pennsylvania
DEPARTMENT OF HUMAN SERVICES

NOV 16 2017

Mr. Jeff Naden
President
Nasun, Inc.
1575 Grand Boulevard
Monessen, Pennsylvania 15062

RE: Hallsworth House
Certificate #: 428970

Dear Mr. Naden:

As a result of the Department of Human Services' annual licensing inspection on April 3, 2017 and April 4, 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: HALLSWORTH HOUSE	License Number: 42897
Address: 1575 GRAND BOULEVARD, MONESSEN, PA 15062	County: Westmoreland
Administrator: Jan DeForrest	Region: WEST
Legal Entity Name: NASUN INC	
Legal Entity Address: 1575 GRAND BOULEVARD, MONESSEN, PA 15062	

Certificate(s) of Occupancy

Other	I-2
11/14/2014	02/25/2011
Uniontown	City of Monessen

Staffing Hours

Resident Support: 0 | Total Daily Staff: 80 | Waking Staff: 60

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

Reason(s) for Inspection(s)

Renewal, Incident

On-Site Inspections Dates and Department Representatives On-Site

04/03/2017: Summers, Vicky; Roser, Ashley
04/04/2017: Summers, Vicky; Roser, Ashley

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: 63	Number of Residents who:
Number of Residents Served: 52	Receive Supplemental Security Income: 1
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 52
Area:	Have Mental Illness: 1
Secured Dementia Unit Capacity, if Applicable:	Have an Intellectual Disability: 1
Number of Residents Served in Secured Dementia Care Unit, if applicable:	Have a Mobility Need: 28
Number of Current Hospice Residents: 14	Have a Physical Disability: 0
Number of Hospice Residents in past year: 25	

Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

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

On 4/3/17, the license inspection summary, dated 1/18/17, containing the resident privacy coding document that included the names of residents #1, #2, #3 and #4 was posted in the home.

On 4/4/17, a white binder containing hospice information with addresses, social security numbers, insurance information, and emergency contact information was unlocked, unattended, and accessible in the small conference 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.

#1 Privacy coding document was removed day of inspection

#2 Binder was not our property, Hospice company left binder in room, was removed day of inspection

Immediately and for future all documents that relate to private resident records will be secured properly. Visiting agencies will be educated and required to use the existing lockable storage cabinet currently in use for such purpose. Administrator will complete random checks on staff compliance with regulations.

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

Signature of Legal Entity Representative (Required on EVERY Page) JM

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) JEFF NADEN, Administrator

Date 5-26-17

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

The above plan of correction is approved as of 10/11/17 (Date)

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

Plan of correction implementation status as of 10/11/17 (Date)

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

Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.18 - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2a. DESCRIPTION OF VIOLATION
The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The home has fossil fuel burning devices and does not have any carbon monoxide detectors.

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.

We did have detectors in place in most areas, we did miss the attic space for detectors. The detectors installed apparently do not meet requirements.

Immediately, owner will seek out a company to contract with that can install/provide detectors that meet the new code within 30 days of this reply and depending on their schedule and product supply, have the new detectors installed shortly thereafter.

The plan is to have a group of hardwired detectors that tie into the existing fire alarm system. Initial research shows this is possible.

within 30 days of receipt of the plan of correction. JW 10/11/17

Installation of carbon monoxide alarms was initiated on 8/8/17. JW. 10/11/17

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

Date 5-26-17

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Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.65(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 A did not receive annual training in 2016 on the following topics:

- Medication self-administration
- Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan
- Personal care service needs of the resident

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 person "A" is a part time employee. Due to their availability restrictions they missed the planned classes. We did fail to properly reschedule appropriate training.

Immediately administrator will plan an audit period in November of each year to assess any and all staff persons who may have missed any training and provide them the proper training prior to the end of our staff training year which ends the last day of December.

Staff person A received training in the areas aforementioned on 5/19/17. JLL 10/11/17

Immediately the administrator will review all staff person training as part of the quality management review process to ensure each direct care staff person receives training in all topics in accordance with 2600-65f during each training year. JLL 10/11/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/25/2016 et al		

Signature of Legal Entity Representative (Required on EVERY Page) JM

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

Date 5-26-17

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Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

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

2a. DESCRIPTION OF VIOLATION
Resident #5 and resident #6 are both prescribed blood glucose monitoring three times daily and their glucometers have been shared with each other. The glucometer labeled for resident #6 was used to measure blood glucose levels for resident #5 on 4/1/17 at 7:00 a.m. The glucometer labeled for resident #5 was used to measure blood glucose levels for resident #6 on the following dates and times:

- 4/3/17: 7:30 a.m.
- 4/1/17: 7:30 a.m.
- 4/1/17: 11:30 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.

Day of Inspection, ALL glucometers were replaced with new devices. Also, prior to the next med pass, ALL med staff were spoken to individually about the violation and correct method of testing blood sugars. Documentation of staff training shall be kept. gw. 10/11/17

Audits of med staff efforts were scheduled immediately. The attached schedule is the current audit plan. If errors end up being found we may alter the current plan to adapt to the errors and properly address staff who had the error. Any new med staff in the meantime will be trained appropriately.

within 15 days of receipt of the plan of corrections: The administrator or designee shall review and update the homes policies regarding 2600.185a, specifically addressing the safe storage, access, distribution, and use of glucometers and blood glucose testing equipment. A copy of the updated policy will be provided to and reviewed with all staff qualified to administer medication. gw. 10/11/17

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

Signature of Legal Entity Representative (Required on EVERY Page) JM

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

Date 5-26-17

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

2a. DESCRIPTION OF VIOLATION

At approximately 9:30 a.m. on 4/3/17, the emergency exit door in the living room of the reliance wing was blocked by 4 wheelchairs and 2 walkers, including resident #3's wheelchair. At approximately 12:00 p.m. on 4/4/17, the same exit was blocked by resident #3's wheelchair.

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.

Educated all staff on not blocking ANY door opening or exit for any reason.
Initially, multiple checks each day were performed. We have since scaled down to multiple weekly checks and have not found any non compliance. We will continue to perform multiple weekly checks in order to keep in compliance.

For future administrator will assign duty or complete themselves frequent and random checks of all passageways in the building to verify compliance.

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

Signature of Legal Entity Representative (Required on EVERY Page) JM

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

Date 5-26-17

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Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

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

2a. DESCRIPTION OF VIOLATION
Resident #6's initial medical evaluation, dated [redacted]16, does not include height, weight, pulse rate, blood pressure or temperature.

Resident #7's initial medical evaluation, dated [redacted]17, does not include height, weight, blood pressure or temperature.

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, missing information will be obtained and added to said documents so as to create compliance.

Future, administrator will coordinate with co-administrator on review of and creation of all documents in order for full compliance and avoidance of missing information. This two person review/analysis of information should hopefully create full compliance on all future documentation.

Within 15 days of receipt of the plan of correction, a designated staff person will review all resident files to ensure each resident has a current medical evaluation, completed in its entirety, present in each resident record. JW. 10/11/17

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

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

Date 5-26-17

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Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

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 #6's prescription for Warfarin sodium 3 mg tablet was discontinued on 3/31/17; however, the medication was still stored in the medication cart.

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

All med staff were reminded of the compliance concern over properly stored and maintained medication for all residents. That any and all medication can not "wait" in the med cart until pharmacy picks up the returning medicine for credit, that the storage bin in the med room is to be used for that purpose.

Immediate and future. Administrator and or designee will add this to the routine med compliance audit/inspection that has been mentioned previously in order to randomly check for compliance with this violation. - at least weekly. JW. 10/11/17

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

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Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

1. REGULATION 55 Pa.Code §2600
2600.225(a) - A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

2a. DESCRIPTION OF VIOLATION
Resident #6 was admitted to the home on 10/24/16; however, the initial assessment was not completed until 11/23/16.

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

Immediately and for the future, ALL RASPs and DMEs have a two person review process in order to have proper completion. Currently, and until/if staff changes, both administrators will compliment each others efforts with review, completion, and adherence to regulations for proper completion of documents.

Within 15 days of receipt of the plan of correction: All staff persons responsible for resident assessments will be educated on the accuracy and completion of assessments including the requirement that each new resident have an assessment completed within 15 days of admission. Documentation of staff education shall be kept. JM 10/11/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/25/2016 et al		

Signature of Legal Entity Representative (Required on EVERY Page) JM

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) JEFF NADEN Administrator — Date 5-26-17

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Plan of correction implementation status as of 10/11/17 (Date)

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- ☐ Not Implemented

Violation Report: 42897 - 04/03/2017 - Summers, Vicky
PCH Name: HALLSWORTH HOUSE

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

Resident #4's support plan, dated 1/24/17, indicates the resident requires total physical assistance with 2 person assistance for transfers and 1 person assistance for ambulating; however, the assessment, dated 1/20/17, inaccurately indicates the resident has minimal mobility needs.

#4 JLS. 10/11/17

Resident #8's annual assessment, dated 1/20/17, does not include the resident's need for nectar thick liquids, as indicated on physician's orders dated 1/24/17.

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.

Resident #4 paperwork has been corrected to reflect a matching of mobility needs. The above paragraph is backwards however, the RASP had Minimal and DME had Total. Total is correct.

Resident #8 does not have any of the above noted information,

however, we did find that #4 has this nectar thick notation. This notation came from the hospital discharge papers as their treatments, however, our paperwork was not adjusted. We have confirmed that we are following and have been following the nectar thick requirement on a day to day basis.

In the future, we will be more diligent with keeping records up to date with changes in needs or conditions. Administrator or designee will address this as needed and upon newly created paperwork and or new admissions or significant changes to current residents.

Within 15 days of receipt of the plan of correction: A designated staff person will review all resident records to ensure each resident has a current assessment, completed in its entirety, and present in each record.

JLS. 10/11/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	01/18/2017		

Signature of Legal Entity Representative (Required on EVERY Page)

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

Date 5-26-17

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

The above plan of correction is approved as of 10/4/17 (Date)

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

Plan of correction implementation status as of 10/11/17 (Date)

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