pennsylvania
DEPARTMENT OF HUMAN SERVICES

SEP 29 2017

Ms. Vida Glover,
Administrator
Attn: Amy Zakel, Senior Director
1001 East Second Street
Coudersport, Pennsylvania 16915

RE: Cole Manor
101 Maple Street
Coudersport, Pennsylvania 16915
License #: 242630

Dear Ms. Glover:

As a result of the Department of Human Services' annual licensing inspection on July 18, 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: COLE MANOR	**License Number:** 24263
Address: 101 MAPLE STREET, COUDERSPORT, PA 16915	**County:** Potter
Administrator: Vida Glover	**Region:** NORTHEAST

Legal Entity Name: HENDORN INC

Legal Entity Address: 1001 EAST SECOND STREET, COUDERSPORT, PA 16915

Certificate(s) of Occupancy

C-2 LP
10/21/1987
L&I

Staffing Hours

Resident Support: 0	**Total Daily Staff:** 17	**Waking Staff:** 13

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

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

07/18/2017: Novak, Ryan; OHaire, Anne

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: 30	**Number of Residents who:**
Number of Residents Served: 17	**Receive Supplemental Security Income:** 3
Secured Dementia Care Unit in Home: No	**Are 60 Years of Age or Older:** 17
Area:	**Have Mental Illness:** 2
Secured Dementia Unit Capacity, if Applicable:	**Have an Intellectual Disability:** 2
Number of Residents Served in Secured Dementia Care Unit, if applicable:	**Have a Mobility Need:** 0
Number of Current Hospice Residents: 1	**Have a Physical Disability:** 0
Number of Hospice Residents in past year: 1	

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

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 home did not have the Influenza poster posted in a public conspicuous area of the home as required by the Influenza Awareness Act.

The home utilizes a gas fired boiler and a gas fired cooking stove, the carbon monoxide detectors are not located at least 15 feet from the fossil fuel burning device as required by the Care Facilities Carbon Monoxide Standards 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.

See attached

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/09/2016		

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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

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

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

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

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

Hendorn, Inc., Cole Manor Plan of Correction

P2A8C3

Survey: July 18, 2017

Regulation: 2600.18
A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Violation: The Home did not have the influenza poster posted in a public conspicuous area of the home as required by the Influenza Awareness Act.

The home utilizes a gas fired boiler and a gas fired cooking stove, the carbon monoxide detectors are not located at least 15 feet from the fossil fuel burning device as required by the Care Facilities Carbon Monoxide Standards Act.

Plan of Correction:

Why is the regulation important? The regulation is important to ensure the home promotes protecting yourself, your family and community against acquiring the flu.

The regulation is important to ensure the home is safely monitoring carbon monoxide in areas where there is a fossil fuel burning device / source.

The regulation is important to ensure the home remains complaint with all regulations, and aware of updates.

How was the regulation violated? The regulation was violated because the home did not have a Pennsylvania Department of Health "Stopping the Flu Starts with You!" poster displayed in a public conspicuous area of the home.

The regulation was violated because the carbon monoxide detector in the kitchen was approximately 11 feet from the fossil fuel burning device, and the detector in the boiler room was approximately 5 feet from the fossil fuel burning device.

What caused the violation? The Administrator was unaware of the requirement to post the poster from the Pennsylvania Department of Health.

The Administrator was aware of the need for a carbon monoxide detector, but not of the fact it needed to be located at least 15 feet from the fossil fuel burning device.

What can be done right away to fix the violation?
On July 18, 2017, the date of the survey, the poster was placed on display in a public area (first floor bulletin board).

On July 31, 2017, the home's Administrator reviewed the Influenza Awareness Act – Act of Nov. 21, 2016, P.L. 1514, No. 173, to ensure understanding of the requirement.

8-8-17

P208-3

On July 18, 2017, the date of the survey, the carbon monoxide detectors were moved greater than 15 feet from the fossil fuel source.

On July 30, 2017, the policy titled "Carbon Monoxide Detectors" was created.

What can be done to prevent future violations?
Administrator, or designee, will complete a monthly facility safety checklist that monitors display of the flu prevention poster, as well as the location of the carbon monoxide detectors.

On or before, August 10, 2017, staff will be educated on the carbon monoxide policy as well as the Influenza Awareness Act.

Starting on August 1, 2017, the Executive Director of Post-Acute Services and Community Relations, or designee, will monitor the Provider Information: Human Licensing: General – Policy, Regulations and Interpretation Information Q & A on a monthly basis to review for changes and updates.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08/01/2017

Vida Glover
Vida Glover, Administrator

Dated: 08/01/2017

Amy M Hunt
Amy M Hunt, Executive Director
Post-Acute Services and Community Relations

D.H.
8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

1. REGULATION 55 Pa.Code §2600
2600.64(c) - An administrator shall have at least 24 hours of annual training relating to the job duties.

2a. DESCRIPTION OF VIOLATION
The home's Administrator only completed 15 of the required 24 hours of annual training for 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.

See attached

By January 21, 2018 the Administrator will fax or E-Mail documentation for all of 2017's 24 hours of approved administrator training to the NE Regional Office. Q.K. 8-8-17

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

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P3 A 8 3

Hendorn, Inc., Cole Manor Plan of Correction

Survey: July 18, 2017

Regulation: 2600.64 (c)
An administrator shall have at least 24 hours of annual training relating to the job duties.

Violation: The home's Administrator only completed 15 of the required 24 hours of annual training during 2016.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure that the home's Administrator stays current with required education and training to ensure the safe operation of the home and care of the residents.

How was the regulation violated? The home's Administrator only completed 15 of the required 24 hours of annual training during 2016.

What caused the violation? The home's Administrator was on a medical leave of absence during the last quarter of the year. The additional 9 hours of training have been completed in 2017.

What can be done right away to fix the violation? The home's Administrator will complete an additional 24 hours of approved education / training during 2017, to be completed on or before December 31, 2017. Training documents are to be noted "2016" or "2017" to indicate the hours for what year are completed.
On July 28, 2017, the home's Administrator reviewed Pa Code 2600.64 to ensure complete understanding of the requirement.
8-8-17

What can be done to prevent future violations? The home's Administrator will adhere to the regulation, by completing 24 hours of training per calendar year. Proof of training will be submitted to Staff Development Department and reported to the Executive Director of Post-Acute Services and Community Relations each calendar year, on or before December 31, 2017.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover
Vida Glover, Administrator

8-8-17

P3 8 of 13

Dated: 08/01/2017

Amy M. Hunt, Executive Director
Post-Acute Services and Community Relations

8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE 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

Ancillarty Staff person A hired 2/28/05 did not receive training in falls and accident prevention in 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.

See attached

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

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

Hendorn, Inc., Cole Manor Plan of Correction

P 4A 8 13

Survey: July 18, 2017

Regulation: 2600.65(g)
Director 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 populations groups that are being served at the home that were not previously served, if applicable.

Violation: One employee did not complete the Falls and Accident Prevention training during the 2016 calendar year.

Plan of Correction:

Why is the regulation important? The regulation is important to ensure that staff has the education and training necessary to safely care for the residents in the home.

How was the regulation violated? Ancillary staff person hired on 02/28/05 did not receive training in falls and accident prevention in 2016.

What caused the violation? The employee completed annual training during 2016, but failed to complete the Falls and Accident Prevention training.

What can be done right away to fix the violation? The employee completed the Falls and Accident Prevention training on July 21, 2017.

What can be done to prevent future violations? It is the policy of Cole Memorial, that all employees complete the online learning modules by the end of each calendar year. In addition, education that is not included in the online learning modules, will be provided by the home's Administrator. This education will be submitted to Staff Development. This is monitored by Staff Development and the home's Administrator. This employee will complete the Falls and Accident Prevention training again during 2017.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's

8-8-2017

Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Executive Director
Post-Acute Services and Community Relations

QA
8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

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 Frigidaire chest freezer located in the kitchen did not contain a thermometer.

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

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P 5A 8 13

Hendorn, Inc., Cole Manor Plan of Correction

Survey: July 18, 2017

Regulation: 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 the refrigerators and freezers.

Violation: The Frigidaire chest freezer locating in the kitchen did not contain a thermometer.

Plan of Correction:

Why is the regulation important? The regulation is import to ensure that the food prepared for the residents is safe for consumption.

How was the regulation violated? The regulation was violated because without a thermometer, staff cannot know if the food (popsicles – only food in the freezer) were kept at or below 0°F.

What caused the violation? Staff placed food (popsicles) in a small, empty, non-food chest freezer. The freezer did not have a thermometer.

What can be done right away to fix the violation? On July 19, 2017, a thermometer was placed in the freezer. Additionally, the freezer is labeled as a non-food freezer.

What can be done to prevent future violations? The home's Administrator, or designee, will monitor all non-food storing refrigerators or freezers on a monthly basis to ensure that food is not being stored. The home's Administrator, or designee, will monitor all food storing refrigerators and freezers for a thermometer monthly. It will be recorded on the facility's monthly safety checklist. Findings will be reviewed with employees during the monthly quality assurance meeting.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Executive Director
Post-Acute Services and Community Relations

8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

1. REGULATION 55 Pa.Code §2600

2600.130(e) - If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

2a. DESCRIPTION OF VIOLATION

Resident #1 is unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that the resident is alerted in the event of a fire.

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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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Hendorn, Inc., Cole Manor Plan of Correction

P 6A 8 13

Survey: July 18, 2017

Regulation: 2600.130(e)
If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Violation: A resident is unable to hear the fire alarm system. The home does not have a signaling device, approved by the fire safety expert and tested to ensure that the resident is alerted in the event of a fire.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure a resident is able to appropriately respond during the event of a fire.

How was the regulation violated? A resident, that is hard of hearing, does not have access to signaling device, approved by the fire safety expert and tested, to ensure he is alerted in the event of a fire.

What caused the violation? The violation was caused by the home's failure to obtain an additional signaling device to appropriately alert the resident in the event of a fire.

What can be done right away to fix the violation? On July 30, 2017, the policy "Alternative Signaling Devices" was created.

On or before August 1, 2017, staff will be education on the need to physically notify the resident in the event of an actual fire, or drill to ensure the resident is alerted.

On July 31, 2017, an alternative alarming device was purchased online from SafeAwake, LLC. It arrived to the facility on August 2, 107.

What can be done to prevent future violations? Upon inspection of the alternative alarming device, it will be installed in the resident's room. The resident and staff will be educated on the new device at the time of installation.

In addition, to ensure all other residents of the home are safe during a fire event, by August 4, 2017 the Administrator will assess and document each resident's ability to hear and respond to the current fire alarm system. At any time, during this assessment or during future fire drills, a resident is noted to have difficulty being alerted by the fire alarm system, an alternative signaling device will be obtain for the resident.

On or before August 10, 2017, staff will be educated on the policy "Alternative Signaling Devices"

8-8-17

KB 8-13

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Services. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Executive Director
Post-Acute Services and Community Relations

8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

1. REGULATION 55 Pa.Code §2600
2600.132(b) - A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

2a. DESCRIPTION OF VIOLATION
The letter from the fire safety expert dated 9/27/16 does not indicate a fire safety inspection was completed.

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

* Phone call 8-10-17
Qum will send copy of 1324 letter as soon as the local fire company makes the on-site safety inspection & completes the documentation. 8-10-17

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

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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Hendorn, Inc., Cole Manor Plan of Correction

P7A of 13

Survey: July 18, 2017

Regulation: 2600.132(b)
A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Violation: The letter from the fire safety expert, dated 09/27/16, does not indicate a fire safety inspection was completed.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure that the home has a current fire safety inspection on an annual basis.

How was the regulation violated? Although the fire safety expert had conducted a fire drill and inspection in September of 2016, the letter dated on 09/27/2016 does not indicate that the safety inspection was completed at this time.

What caused the violation? The violation was caused when the home's Administrator failed to identify that the documentation provided by the fire safety expert failed to meet the requirement.

What can be done right away to fix the violation? On July 28, 2017, the fire safety expert was contacted to request that a repeat fire safety inspection be completed as soon as possible.

On 07/30/17, the policy "Fire Drills" was created.

What can be done to prevent future violations? In the future, upon receiving the fire safety expert's letter, the home's Administrator will review the documentation to ensure that it meets the requirement. If the documentation does not meet the requirement, the home's Administrator will contact the fire safety expert immediately. At that time, the fire safety expert will either complete an addendum to the documentation so the documentation accurately reflects what was completed, or will schedule a follow up appointment with the home to conduct an additional inspection and / or drill.

On or before, 08/04/17, staff will be educated on the policy "Fire Drills".

8-10-17

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Services and Community Relations

P2B of 3

QY1
8-10-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

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 fire drill conducted on 8/31/16 at 1:50 does not indicate if the drill was conducted in the am or pm.

The fire drill conducted on 1/31/17 at 5:45am notes 4 staff participated in the fire drill, only 2 staff persons participated in the drill. The fire drill log in not documented correctly.

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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Hendorn, Inc., Cole Manor Plan of Correction

P 8/8/13

Survey: July 18, 2017

Regulation: 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 the staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Violation: The fire drill conducted on 08/31/16 at 1:50 does not indicate if the drill was conducted in the am or pm.

The fire drill conducted on 01/31/17 at 5:45 am notes 4 staff participated in the fire drill, only 2 staff persons participated in the drill. The fire drill log is not documented correctly.

Plan of Correction:
Why is the regulation important? The regulation is important to be able to demonstrate complete compliance with monitoring the fire drill activity. The regulation ensures that drills are conducted in a safe manner.

How was the regulation violated? The regulation is violated due to two errors with the documentation of monthly fire drills. The first error was a clerical error made by the home's Administrator, when she failed to indicate if the drill was completed in the am or pm. The second error occurred when including that observing staff was "staff persons participating" on the fire drill log sheet.

What caused the violation? The violation was caused when the home's Administrator recorded that two observing staff were participating staff during a fire drill.

What can be done right away to fix the violation? The home's Administrator conducted a fire drill on 07/26/17 at 4:55am. The Executive Director reviewed the fire drill log on 07/28/17, and determined the drill was recorded without error.

On 07/28/17, the Executive Director of Post Acute Services and Community Relations required the home's Administrator to review Pa Code 2600.132(c) to ensure complete understanding of documentation requirements of the fire drill.

On 07/28/17, the fire drill record form was reviewed by the Executive Director of Post-Acute Services and Community Relations, and determined to be appropriate to accurately document each drill.

On July 30, 2017, the policy "Fire Drills" was created.

8-8-17

P8 9 13

What can be done to prevent future violations? On or before, August 4, 2017, staff will be educated on the policy "Fire Drills".

During the routine quality assurance meetings, the home's Administrator will review all fire drills that have occurred since the prior quality assurance meeting. The review will include the date, time, evacuation time, exit routes utilized, number of residents in the home, number of residents evacuated, number of staff participating, alarm activation and operation and any additional problems identified or actions required. If at any time it is identified that the documentation of the drill does not meet the requirements, a follow up drill will be completed within seven (7) calendar days and documented.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Services and Community Relations

8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

1. REGULATION 55 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
It has been determined through staff interviews that the home utilizes an internal fire safe stairwell when the weather is inclement. The letter from the fire safety expert dated 9/27/16 does not indicate the home has internal fire safe areas in the home.

The fire drill conducted on 9/27/16 at 6:30pm took 3 minutes and 10 seconds for evacuation. The fire drill conducted on 10/21/16 at 8:25am took 3 minutes and 25seconds for evacuation. The letter from the fire safety expert dated 9/27/16 notes a safe evacuation time of 3 minutes.

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

Phone Conf w/ Adm 8-10-17
Adm will send a copy of completed documentation with specific time for safe evacuation of the home as soon as the fire safety expert gets to the home's. does the letter. CP 8-10-17

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

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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

The above plan of correction is approved as of 8-10-17 (Date)

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

Plan of correction implementation status as of 8-10-17 (Date)

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

Hendorn, Inc., Cole Manor Plan of Correction

P9A8-13

Survey: July 18, 2017

Regulation: 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.

Violation: It has been determined through staff interviews that the home utilizes an internal fire safe stairwell when the weather is inclement. The letter from the fire safety expert dated 9/27/16 does not indicate the home has an internal fire safe area in the home.

The fire drill conducted on 09/27/17 at 6:30pm took 3 minutes and 10 seconds for evacuation. The fire drill conducted on 10/21/16 at 8:25am took 3 minutes and 25 seconds for evacuation. The letter from the fire safety expert dated 9/27/16 notes a safe evacuation time of 3 minutes.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure the home is able to safely evacuate residents in a timely manner in the event of a fire.

How was the regulation violated? The regulation was violated when the fire safety expert failed to include documentation of the fire-safe area in the annual inspection letter. In addition, the regulation was violated when the home failed to complete a monthly drill in the 3 minutes or less safe evacuation time. When the drill was completed on 10/21/16, it was noted that it did not meet the required evacuation time. A repeat drill was conducted on 10/31/16, and the home was evacuated in 2 minutes and 59 seconds.

What caused the violation? Upon receiving the letter from the fire safety expert, the home's Administrator failed to identify that the documentation did not address the area of refuge / internal fire safe stairwell. Additionally, the home failed to complete two drills within the 3 minutes or less, as recommended by the fire safe expert to qualify for a safe evacuation of the facility.

What can be done right away to fix the violation? The Executive Director of Post Acute Services and Community Relations required the home's Administrator to review Pa Code 2600.132(d) on July 28, 2017, to ensure complete understanding of evacuation requirements.

The fire safe expert was contacted on 07/28/17, to request a re-inspection of the home, and document on the area of refuge / fire – safe designated area. A date for re-inspection has not been confirmed. Anticipate it will occur within 30 days.

On 07/30/17, the policy "Fire Drills" was created.

F908-3

What can be done to prevent future violations? During the routine quality assurance meetings, the home's Administrator will review all fire drills that have occurred since the prior quality assurance meeting. The review will include the date, time, evacuation time, exit routes utilized, number of residents in the home, number of residents evacuated, number of staff participating, alarm activation and operation and any additional problems identified or actions required. If at any time it is identified that the actual drill does not meet the requirements, a follow up drill will be completed and documented in 7 days or less. Documentation will include an assessment of why the actual drill failed to meet the requirements and the corrective action needed.

On or before, 08/04/17, staff will be educated on the policy "Fire Drills".

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Care and Rehabilitation Services

8-10-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

1. REGULATION 55 Pa.Code §2600
2600.132(f) - Alternate exit routes shall be used during fire drills.

2a. DESCRIPTION OF VIOLATION
The fire drills conducted from 5/17/16 - 10/21/16 and from 2/28/17-6/1/17 note "all exits" used. The home is not alternating exits used 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.

See attached

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

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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

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

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

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

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

Hendorn, Inc., Cole Manor Plan of Correction

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Survey: July 18, 2017

Regulation: 2600.132(*l*)
Alternative exit routes shall be used during fire drills.

Violation: The fire drills conducted from 5/17/16-10/21/16 and from 2/28/17-6/1/17 note "all exits" used. The home is not alternating exits used.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure the home is able to safely evacuate residents in a timely manner in the event of a fire regardless of the location of the fire.

How was the regulation violated? The regulation is violated because the home did not require the residents to identify an alternative exit route by blocking random exits during each drill.

What caused the violation? The violation occurred when the home's Administrator failed to block an exit route during routine fire drills, causing resident's to identify alternative exit route.

What can be done right away to fix the violation? The Administrator conducted a fire drill on 07/26/17 at 4:55am and blocked the front door exit.

On 07/30/17, the policy "Fire Drills" was created.

What can be done to prevent future violations? During each fire drill, the Administrator, or designee, will block a minimum of one exit per drill to encourage residents to identify an alternative exit route.

During the routine quality assurance meetings, the home's Administrator will review all fire drills that have occurred since the prior quality assurance meeting. The review will include exit routes utilized. If at any time it is identified that the actual drill does not meet the requirement, a follow up drill will be completed and documented within seven (7) calendar days. Documentation will include an assessment of why the actual drill failed to meet the requirements and the corrective action needed.

On or before 08/04/17, staff will be educated on the policy "Fire Drills".

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and

8-8-17

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any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Services and Community Relations

8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

1. REGULATION 55 Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

(1) Resident's name.
(2) Drug allergies.
(3) Name of medication.
(4) Strength.
(5) Dosage form.
(6) Dose.
(7) Route of administration.
(8) Frequency of administration.
(9) Administration times.
(10) Duration of therapy, if applicable.
(11) Special precautions, if applicable.
(12) Diagnosis or purpose for the medication, including pro re nata (PRN).
(13) Date and time of medication administration.
(14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION within this part of visit. VG 8-25-17

[redacted]

Resident #3's Januvia does not include a diagnosis or purpose on the MAR.

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
Phone Conf - 8-10-17
In addition to all other steps attached the Adm will continue to have med techs check their own work every shift.
Even after all weekly audits are done - Adm/ designee will continue to do random audits of the hsno's MARs. 8-10-17

Repeat Violation: Yes	Date(s) of Previous Violation(s): 06/09/2016		

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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

The above plan of correction is approved as of 8-10-17 (Date)

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

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

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

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Hendorn, Inc., Cole Manor Plan of Correction

Survey: July 18, 2017

Regulation: 2600.187(a)
A medication record shall be kept to include the following for each resident for who medications are administered:

1. Resident's name
2. Drug allergies
3. Name of medication
4. Strength
5. Dosage from
6. Dose
7. Route of administration
8. Frequency of administration
9. Administration times
10. Duration of therapy, if applicable
11. Special precautions, if applicable
12. Diagnosis or purpose for the medication, including pro re nata (PRN)
13. Name and initials of the staff person administering the medication

Violation: The regulation was violated [redacted] Additionally, one medication on a resident's MAR did not include the diagnosis / purpose.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure that medication is safely administered to the residents.

How was the regulation violated? The regulation was violated when staff did not accurately record the required information on the MAR.

[redacted]

On a MAR the medication Januvia, does not have a diagnosis or purpose. The dosage was changed. When the old entry on the MAR was crossed out, and it was re-documented below to reflect the new order, the home's Administrator failed to include the diagnosis, which had been documented initially.

8-10-17

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What caused the violation? [redacted] The violation was caused by failure to include a diagnosis for a medication on the MAR.

What can be done right away to fix the violation? On July 18, 2017, the MAR was amended to include the diagnosis for the Januvia.

[redacted]

What can we do to prevent future violations? On or before August 4, 2017, the home's Administrator and staff which are trained to administer medications, will read the article "Legal Issues....Never Events: Medication Errors" by Levy N; Pravikoff D: CINAHL Nursing Guide, 2016 Aug 12. Reading the article will review the rights of safe medication administration, including documentation.

In addition, the home's Administration will complete random review of a minimum of 5 MAR, approximately 25% of the home's residents, on a weekly basis for a minimum of 4 weeks. [redacted] The results will be reported to the Executive Director of Post-Acute Services and Community Relations. If the MAR are found to be 100% accurate, the audits may decrease to monthly. Findings will be reported during quality assurance meetings. Adm will still perform random audits to ensure ongoing compliance. CP 8-10-17

Via phone 8-1-17

In addition, the Director of Staff Development, or designee, will complete a minimum of 4 medication administration observations / audits by December 31, 2017. The Director of Staff Development will notify the home's Administrator and the Executive Director of Post-Acute Services and Community Relations of all findings and recommend staff education strategies, if applicable based upon findings.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Services and Community Relations

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE MANOR

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 #4's RASP dated 1/19/17 was incompleted as there was nothing noted for social and recreational needs.

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

See attached

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

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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

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

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

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

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

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Hendorn, Inc., Cole Manor Plan of Correction

Survey: July 18, 2017

Regulation: 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 human service agency may complete the initial assessment.

Violation: Resident #4's RASP dated 01/19/17 was incomplete as there was nothing noted for social and recreational needs.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure that we accurately document the resident's needs.

How was the regulation violated? The regulation was violated when the home's Administrator failed to document on the RASP completely, as it did not include information for each area under the social and recreational sections. We did meet the resident's social and recreational needs during this time.

What caused the violation? The violation occurred when the home's Administrator failed to adequately document on the initial RASP under the heading of social and recreational needs.

What can be done right away to fix the violation? Resident #4's RASP was reviewed by the home's Administrator on 07/28/17, and amended to include adequate information regarding the resident's social and recreational needs.

What can be done to prevent future violations? On July 30, 2017, the "Development of Support Plan" policy was revised to include language requiring that each section of the RASP must be addressed, and sections are not to be left blank.

On or before August 4, 2017, the home's Administrator and all staff will review the revised policy, "Development of Support Plan".

On or before, August 10th, the home's Administrator will review each resident's current RASP to ensure that it includes adequate information under each section.

To ensure that a resident's RASP accurately reflects current information, the Executive Director of Post-Acute Services and Community Relations, or designee, will review each RASP monthly, for a minimum of four months. If after four consecutive months, compliance is at 100%, RASP audits can be reduced to random audits on a quarterly basis. Audit findings will be reported during the quality assurance meetings.

8-8-17

P12B813

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Services and Community Relations

8-8-17

Violation Report: 24263 - 07/18/2017 - Novak, Ryan
PCH Name: COLE 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
Resident #5 starting receiving hospice services on [redacted]17, the residents RASP dated 9/23/16 has not been updated to include the residents current care needs.

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

See attached

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

Signature of Legal Entity Representative (Required on EVERY Page) Vida Glover

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

Date 8-2-17

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

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

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

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

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

8/3/17

Hendorn, Inc., Cole Manor Plan of Correction

Survey: July 18, 2017

Regulation: 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 serves.

Violation: Resident #5 started receiving hospice service on [redacted]17, the resident's RASP dated 09/23/16 has not been updated to include the resident's current care needs.

Plan of Correction:
Why is the regulation important? The regulation is important to ensure the RASP accurately reflects the current needs of the resident. It is important to have an accurate RASP, so all direct care workers are informed the of the resident's needs.

How was the regulation violated? The regulation was violated when the home's Administrator failed to document the change in the resident's services when he started to receive hospice care. The home did meet the resident's needs during this time.

What caused the violation? The violation was caused by the home's Administrator's failure to document on the RASP the change in the resident's needs when he started to receive hospice care. It was documented within the resident's medical record, just not on the RASP, as his needs regarding Activities of Daily Living had not changed.

What can be done right away to fix the violation? On July 28, 2017, the home's Administrator reviewed and revised Resident #5's RASP.

On July 30, 2017, the policy "Development of Support Plan" was reviewed and revised to include language pertaining to documenting any change is the resident's current care needs, at the time the change is identified.

On or before August 4, 2017, home's Administrator and staff will review the revised policy "Development of Support Plan".

What can be done to prevent future violations? To ensure that a resident's RASP accurately reflects current information, the home's Administrator, or designee, will review each RASP monthly, for a minimum of four months. If after four consecutive months, compliance is at 100%, RASP audits can be reduced to random audits on a quarterly basis. Audit findings will be reported during the quality assurance meetings.

Who will be responsible for preventing future violations? The day to day responsibility for adherence to this Plan of Correction is the responsibility of the facility's Administrator who will

8-8-17

F138 & 13

monitor adherence to the Plan of Correction and take any corrective action that may be needed. The overall responsibility for compliance with this plan of correction rests with the facility's Administrator and the Executive Director, Post-Acute Services and Community Relations. The Executive Director will ensure a status report of compliance with this Plan of Correction, and any corrective action taken, is submitted to the Board of Directors on a monthly basis, or as otherwise directed.

Dated: 08-01-2017

Vida Glover, Administrator

Dated: 08/01/2017

Amy M. Hunt, Senior Director
Post-Acute Services and Community Relations