pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 15 2017

Ms. Cynthia K. Lilly,
Administrator
Loyalhanna Health Center Associates
543 McFarland Road
Latrobe, Pennsylvania 15650

RE: Loyalhanna Care Center
License #: 446590

Dear Ms. Lilly:

As a result of the Department of Human Services' annual licensing inspection on January 6, 2017 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

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

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

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

PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES	License Number: 44659
Address: 543 MCFARLAND ROAD, LATROBE, PA 15650	County: Westmoreland
Administrator: Cindy Kuzneski Lilly	Region: WEST
Legal Entity Name: LOYALHANNA HEALTH CARE ASSOCIATES	
Legal Entity Address: 543 MCFARLAND ROAD, LATROBE, PA 15650	

Certificate(s) of Occupancy
I-2
11/30/2014
Derry Township

Staffing Hours

Resident Support: 0	Total Daily Staff: 53	Waking Staff: 40
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Complaint

On-Site Inspections Dates and Department Representatives On-Site
01/06/2017: Garrigan, Laurie; Quinn, Suzanne; Hoover, Josh

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: 84	Number of Residents who:
Number of Residents Served: 46	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 45
Area:	Have Mental Illness: 0
Secured Dementia Unit Capacity, If Applicable:	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, If applicable:	Have a Mobility Need: 7
Number of Current Hospice Residents: 3	Have a Physical Disability: 1
Number of Hospice Residents in past year: 5	

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600

2600.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2a. DESCRIPTION OF VIOLATION

At 10:00 a.m., resident #1's medication administration record (MAR) was unattended and accessible at the fourth floor nurses' station on the screen of an open laptop.

At 11:05 a.m., the administrator's office was unlocked and unattended leaving multiple residents' information accessible to include the following:

* A folder with a resident list and veteran's discount information including resident #2
* A resident list of scheduled admissions including resident #3
* A black binder of resident contracts including the contracts for residents #4, and #5

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

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

SEE ATTACHED

See pages 2A and 2B of 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Cynthia K Lilly

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY ADMINISTRATOR Date 1.8.17

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

The above plan of correction is approved as of 3/13/17 (Date)

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

Plan of correction implementation status as of 3/13/17 (Date)

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

Laptop open
Admin office open

Open laptop

Immediate correction

A memo was taped to each computer on 1.7.17 instructing all users to minimize AND close the computer when not in use. This applies to all lap tops, pc's and notebooks used by all departments throughout the building. A copy of said memo is included. The laptop was closed which showed resident #4's MAR.
3/13/17

Ongoing compliance

Random checks will be conducted during rounds and while working in the building by the Wellness Director and Administrator whenever they are onsite. This will be ongoing. and conducted at least weekly. 3/13/17

On the agenda for the February 9, 2017 all care staff meeting is a discussion of computer use and the use of other forms of technology with an emphasis on confidentiality and compliance with HIPPA regulations. Agenda attached.

Open office

Immediate correction

The Administrator office was locked by the Administrative Assistant before noon on 1.6.17.

On going compliance Immediately - A designated staff person on each shift will monitor the home daily to ensure all resident records including information on computers are confidential, kept safe and locked. 3/13/17

The Administrator's office will be locked at all times when not occupied. Those needing access to that office or files has been informed of the location of a key for admission. The Administrative Assistant or designee shall be responsible for monitoring the office during the Administrator's absence.

Cynthia K. Lilly
CYNTHIA K. LILLY, ADMINISTRATOR
3.8.17

Since leases and other confidential information is located in the Administrator's office the door shall remain locked as required. During a review of the surveyors observations on 1.7.17 all department heads were re-educated on the requirement of strict confidentiality and HIPPA regulations pertaining to all residents in addition to discussions and assignments given for the POC. This was again addressed during the Stand up Meeting held 1.9.17. Notes of the meeting are attached.

Cynthia K. Lilly
CYNTHIA K. LILLY, ADMINISTRATOR
3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600
2600.85(d) - Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

2a. DESCRIPTION OF VIOLATION
At 10:42 a.m., there was no lid on the trash can, which contained trash, located in the second floor common bathroom by the nurses' station.

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

SEE ATTACHED

see page 3A of 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Cynthia K. Lilley

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY

Date 2.8.17

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Plan of correction implementation status as of 3/13/17 (Date)

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Covered trash can receptacles

Immediate compliance:

The trash can located in the second floor bathroom behind the wellness area was replaced on 1.6.17 with a covered receptacle

Ongoing compliance:

The Housekeeping Supervisor will do random checks of the buildings' receptacles to insure that all are covered trash cans as per regulations. checks will be completed at least weekly. ✓ 3/13/17
A par level of 4 extra covered receptacles will be kept on hand to replace any receptacles found to be lacking a lid to insure continued compliance.

The facility is in compliance effective 1.31.17 and the extra receptacles stored in the trash room.

Cynthia K. Lilly
CYNTHIA K. LILLY ADMINISTRATOR 3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

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 first aid kit in the employee break room did not include scissors, eye coverings and tweezers. Other first aid kits in the home were attached to the wall an could not be removed for use.

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.

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See page 4A of 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Cynthia K Lilly

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY ADMIN. Date 2.8.17

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

First Aid Kit

Immediate Correction

The first aid kit in the Administrator's was removed from the wall by the Food Service Director and Maintenance Supervisor on 1.9.17. A pair of scissors, google eye coverings and tweezers was added to the kit. It was placed in the Employee Break room on the counter near the time clock. Picture included. 3/13/17

On Going Compliance

A memo for all staff was posted on 2.1.17. It identifies the location of the portable first aid kit. It has been placed in an area which is easily accessible to staff.

The portable first aid kit complete with the missing items added is to remain in the employee break room unless in use. The Food Service Director or designee will monitor the kit on a monthly basis and a log will be kept effective 2.1.17. Copy attached.

Cynthia K. Lilly
CYNTHIA K. LILLY, ADMINISTRATOR
3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600
2600.107(c) - The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

2a. DESCRIPTION OF VIOLATION
The home currently serves 46 residents requiring a minimum of 138 gallon of drinking water for a 3-day emergency supply. However, only 120 gallons of emergency drinking water were 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 ATTACHED

see page 5A of 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Cynthia K. Lilly

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY, ADMIN

Date 2.8.17

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Plan of correction implementation status as of 3/13/17 (Date)

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

3 day supply of emergency drinking water

Immediate correction:

The day of the survey, 1.6.17, 120 gallons were on hand for 46 residents with the minimum requirement being 138 gallons. Eighteen gallons were brought on site on 1.6.2017 bringing us into compliance.. On 2.7.17 an additional 20 gallons of water was purchased bringing the total to 140 gallons with 138 gallons required. Receipt included.

On going compliance:

As of 2.8.17 the personal care census is 43 residents requiring an emergency water supply of 129 gallons of water . We continue to have the 138 gallons stored.

The facility will maintain a supply of minimally 150 gallons of water- enough to supply the emergency needs of 50 personal care residents. This will account for a fluctuation of census. An additional 20 gallons was purchased and stored on site 2.10.17 bringing the total number of gallons to 158 in stock.

The Food Service Director or designee will conduct an audit of the emergency 3 day supply of water on a quarterly basis.

The first audit was completed by 2.7.17. Audit tool included.

Cynthia K. Lilly
CYNTHIA K. LILLY, ADMINISTRATOR 3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

The home's fire drill record for the fire drill conducted on 7/1/16 does not include the following:
* Time of the drill
* Amount of time to evacuate
* Exit routes used

The home's fire drill record for the fire drill conducted on 10/26/16 at 2:15 a.m. does not include the following:
* Amount of time to evacuate
* Exit routes used
* Number of residents evacuated

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

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

SEE ATTACHED

See page 6A of 11

Repeat Violation: Yes	Date(s) of Previous Violation(s):	01/14/2016		

Signature of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. Lilly

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY ADMIN Date 2.8.17

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Fire Drill Documentation

Immediate compliance:

The fire drill reports for 7.1 and 10.26.16 were incompletely filled out. Maintenance Supervisor and Administrator reviewed the regulation and required state forms on 1.10.17. The January fire drill was conducted on 1.31.17 and the fire drill reports were completed correctly with all categories filled in.

Ongoing compliance:

The Maintenance Supervisor or designee will continue to take the lead with conducting the monthly fire drills according to state regulations.

The Administrator or designee will review the completed fire drill forms within 48 hours of each fire drill to insure continued compliance.

Immediately- All staff persons completing the fire drill record will be educated regarding the required information to be documented on the record per regulation 26 00.132c. Documentation of training shall be kept.

3/13/17

Cynthia K. Lilly

CYNTHIA K. LILLY, ADMINISTRATOR 3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600
2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION
Resident #7's most recent medical evaluation was completed on 8/19/15.

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.

SEE ATTACHED

See page 7A of 11

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

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY ADMIN

Date 2.8.17

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

Plan of correction implementation status as of 3/13/17 (Date)

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

Annual medical evaluation

Immediate compliance:

Wellness Director contacted the resident #7's physician on 1.10.17 to schedule a new medical evaluation. This was completed on 1.11.17 and a signed copy is included.

On-going compliance:

The Wellness Director or designee has developed a tickler file to indicate when each resident's annual DME is to be completed. This consists of a list by month of assessments due and will be updated monthly.

Quarterly audits using the Content of Resident Records Checklist now include a notation/reminder of DME's needed at least annually. The first audit is to be completed by March 15, 2017 by the Wellness Director and/or designee and will insure continued compliance.

A copy of the revised checklist is included.

Cynthia K. Lilly CYNTHIA K. LILLY, ADMINISTRATOR 3.8.17

RECEIVED
FEB 10 2017
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600
2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION
Resident #7's Novolog Flexpen was opened on 11/12/16 and was present in the medication cart. According to manufacturer's instructions, the Novolog should of been discarded 28 days after opening.

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

SEE ATTACHED

See page 8A of 11

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Signature of Legal Entity Representative (Required on EVERY Page) Cynthia K Lilly

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K LILLY ADMIN. Date 2.8.17

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

Only current prescription may be kept

Immediate compliance:

Resident #7's expired Novolog Flexpen was discarded 1.6.17.

On-going compliance:

A meeting and discussion was held with the lead med techs regarding the development of new procedures to insure on going compliance with regulation 2600.183(d) and new protocols were initiated.

Med labels will be checked weekly by the lead med tech assigned to each PC floor.

A weekly audit will be conducted on each medication cart. The staff member completing the audit will sign and date the cart log/audit sheet. Sample sheet included.

This log is to be kept in a labeled binder located in the Wellness office.

The Wellness Director or designee will review the audit sheet monthly to insure continued compliance.

Audits will begin the week of February 6th.

A copy of the protocol is attached.

Cynthia K. Lilly
CYNTHIA K. LILLY, ADMINISTRATOR
3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600

2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

(1) The resident's name.
(2) The name of the medication.
(3) The date the prescription was issued.
(4) The prescribed dosage and instructions for administration.
(5) The name and title of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #7 is prescribed, "Flonase-One spray in each nostril one time daily"; however, the pharmacy label indicates, "Flonase-One spray in each nostril two times daily".

Resident #7 is prescribed, "Novolog Flexpen-according to sliding scale. Do not give if blood sugar is below 201"; however, the pharmacy label indicates, "Novolog Flexpen-Inject 6 units subcutaneously before meals if blood sugar reading is 101-200 per sliding scale".

Resident #7 is prescribed, "Levemir Flex Touch Solution pen-100u/ml-Inject 20 units subcutaneously at bedtime"; however, the pharmacy label indicates, "Levemir Flex Touch Solution pen-100 u/ml-Inject 22 units subcutaneously at bed time".

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

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

SEE ATTACHED

See page 9A of 11

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Signature of Legal Entity Representative (Required on EVERY Page) Cynthia K Lilly

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

Date 2.8.17

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- ☐ Not Implemented

Pharmacy labels

Immediate compliance:

A "check the order" label was signed and placed by the Wellness Director onto the existing Flonase, Novo log and Levemir labels on 1.6.17.

On-going compliance:

A medication label check system was initiated 1.8.17 in the facility. Copy attached.

Lead med techs will check medication labels against the orders/E-mar when they are delivered by the pharmacy.

Wellness Director or designee will audit monthly to insure compliance.

Unannounced random checks of each med cart for discrepancies with the orders and medication labels will be conducted by the Wellness Director or designee.

Additional training to be given to the Med Tech on how to double check med/labels and correct if needed. The attached Medication Labels Checks protocols will be use. Training to be included at the care staff meeting scheduled 2.9.17. Agenda attached.

Cynthia K. Lilly
CYNTHIA K. LILLY, ADMINISTRATOR
3.8.17

Violation Report: 44659 - 01/06/2017 - Garrigan, Laurie
PCH Name: LOYALHANNA HEALTH CARE ASSOCIATES

1. REGULATION 55 Pa.Code §2600

2600.227(d) - Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.

2a. DESCRIPTION OF VIOLATION -

Resident #6's assessment, dated 6/15/16, indicates the resident is receiving hospice services as of 8/18/16; however, the resident's support plan, dated 6/15/16, does not indicate what services are being provided by hospice or the frequency of services.

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

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

SEE ATTACHED

See page 11A of 11

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CYNTHIA K. LILLY ADMIN

Date 2.8.17

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Document support plan

Immediate compliance:

The Wellness Director corrected the residents support plan with a Support Plan Update noting the addition of hospice services. A copy of the Plan is attached. Resident #6's support plan was updated on 2/8/17 to include specific services provided by hospice and the frequency of those services.

On-going compliance: 2/13/17

Any resident receiving additional services will require documentation of said services on the Support Plan Update.

Care staff has been educated to report any changes in services by outside providers to the Wellness Director to insure that all resident needs are being meet.

The Quarterly audits completed with the Content of Resident Records Checklist will issue compliance as item # 12 requires documentation of health care services and orders including home health/hospice agencies.

Checklist attached.

Cynthia K. Lilly

CYNTHIA K. LILLY, ADMINISTRATOR 3.8.17