of Previous Violation(s): 11/23/2015

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

Violation Report: 44629 - 10/25/2016 - Georgoulis, Karen
 PCH Name: COUNTRY MANOR

RECEIVED

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

JAN 06 2017

WEST REGION FIELD OFFICE
 Human Services Licensing

2a. DESCRIPTION OF VIOLATION

Resident #4 is prescribed Oxycodone HCL 10mg tablets take 2 tablets by mouth at 8:00 a.m. and 8:00 p.m. for pain; however, the medication was not available on 10/6/16 at 8:00 a.m. through 10/9/16 at 8:00 a.m.

Resident #5 is prescribed the following medications; however, the medications were not available in the home, to include:
 *Hydrocodone W/APAP 7.5/325mg, take one tablet daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m.; however, the medication was not available in the home on 10/8/16 through 10/11/16.
 *Tramadol 50mg tablets take one tablet daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m.. The start date was 10/11/16 at 8:00 p.m.; however, the medication was not available in the home on 10/21/16 at 8:00 p.m. through 10/25/16 at 5:00 p.m.

Resident #6 is prescribed the following medications; however, the medications were not available in the home, to include:
 *Carbamazepine 200mg tablet, take one tablet every 8 hours for nerve pain; however, the medication was not available in the home on 10/23/16 at 10:00 p.m. through 10/24/16 at 8:00 p.m.
 *Oxycodone HCL 5mg tablet take one tablet by mouth every 4 hours as needed; however, the medication was not available in the home. The original date ordered was September 9, 2016 and discontinued on 10/11/16.

Resident #7 is prescribed Oxycodone HCL 10mg tablet take one tablet at 8:00 a.m., 2:00 p.m. and 8:00 p.m. for pain; however the medication was not available in the home on 10/9/16 at 2:00 p.m. to 10/10/16 at 2:00 p.m.

Resident #8 is prescribed the following medications; however, the medication was not available in the home, to include:
 *Oxycodone HCL 5mg tablet take one tablet at 8:00 a.m., 2:00 p.m. and 8:00 p.m. as needed for pain; however, the medication was not available in the home on 9/6/16 at 8:00 a.m., 9/24/16 at 8:00 p.m. to 9/25/16 at 2:00 p.m. and 10/12/16 at 2:00 p.m.
 *Bultrans Transd 10 MCG/HR Patch apply one patch topically once a week (Fridays) for pain on 10/14/16 at 8:00 a.m., the medication was not available in the home. The MAR indicates the last patch application was on 10/7/16.
 *Nicotine 7MG/24hr Patch apply one patch topically once a day (8:00 a.m.) remove as per schedule. The medication was not available in the home on 9/22/16, 9/24/16 through 9/26/16.

Resident #9 is prescribed the following medications; however, the medications were not available in the home, to include:
 *Lorazepam 0.5 mg tablet take 1/2 tablet (0.25mg) at 8:00 a.m. and 12 p.m.; however the medication was not available in the home on 9/30/16 at 8:00 a.m. through 10/1/16.
 *Oxycodone HCL 5 mg take one tablet at bedtime 8:00 p.m.; however, the medication was not available in the home on 10/8/16 to 10/25/16.
 *Oxytrol 3.9 mg patch, apply one patch once a week (9:00 a.m., Thursday); however, on 10/6/16 the medication was not available in the home.
 *Namenda XR 14 mg take one capsule by mouth at 12:00 p.m.; however on 10/9/16, the medication was not available in 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.

See page 6A of 6 and 6B of 6
 Attached as 6A, 6B, 6C, 6D, 6E, 6F

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

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of <u>1/20/17</u> (Date)	Plan of correction implementation status as of <u>1/20/17</u> (Date)
The above plan of correction was approved by <u>BB</u> (Initials)	<input type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input checked="" type="checkbox"/> Partially Implemented - Inadequate Progress <i>BB</i> <input type="checkbox"/> Not Implemented

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JAN 06 2017

WEST REGION FIELD OFFICE
Human Services Licensing

On 10-11-2016 it was discovered by the Administration that narcotics were missing. The incident was reported to DHS and the State Police. Through an investigation by the PA State Police, it was discovered that 2 Employees from the Facility had stolen many narcotics from the Facility. One of the Employees was a long-time Employee that had been trusted to do the med ordering. Both Employees were dismissed immediately and the State Police were left to press charges against them. All of the medications listed in this violation were the medications that were stolen, which is why they were not in the Facility for administration to the Residents. During the week of October 20, a new plan for narcotic counting was started. The new system is making each DCS and Administration more accountable for all medications with extra emphasis on narcotics. The House Pharmacy has done a training with the Administration and is working closely with the Home to ensure that all medications are properly stored, secured and distributed properly. All medications are counted as required. The Administration is working closely with all Med Techs to use this plan to the best benefit of all Residents. All new DCS Med Techs will be trained as part of their med training before passing any medications. All Med Techs were observed weekly with documentation to ensure that they were following the directions of the prescriber. MAR reviews have been being done by the Administration since October of 2016. The Administration will continue to do MAR reviews with documentation monthly. They had been done weekly for 2 months. The Administration will look for any holes and missed medications and address each issue as warranted. As each prescription is delivered, the bottle will be checked with the EMAR to ensure the directions are written & followed properly. The Administration will approve all medications through the EMAR. DCS will also be informed of any new medication and how it is to be administered to be sure the Physician orders are followed correctly.

Caroline Dunn - Executive Director

Caroline Dunn - 1-6-17 6A

BB 1/6/17

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WEST REGION FIELD OFFICE
Human Services Licensing

During this process, it has become necessary to not put trust in just one person for the management of medications. The Administrator and or Designee and the Pharmacy will overlook all narcotic related items. A system is being used and tested to be sure that nothing like this happens again. The Administration is working closely with the Med Techs on the counting of narcotics and accountability of all narcotics. All narcotics are kept in a double locked system as required and the margin for error has been reduced due to the new system being implemented. This is a new system for the Pharmacy and for our Facility, but we are confident that we will be able to make it a much better system for our Facility.

Staff members C & D are no longer employed at Country Manor & are awaiting charges for theft of narcotics.

Caroline Dunn - Executive Director
Caroline Dunn 1-6-17

6F

Within 7 days of receipt of these plans of correction and twice monthly thereafter - The administrator or designee qualified to administer medications will observe at least 1 medication administration for each staff person who administers medications to ensure directions of the prescriber are followed. Documentation of the observed medication administrations will be documented. BB 1/26/17

Within 7 days of receipt of these plans of correction and twice monthly thereafter - The administrator or designee will check all current prescriber's orders, medication storage areas, and medication administration records to ensure each resident's medications are available for administration per the orders. BB 1/26/17

Within 7 days of receipt of these plans of correction - The home will develop and implement written policies and procedures for a system regarding narcotic accountability. The system will include at least 2 staff persons counting all narcotics per shift. BB

Within 15 days of receipt of these plans of correction - All staff persons will be trained on the narcotic system policies and procedures. Documentation will be kept. RR 1/26/17

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

PCH Name: COUNTRY MANOR		License Number: 44629
Address: 111 ALTMAYER DRIVE, KITTANNING, PA 16201		County: Armstrong
Administrator: Tara Beck		Region: WEST
Legal Entity Name: COUNTRY MANOR PCH LP		
Legal Entity Address: 111 ALTMAYER DRIVE, KITTANNING, PA 16201		
Certificate(s) of Occupancy C-2 LP 06/20/1996 Dept. of L & I		
Staffing Hours		
Resident Support: 0	Total Daily Staff: 35	Waking Staff: 26
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Interim		
On-Site Inspections Dates and Department Representatives On-Site 11/21/2016: Cutler, Jan; Park, Both		
RECEIVED JAN 08 WEST REGISTRATION Human Services		
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: 40 Number of Residents Served: 30 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: 12	Number of Residents who: Receive Supplemental Security Income: 4 Are 60 Years of Age or Older: 29 Have Mental Illness: 8 Have an Intellectual Disability: 0 Have a Mobility Need: 5 Have a Physical Disability: 1	

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JAN 08 2017

Violation Report: 44629 - 11/21/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.29a(b)(1) - A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met: A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

2a. DESCRIPTION OF VIOLATION

Resident #1 receives hospice services and was not evacuated during fire drills on 9/30/2016 and 10/15/2016. The resident did not have written certification from a doctor that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

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.

Immediately All staff including agency personnel will be educated on the home's evacuation procedures and designated meeting place away from the building unless a hospice resident meets the requirements of Chapter 2600.29a(b)(1). Documentation of education will be kept. *BB* Immediately - The administrator will review fire drill records monthly to ensure all residents evacuate. *BB*

The Hospice Resident (Resident #1) that was not evacuated during the fire drills on 9/30/2016 and 10/15/2016 will be evacuated with everyone else for all future fire drills, as will all other Hospice Residents unless they meet the criteria in 29 a (b) (1). The Hospice Nurse had requested the Resident stay in [redacted] room due to [redacted] weakness at the time. The Administration was under the assumption that this was not violating a regulation. The reason for not knowing this was that the Director of the Facility was using the Pennsylvania code book that she had always used, unaware that it had been updated at some point over the last few years. The book has no reference to date on the front or any other pages to indicate that a change had been made. The Inspector compared the books on the day of the inspection to make the Director aware that it was updated at some point. For all future references to regulations, the new book will be used. The Administration also compared all other code books in the Facility to be sure the updated ones were being used. For the future purposes of this violation, all Residents will be evacuated during a fire drill unless they meet the criteria in the code book.

If the home does not evacuate a hospice resident who is actively dying then all of the requirements will be met in accordance with Chapter 2600.29a(b)(1) - (b)(11). *BB 1/26/17*

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

RECEIVED

JAN 06 2017

Violation Report: 44629 - 11/21/2016 - Culler, Jan
PCH Name: COUNTRY MANOR

WEST HESKON FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.29a(b)(2) - A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600 29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met: The resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative has provided written informed consent that the person is not to evacuate in a fire drill.

2a. DESCRIPTION OF VIOLATION

There is no written informed consent from anyone pertaining to resident #1, including the resident, about the resident not evacuating during fire drills. The resident was not evacuated during fire drills on 9/30/2016 and 10/15/2016.

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.

Immediately - All staff including agency personnel will be educated on the home's evacuation procedures and designated meeting place away from the building unless a hospice resident meets the requirements of Chapter 2600.29a(c)(1). Documentation of education will be kept. BB 1/26/17
Immediately - The administrator will review fire drill records monthly to ensure all residents evacuate. BB 1/26/17

The Hospice Resident (Resident #1) that was not evacuated during the fire drills on 9/30/2016 and 10/15/2016 will be evacuated with everyone else for all future fire drills, as will all other Hospice Residents unless they meet the criteria in 29 a (b) (1). The Hospice Nurse had requested the Resident stay in [redacted] room due to [redacted] weakness at the time. The Administration was under the assumption that this was not violating a regulation. The reason for not knowing this was that the Director of the Facility was using the Pennsylvania code book that she had always used, unaware that it had been updated at some point over the last few years. The book has no reference to date on the front or any other pages to indicate that a change had been made. The Inspector compared the books on the day of the inspection to make the Director aware that it was updated at some point. For all future references to regulations, the new book will be used. The Administration also compared all other code books in the Facility to be sure the updated ones were being used. For the future purposes of this violation, all Residents will be evacuated during a fire drill unless they meet the criteria in the code book.

If the home does not evacuate a hospice resident who is actively dying then all of the requirements will be met in accordance with Chapter 2600.29a(b)(1)-(b)(11). BB 1/26/17

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

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

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Violation Report: 44629 - 11/21/2016 - Cutler, Jan
PCH Name: COUNTRY MANOR

JAN 06 2017

WEST REGION FIELD OFFICE
Human Services Licensing

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

2a. DESCRIPTION OF VIOLATION

Resident #2's glucometer was used to measure the blood sugar level of resident #3 on the following dates and times:

- 11/16/2016 at 4:06 p.m.
- 11/16/2016 at 10:25 a.m.
- 11/16/2016 at 6:50 a.m.
- 11/15/2016 at 4:11 p.m.
- 11/15/2016 at 10:51 a.m.
- 11/15/2016 at 7:13 a.m.
- 11/14/2016 at 3:57 p.m.
- 11/14/2016 at 11:04 a.m.
- 11/14/2016 at 7:36 a.m.
- 11/13/2016 at 3:50 p.m.
- 11/13/2016 at 10:55 a.m.
- 11/13/2016 at 7:04 a.m.
- 11/12/2016 at 3:56 p.m.
- 11/12/2016 at 7:09 a.m.

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.

Immediately on 11-21-2016 all glucometers in question were thrown away. New glucometers had recently been obtained for all diabetics and had not yet been used. The new glucometers were marked with each person's name on the front and in addition their picture was added to the back of the glucometer. This is to ensure that the glucometer is only used for that person. In addition, most of the diabetics use the same brand of glucometer and testing strips. There is also a house stock supply of testing strips to ensure that the diabetics do not run out of strips. All med tech DCS were trained on the importance of not using any glucometer for anyone other than the intended Resident. Monthly printouts with documentation of glucose readings will be done for each diabetic Resident monitoring the glucometer with the EMAR for a period of one week.

Immediately - The administrator or designee will observe each staff person qualified to administer medications take blood glucose tests and record the results on the medication administration records at least 2 times per week and then monthly for 6 months. Documentation of the observations will be kept. BB 1/26/17

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Duon

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

Caroline Duon - Executive Director

Date 12-30-16

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

The above plan of correction is approved as of

1/26/17
(Date)

Plan of correction implementation status as of

1/26/17
(Date)

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

The above plan of correction was approved by

BB
(Initials)

RECEIVED

JAN 06 2017

Violation Report: 44629 - 11/21/2016 - Cutter, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.96(a) - The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

2a. DESCRIPTION OF VIOLATION

The home's first aid kit did not include gauze pads.

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.

Immediately on 11-21-2016- the day of inspection, the Homes first aid kit was replenished with the item missing (gauze pads). An inventory sheet with the regulation with the items to be in the first aid kit was also placed in the kit. All Staff were re-trained on replenishing the kit when an item is removed. The list in the kit will remind DCS to replace any items taken out

All Staff will make a note on the inventory sheet of any item used and be sure it gets replaced as soon as possible. Documentation will be kept with signatures showing that the Staff are aware of this regulation. The inventory will be checked monthly going forward. Documentation will be kept with the first aid kit along with the reviewed monthly inventory list.

Immediately and weekly thereafter - The administrator or designee will check the first aid kit for all of the required contents in accordance with Chapter 2600.96(a). *BB 1/26/17*

Immediately - A designated staff person will check the first aid kit daily for all of the requirements in accordance with Chapter 2600.96(a). *BB 1/26/17*

Immediate action will be taken to replenish any items missing from the first aid kit upon any of the checks. *BB 1/26/17*

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn Executive Director* Date *1-30-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

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JAN 08 2017

Violation Report: 44629 - 11/21/2016 - Cutter, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.103(c) - Food shall be protected from contamination while being stored, prepared, transported and served.

2a. DESCRIPTION OF VIOLATION
There was a large uncovered bowl of egg salad in the white refrigerator in the kitchen at 10:30 a.m.

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.

Immediately on 11-21-2016 the bowl of egg salad was covered correctly. The Cook that was on Staff is no longer an Employee at the Facility, but all future Kitchen Staff are trained from the beginning on how food should be prepared stored, transported and served. A copy of the food regulations (103) is now given to all DCS that help with the food. A copy of the regulation (103) is also posted in the kitchen with each DCS signing that they are aware of the regulations.

Immediately - A designated staff person will check food storage areas daily to ensure safe storage of food including food covering and protection from contamination.

BB
1/26/17

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17
(Date)

Plan of correction implementation status as of 1/26/17
(Date)

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

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

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JAN 06 2017

Violation Report: 44629 - 11/21/2016 - Cutter, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Public Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.103(f) - Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F
Thermometers are required in refrigerators and freezers.

2a. DESCRIPTION OF VIOLATION

The temperature in the black refrigerator in the kitchen was 55 degrees Fahrenheit at 10:30 a.m. and 54 degrees Fahrenheit at 4:35 p.m. The temperature in the black freezer in the kitchen was 22 degrees Fahrenheit at 10:30 a.m. and 6 degrees Fahrenheit at 4:35 p.m.

The temperature in the white refrigerator in the kitchen was 46 degrees Fahrenheit at 10:30 a.m. and 48 degrees Fahrenheit at 4:35 p.m. The thermometer in the white freezer was broken.

There were no thermometers in the small upright freezer or the "Pepsi" glass front refrigerator in the storage room.

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

Immediately on 11-21-2016 working thermometers were used to check for the correct temperatures in all refrigerators and freezers. New digital thermometers were ordered for all refrigerators and freezers. (receipt attached). A chart for the month is kept on the refrigerator to document the temperature each day. This is done by the Kitchen Staff daily and looked over by the Administrator or designated person monthly. The Kitchen Staff is aware that they are to report to the Administration if the temperatures for the refrigerators are not staying at or below 40 degrees and the freezers at or below 0 degrees.

Immediately and weekly thereafter - The administrator or designee will check each refrigerator and freezer to ensure thermometers are present and temperatures are compliant with this regulation. If any refrigerator or freezer is observed with noncompliant temperatures then temperatures will be rechecked within 1 hour and documented.

7A is attached

If temperatures remain noncompliant then food will be immediately removed and stored in refrigerators and freezers with compliant temperatures. BB 1/26/17

Immediately - A designated staff person will check each refrigerator and freezer at least twice per day and document the

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *12-30-16*

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

The above plan of correction is approved as of 1/26/17 (Date)

Plan of correction implementation status as of 1/26/17 (Date)

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

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

temperature
BB
1/26/17

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JAN 06 2017

Violation Report: 4462B - 11/21/2016 - Cutter, Jan
PCH Name: COUNTRY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 66 Pa.Code §2600

2600.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

2a. DESCRIPTION OF VIOLATION

The home's fire drill records indicated that not all residents in the home at the time of the drill were evacuated for the following fire drills:

DATE	TIME	# of Residents in the home	# of Residents evacuated
9/30/2016	8:22 a.m.	35	34
10/15/2016	10:02 a.m.	34	33

Resident #1 receives hospice services and was not evacuated during fire drills on 9/30/2016 and 10/15/2016. The resident did not have written certification from a doctor that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill. There is no written informed consent from anyone pertaining to resident #1, including the resident, about the resident not evacuating during fire drills.

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

Attached due to the length as

See page 8A of 9

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Caroline Ann

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

Caroline Ann - Executive Director

Date *1-6-17*

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

The above plan of correction is approved as of 1/6/17
(Date)

Plan of correction implementation status as of 1/6/17
(Date)

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

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

The Hospice Resident (Resident #1) that was not evacuated during the fire drills on 9/30/2016 and 10/15/2016 will be evacuated with everyone else for all future fire drills, as will all other Hospice Residents unless they meet the criteria in 29 a (b) (1). The Hospice Nurse had requested the Resident stay in [redacted] room due to [redacted] weakness at the time. The Administration was under the assumption that this was not violating a regulation. The reason for not knowing this was that the Director of the Facility was using the Pennsylvania code book that she had always used, unaware that it had been updated at some point over the last few years. The book has no reference to date on the front or any other pages to indicate that a change had been made. The Inspector compared the books on the day of the inspection to make the Director aware that it was updated at some point. For all future references to regulations, the new book will be used. The Administration also compared all other code books in the Facility to be sure the updated ones were being used. For the future purposes of this violation, all Residents will be evacuated during a fire drill unless they meet the criteria in the code book.

It may have taken a little longer, but if Resident #1 had been evacuated with everyone else, the evacuation would have still met the evacuation time as designated by the fire safety expert. The reason being that the Resident had the same mobility needs in the few months before these drills and all times were met correctly, (drills attached). The Resident was put on Hospice, but that did not change the mobility need that already existed. (2 person assist). The thing that was different was the weakness in the Resident which was why it was decided to not have the Resident endure the fire drill on those months. It is now known that is not a choice we are permitted to make unless all the criteria is met from regulation 29.

Immediately - All staff including agency personnel will be educated on the home's evacuation procedures and designated meeting place away from the building unless a hospice resident meets the requirements of chapter 2600.29a(b)(1). Documentation of education will be kept. BB 1/26/17

Immediately - The administrator will review fire drill records monthly to ensure all residents evacuate. BB 1/26/17
If the home does not evacuate a hospice resident who is actively dying than all of the requirements will be met in accordance with Chapter 2600.29a(b)(1)-(b)(11). BB 1/26/17

RECEIVED

JAN 06 2017

WEST REGION FIELD OFFICE
Human Services Licensing

Caroline Dunn
Caroline Dunn - Executive Director
1-6-17

8A

BB
1/26/17

RECEIVED

JAN 06 2017

WEST REGION FIELD OFFICE
Human Services Licensing

Page 9 of 9

Violation Report: 44629 - 11/21/2016 Cutter, Jan
PCH Name: COUNTRY MANOR

1. REGULATION 55 Pa.Code §2600

2600 185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

Resident #2 is prescribed blood glucose testing to be completed three times a day (7:00 a.m., 11:00 a.m. and 4:00 p.m.) The readings on the resident's accucheck machine did not correspond with the November 2016 medication administration records on the following dates and times

DATE	TIME	METER READING	MEDICATION ADMINISTRATION RECORDS
11/18/2016	3:56 p.m.	113	121
11/16/2016	10:15 a.m.	172	123
11/16/2016	6:33 a.m.	114	123
11/16/2016	3:37 p.m.	147	148
11/15/2016	10:40 a.m.	67	152
11/15/2016	6:41 a.m.	113	134
11/14/2016	3:55 p.m.	166	185
11/14/2016	10:54 a.m.	91	125
11/14/2016	6:42 a.m.	114	141

Resident #3 is prescribed blood glucose testing to be completed three times a day (7:00 a.m., 11:00 a.m. and 4:00 p.m.) The readings on the resident's accucheck machine did not correspond with the November 2016 medication administration records on the following dates and times.

DATE	TIME	METER READING	MEDICATION ADMINISTRATION RECORDS
11/18/2016	4:06 p.m.	121	113
11/18/2016	10:25 a.m.	123	172
11/18/2016	6:50 a.m.	123	114
11/15/2016	10:51 a.m.	152	57
11/15/2016	7:13 a.m.	154	113
11/14/2016	3:57 p.m.	185	186
11/14/2016	11:04 a.m.	125	91
11/14/2016	7:38 a.m.	145	114

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.

Attached due to length
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See page 9A of 9

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn - Executive Director* Date *1-6-17*

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

The above plan of correction is approved as of 1/6/17
(Date)

Plan of correction implementation status as of 1/6/17
(Date)

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

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

Immediately on 11-21-2016 all glucometers in question were thrown away. New glucometers had recently been obtained for all diabetics and had not yet been used. The new glucometers were marked with each person's name on the front and in addition their picture was added to the back of the glucometer. This is to ensure that the glucometer is only used for that person. In addition, most of the diabetics use the same brand of glucometer and testing strips. There is also a house stock supply of testing strips to ensure that the diabetics do not run out of strips. All med tech DCS were trained on the importance of not using any glucometer for anyone other than the intended Resident. Monthly printouts with documentation of glucose readings will be done for each diabetic Resident monitoring the glucometer with the EMAR for a period of one week. Any other medications or medical equipment that would need any special procedures for safe storage, access, security, distribution and usage will be accessed as they are needed. All DCS will be informed of any special instructions.

Immediately - The administrator or designee will observe each staff person qualified to administer medications take blood glucose tests and record the results on the medication administration records at least 2 times per week and then monthly for 6 months. Documentation of the observations will be kept. *BB 1/26/17*

RECEIVED

JAN 06 2017

WEST REGION FIELD OFFICE
Human Services Licensing

Caroline Dunn
 Caroline Dunn-Executive Director
 16-17

9A

BB 1/26/17