pennsylvania
DEPARTMENT OF HUMAN SERVICES

NOV 0 9 2017

Mr. Raymond L. Wolfe
Chief Operating Officer
Mercy Life Center Corporation
Attn: Cheri Richard
1200 Reedsdale Street
Pittsburgh, Pennsylvania 15233

RE: Garden View Manor
441 Swissvale Avenue
Pittsburgh, Pennsylvania 15221
Certificate #: 440690

Dear Mr. Wolfe:

As a result of the Department of Human Services' annual licensing inspection on April 18, 2017 and April 19, 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: GARDEN VIEW MANOR	License Number: 44069
Address: 441 SWISSVALE AVENUE, PITTSBURGH, PA 15221	County: Allegheny
Administrator: Laurel Spigler	Region: WEST
Legal Entity Name: MERCY LIFE CENTER CORPORATION	
Legal Entity Address: 1200 REEDSDALE STREET, PITTSBURGH, PA 15233	

Certificate(s) of Occupancy

I-2
04/08/2010
Borough if Wilkinsburg

Staffing Hours

Resident Support: 0 | Total Daily Staff: 55 | Waking Staff: 41

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

04/18/2017: Quinn, Suzanne; Garrigan, Laurie
04/19/2017: Quinn, Suzanne; Garrigan, Laurie

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: 56

Number of Residents Served: 55

Secured Dementia Care Unit In Home: No

Area:

Secured Dementia Unit Capacity, if Applicable:

Number of Residents Served in Secured Dementia Care Unit, if applicable:

Number of Current Hospice Residents: 0

Number of Hospice Residents in past year: 1

Number of Residents who:

- Receive Supplemental Security Income: 55
- Are 60 Years of Age or Older: 22
- Have Mental Illness: 55
- Have an Intellectual Disability: 0
- Have a Mobility Need: 0
- Have a Physical Disability: 1

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

1. REGULATION 55 Pa.Code §2600

2600.26(b) - The quality management plan shall address the periodic review and evaluation of the following:

(1) The reportable incident and condition reporting procedures.
(2) Complaint procedures.
(3) Staff person training.
(4) Licensing violations and plans of correction, if applicable.
(5) Resident or family councils, or both, if applicable.

2a. DESCRIPTION OF VIOLATION

Reportable incidents and conditions procedures were not reviewed during the home's annual quality management review, which was held on 12/5/16.

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

On 8/7/17, The administrator updated the Annual Quality Management plan to include the previously omitted section of reportable incidents and condition procedures to prevent future omissions. This form will be utilized by the program administrator and designated reviewers at the next annual quality management review scheduled for December of 2017. Additionally, the Quality Management Procedure has been updated to reflect the regulation and all required elements. The administrator will be responsible for ensuring the Quality Management Plan is reviewed and required actions are taken to ensure quality resident care and program operations. Attached are two monthly documents which are also utilized by the organization to review and communicate quality management issues. These are reviewed on a monthly basis by the program administrators and are also submitted to the organization for review.

See attached documents:
Page 2A – 44069 Updated Annual Quality Management Plan
Page 2b – 44069 Updated Quality Management Procedures
Page 2C – 44069 Copy of June 2017 Med Error Report
Page 2D – 44069 Copy of June 2017 Monthly Report

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) Laurel Spigler, PCHA

Date 8/17/17

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

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

The above plan of correction was approved by JN. (Initials)

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

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

Direct care staff member A, hired 12/1/06, did not receive training on the following topics during the 7/1/15 through 6/30/16 training year:
* Medication self-administration training
* 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 dementia and cognitive impairments
* Infection control and general principles of cleanliness and hygiene areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration

Direct care staff member E, hired in 2011, did not receive training on the following topics during the 7/1/15 through 6/30/16 training year:
* 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

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.

Administrators ensured that staff members A & E completed all of the trainings listed that were not completed during the 7/1/15-6/30/16 training year. See attached records for proof. Moving forward, administrators will ensure all required trainings are completed. Starting 9/1/17, Team Leader and Resident Advisor will track training progress monthly. They will send out reminder emails about the monthly training. They will check progress and report any issues to administrators. Administrators will follow up with staff not staying on target with completion. Administrators will also offer trainings during monthly staff meetings and ensure proper sign in/proof is provided. Prior to the end of the training year, administers will ensure all training are completed in time. See attached documents: Page 4A- 44069 Medication Self-Administration staff A; Page 4B - 44069 Meeting the Needs of Residents staff A; Page 4C - 44069 Dementia and Alzheimer's Residents staff A;

Page 4D - 44069 - Universal Percautions staff A; Page 4E - 44069 Meeting the needs of resident staff E; Page 4F- 44069 Medication Self-administration staff E

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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

The above plan of correction was approved by JW. (Initials)

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

1. REGULATION 55 Pa.Code §2600

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

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

2a. DESCRIPTION OF VIOLATION

Direct care staff member A, hired 12/1/06, did not receive training on the following topics during the 7/1/15 through 6/30/16 training year:

* Emergency preparedness procedures and recognition and response to crises and emergency situations

Direct care staff member E, hired in 2011, did not receive training on the following topics during the 7/1/15 through 6/30/16 training year:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert
* Resident rights
* Falls and accident prevention

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.

Administrators will ensure that all mandatory trainings are completed annually. Direct Care Staff member A completed Emergency preparedness training , see attached proof. Direct Care Staff E had completed Fire Safety Training on video by fire safety expert not in person with Fire safety expert. Staff E has now completed the fire safety training by a fire safety expert, see attached proof. In addition, Staff E completed Residents Rights and Falls and Accident prevention, see attached. Moving forward, administrators will ensure that staff complete their required trainings yearly. Administrators will remind Casual Pool staff (E) /Casual Pool supervisor of the required annual trainings so that they stay in compliance with regulations. Team Leaders and Resident Advisor will track monthly progress of trainings and send reminder emails. Administrators will check in with staff and prior to end of training year, ensure all trainings are completed.

Page 5A - 44069 Emergency Preparedness staff A
Page 5B - 44069 Fire Safety Sign-In sheet staff E
Page 5C - 44069 Resident Rights staff E
Page 5D - 44069 Prevention of Falls staff E

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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

The above plan of correction was approved by DW. (Initials)

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

1. REGULATION 55 Pa.Code §2600
2600.103(g) - Food shall be stored in closed or sealed containers.

2a. DESCRIPTION OF VIOLATION
On 4/18/17 at 11:12 AM, 6 open and unsealed boxes of various types of cereal were in the cereal storage area in the front of the kitchen.

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.

After DHS notified kitchen staff that the cereal boxes were not properly sealed, kitchen supervisor emailed all staff and reviewed the expectation that all cereals would be sealed with tape or clips after opening. On the day of audit, this issue was immediately addressed and boxes were sealed. It has been determined that tape would be used as a long term solution for this to avoid the risk of plastic clips breaking and contaminating food items. Signage is posted near the storage area for cereal boxes currently in use. Staff continue to seal the cereal and this is monitored by kitchen staff. Please see attached photographs documenting the signage and current state of the cereal storage as of 8/7/17.

See attached documents:
Page 6A – 44069 Signage near cereal storage area
Page 6B – 44069 Cereal box grouping 1 as of 8/7/17
Page 6C – 44069 Cereal box grouping 2 as of 8/7/17

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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

The above plan of correction was approved by QW. (Initials)

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

1. REGULATION 55 Pa.Code §2600
2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION
The most recent fire drill conducted during sleeping hours was held on 02/28/17 at 10:45 PM; however, the previous fire drill conducted during sleeping hours was held on 7/8/16 at 10:45 PM, which exceeded 6 months.

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.

As was submitted in our POC for our violation report from 3/20/2017, Gardenview Manor is now using the DHS recommended sleeping hours of 11 PM to 7 AM for drills. Sleeping hour drills occurred on 3/20/17 at 11:26 PM and on 6/22/17 at 5:21 AM. A third drill is scheduled for the month of December 2017. To ensure that this essential task is not omitted in the future, the organization's email/calendar system has been utilized to set reminders at the start of the month where the sleeping hour drills should occur. They will be occurring in May and November of 2019. A reminder was also set for November 2018 to trigger the scheduling of the sleeping hour drills for 2019. As new sleeping drill months are determined, these reminders will be set. The reminders will always be updated to include the current PCHA/maintenance supervisor. The program administrator will be responsible for ensuring the maintenance supervisor completes all sleeping hour drills in accordance with the schedule.

See attached documents:
Page 8A – 44069 2017 PCH Fire Drill Record showing 2017 fire drills to date and indicating the upcoming Sleeping Hours drill scheduled for December of 2017
Page 8B – 44069 Print out of Outlook calendar reminders sent to PCHAs and the maintenance supervisor triggering the drill to occur.
Page 8C – 44069 Outlook calendar reminder for a sleeping hour drill in November of 2018 and triggering the scheduling of sleeping hour drills for 2019

Within 30 days of receipt of the plan of correction: all staff persons will be educated that a sleeping hours fire drill shall be conducted at least once every 6 months. Documentation of the education shall be kept. / jw. 10/10/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/27/2016 4 al		

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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The above plan of correction was approved by JW. (Initials)

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

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

2a. DESCRIPTION OF VIOLATION
Resident #3's medical evaluation, dated 7/27/16, does not include the resident's temperature. This section of the form is blank.

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 the day of the violation, Resident [redacted] chart did not have the most updated version of her DME in the DPW section of the chart. Upon review, the administrator found two updated versions of the form which were misfiled in the medical information section of the chart. Document 9A and 9B show the document which was in the DPW section of the chart, this was the original form was submitted to the home for review the PCP completed this document on [redacted]/16. Document 9C is an email sent to [redacted] treatment team requesting changes to the DME and additional information. Documents 9D through 9H are an updated DME which was completed by the PCP on 8/25/16, and has incorrect/incomplete information on it as. Document 9I is a second email which is requesting that the PCP make these corrections. Document 9J is the correct DME was faxed to GVM on 8/30 this was misfiled and located in the medical section. This information was submitted to Licensing Supervisor for review on 8/9/17 at 5:23 PM.

Moving forward, nursing staff will continue to assist PCP offices in completing the DME. Depending on the issues discovered, the DME is returned to the PCP by fax or email with specific written instructions or changes will be made with PCP approval by nursing staff. For minor omissions site nurses will contact the PCPs office for verbal information and permission to modify the form. This will be documented in accordance with DHS standards. To avoid the issue of uncorrected DMEs being placed in the chart, staff will be directed to give original copies of the DME to the nurses for review, and the administrators to review prior to being placed in the DPW section of the resident chart.

Page 9A and 9B – 44069 – Original DME with incorrect information as found in DPW section of chart
Page9 C – 44069 – email to [redacted] treatment team regarding needed changes
Page 9D to 9H – 44069 – Updated DME with form completed on 8/25/17 which is still missing the temperature and indicated [redacted] was immobile
Page 9I – 44069 Email sent requesting corrections to the DME including the missing temperature.
Page 9J – 44069 Final correct version of the DME which was faxed to the program on 8/30/17 from the PCP. This version reflects the complete DME.

within 30 days of receipt of the plan of correction: a designated staff person will review all current medical evaluations to ensure accuracy and completion, including temperature. gw. 10/10/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/27/2016 et al	

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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

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

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.171(b)(5) - If staff persons or volunteers of the home provide transportation for the residents, the vehicle must have a first aid kit with the contents in § 2600.96 (relating to first aid kit).

2a. DESCRIPTION OF VIOLATION
On 4/18/17, no first aid kit was present in the 15 passenger van, which is used to transport residents.

On 4/18/17, no goggles were present in the first aid kit in the mini-van, which is used to transport residents.

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 day that the violation was discovered, staff placed first aid kits into the van. See attached documents 10A, 10B and 10D which show the current state of the first aid kits in the vehicles. Document 10C shows our policy for restocking and use of the first aid kits. Moving forward, the program administrators will coordinate with our newly hired Team Leads to ensure that all first aid kits are inventoried on a ~~monthly~~ bi-weekly basis. This will be added to a list of "staff specialty tasks" which we anticipate being implemented by 10/1/17. JW. 10/10/17

See attached documents:
Page 10A- Primary first aid kit in large van
Page 10B- Secondary first aid kit in large van and goggles
Page 10C Signage for use of 1st Aid kits
Page 10D Minivan first aid kit with goggles

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/27/2016 et al		

Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Laurel Spangler, PCHA

Date 8/17/17

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

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

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

1. REGULATION 55 Pa.Code §2600

2600.183(e) - Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

2a. DESCRIPTION OF VIOLATION

An open and undated bottle of Latanoprost-0.005% eye drops, belonging to resident #2, was present in the medication cart. According to the manufacturer's instructions, the eye drops are to be discarded 10 weeks after opening; however, on 4/18/17, they were still present in the home. According to the pharmacy label, the eye drops were filled by the pharmacy on 1/10/17.

An open and undated bottle of Brimonidine Tartrate-0.15% eye drops, belonging to resident #2, was present in the medication cart. According to the manufacturer's instructions, the eye drops are to be discarded 28 days after opening; however, on 4/18/17, they were still present in the home. According to the pharmacy label, the eye drops were filled by the pharmacy on 1/10/17.

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.

Immediately after the discovery of the out of compliance items on 4/18/17, staff and the site nurses reviewed all medications to ensure they were within safe time frames. Medications were disposed of and replaced as needed. An email was sent out to all staff, and the process of labeling medications with both the date opened, and a discard after date was implemented. Please reference documents Page 11A to 11F to see the current state of these products in both the 1st and 2nd floor med rooms. Additionally, the site nurses provided staff with list of expiration dates for medications with short shelf-lives, this is posted and available in the medication rooms. Supervisors are in the process of ordering improved stickers for labeling these medications and anticipate having them on site by 9/15/17. To prevent this event from occurring in the future, nurses will include verification of both the correct labeling and disposal of expired medications when completing routine cart audits. – at least monthly. Documentation of audits shall be kept. JW. 10/10/17

Page 11A – 44069 – 1st floor Med Room
Page 11B – 44069 – 1st floor Med Room
Page 11C – 44069 – 1st floor Med Room
Page 11D – 44069 – 1st floor Med Room
Page 11E – 44069 – 2nd floor Med Room
Page 11F – 44069 – 2nd floor Med Room
Page 11G – 44069- Cart Audit Process and Sheets
Page 11I – 44069 – Information about shelf-life of commonly used medications (3 pages)

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW 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's 8:00 AM glucometer readings from 4/2/17 through 4/18/17 did not match the blood sugar readings documented on the resident's April 2017 medication administration record (MAR) on the following dates:

	Date	Glucometer Reading	MAR Entry
*	4/2/17	115	128
*	4/4/17	133	142
*	4/7/17	101	102
*	4/11/17	No reading	194
*	4/9/17	147	146
*	4/17/17	187	172
*	4/18/17	139	142

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 will begin educating all diabetic residents about the expectation that staff must visually verify glucometer reads. Signage has been posted reminding the residents of this. This will also be discussed in the upcoming August 2017 Resident Council meeting to ensure that all residents are clear with this expectation. On 8/9/17, site nurses began meeting with staff at shift changes to explain the safety guidelines and best practices for verifying glucometer readings. There is also signage posted on the medication carts reminding staff to visually verify the readings. As part of our cart audit process, site nurses will begin to complete spot checks of resident glucometers and MARs to ensure that all staff are complying with the expectation. The nurses are creating a new form to record the information about staff's compliance with this process.

, at least monthly, JW. 10/10/17

See attached documents:
Page 12A – 44069 Signage for residents
Page12B – 44069 Signage for staff
Page 12C – 44069 Cart Audit Form with Glucometer checks

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spicher, MA, PCHA

Date: 8/17/17

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

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The above plan of correction was approved by JW. (Initials)

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

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

Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

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 member A has not successfully completed the Department-approved medication administration program. This staff member administered multiple medications to residents, to include the following:
* Lisinopril-40mg, Levothyroxine-75 mcg and Escitalopram20mg to resident #3 at 8:00 AM on 4/12/17
* Topiramate-200mg, Phenytoin-100mg and Levothyroxine-75mcg to resident #5 at 8:00 AM on 4/14/17

Direct care staff member B has not successfully completed the Department-approved medication administration program. This staff member administered multiple medications to residents, to include the following:
* Lisinopril-40mg, Levothyroxine-75mcg and Escitalopram-20mg to resident #3 at 8:00 AM on 4/11/17
* Haloperidal-5mg, Ketoconazole-2% cream and Clonazepam-0.5 mg to resident #5 at 8:00 AM on 4/13/17

Direct care staff memberC has not successfully completed the Department-approved medication administration program. This staff member administered multiple medications to residents, to include the following:
* Bupropion SR-150 mg, Risperidone 4mg and Lisinopril-40 mg to resident #3 at 8:00 PM on 4/11/17
* Benzotropine-1mg, Carbamazepine-300mg and Phenytoin-100mg to resident #5 at 8:00 AM on 4/2/17

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.

Page 13: Upon notification on day of audit when missing paperwork was not found, staff members were taken off of medication passing. Administrators immediately set up medication training for staff members. They were all retrained on 4/24/17 and correct paperwork placed in charts. Nurses began working with Lead PCH Nurse to ensure that all medication administration documents get completed immediately and placed into staff charts. With the addition of two Team Leaders who will become DHS Medication Trainers and 1 additional Nurse Med Trainer. Administrators will follow up with medication trainers and ensure documents are completed as directed.

See attached documents:
Page 13A – 44069 Staff Certification Form [redacted]
Page 13B- 44069 Staff Data Summery Form [redacted]
Page 13C – 44069 Staff Certification Form [redacted]
Page 13D – 44069 Staff Data Summery Form [redacted]
Page 13E- 44069 Staff Certification Form [redacted]
Page 13F – 44069 Staff Data Summery Form [redacted]

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Laurel Spigler, PCHA

Date: 8/17/17

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

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

The above plan of correction was approved by A.W. (Initials)

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

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress A.W.
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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Violation Report: 44069 - 04/18/2017 - Quinn, Suzanne
PCH Name: GARDEN VIEW MANOR

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

On 3/13/17 at approximately 7:45 PM, resident #1 was found in bed with multiple, self-inflicted cuts to both wrists. This is not addressed on the resident's support plan, dated 12/6/16.

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.

[redacted] had [redacted] initial bout of self-injurious behavior on 3/13/17 where [redacted] engaged in superficial wrist cutting. [redacted] support was arranged through collaboration with CTT and GVM staff regarding [redacted] care. This information was not transcribed onto [redacted] RASP promptly. Due to concerns about [redacted] ability to maintain safety Garden View Manor requested that [redacted] was transported to the Pittsburgh Mercy's secure Crisis Center on [redacted] 17 for assessment, and [redacted] was admitted to Pittsburgh Mercy's DAS program on [redacted] 17. [redacted] remained at the DAS program while undergoing medication changes and intensive support, [redacted] was discharged back to Garden View Manor on [redacted] 7. [redacted] RASP and crisis plan were updated the day of [redacted] return, the plan was reviewed with both [redacted] and staff. [redacted] plan had not been updated on 4/18/17 because [redacted] had not returned from [redacted] stay at the DAS program

Moving forward, the administrators will collaborate with the RN and Team Leaders to help educate all staff about updating RASPs of residents who experience significant mental or medical status changes . Appropriate changes to be made to RASP and shared with all staff.

Page 15A – 44069 Updated RASP from 5/1/17
Page 15B – 44069 Updated Crisis Plan from 5/1/17

Within 15 days of receipt of the plan of correction: a designated staff person will review all current resident support plans for accuracy and completion, including a plan to address any dangerous behaviors. JW. 10/10/17

Within 30 days of receipt of the plan of correction: all staff persons responsible for resident support plans will be educated on the accuracy and completion of support plans including the home's process to update an existing support plan in a timely manner. JW 10/10/17

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Laura Spigler, PCHA

Date 8/17/17

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

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

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

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

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