



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

DEC 28 2017

Mr. Brian Armitage  
Administrator  
Rivercliff Terrace, Inc.  
120 Allegheny Avenue  
Kittanning, Pennsylvania 16201

RE: Rivercliff Terrace  
Certificate #: 426610

Dear Mr. Armitage:

As a result of the Department of Human Services' annual licensing inspection on September 21, 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](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,

A handwritten signature in black ink, appearing to read "J. Rowe".

Jacqueline L. Rowe  
Director

Enclosure  
License Inspection Summary

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

PCH Name: RIVERCLIFF TERRACE		License Number: 42661
Address: 120 ALLEGHENY AVENUE, KITTANNING, PA 16201		County: Armstrong
Administrator: Brian Armitage		Region: WEST
Legal Entity Name: RIVERCLIFF TERRACE INC		
Legal Entity Address: 120 ALLEGHENY AVENUE, KITTANNING, PA 16201		RECEIVED
Certificate(s) of Occupancy LP 03/05/1985 L & I		NOV 27 2017 APPLICABLE FIELD OFFICE HUMAN SERVICES DIVISION
<b>Staffing Hours</b>		
Resident Support: 0	Total Daily Staff: 29	Waking Staff: 22
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Renewal		
On-Site Inspections Dates and Department Representatives On-Site 09/21/2017: Summers, Vicky; Kimberland, Jon		
Off-Site Inspection Dates and Inspectors, If Applicable		
<b>Other Details</b>		
Partial or Full Triggers:		Random Indicators:
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 34 Number of Residents Served: 29 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: 1 Number of Hospice Residents in past year: 1		Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 28 Have Mental Illness: 3 Have an Intellectual Disability: 0 Have a Mobility Need: 0 Have a Physical Disability: 0

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

RESIDENTS' PRIVACY - BATHROOM  
Privacy - Locking

1. REGULATION 55 Pa.Code §2600

2600.42(s) - A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

2a. DESCRIPTION OF VIOLATION

At approximately 12:20 p.m., agents of the Department observed direct care person A measure resident #1's blood sugar level while seated at the dining room table with other residents present.

The door to the 2nd floor common bathroom, on the old side of the home, does not have a means of locking to provide for resident privacy.

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 OF SEPT 22ND, 2017 AND FORWARD, ALL RESIDENTS WHO HAVE GLUCOMETER READINGS WILL HAVE THEM DONE IN A PRIVATE AREA WHERE NO OTHER RESIDENTS ARE PRESENT. AS OF SEPT 22ND THE ADMINISTRATORS EDUCATED ALL STAFF ON THE PROCESS OF INSURING PRIVACY OF THE RESIDENCE.

ON THE DATE OF THE INSPECTION SEPTEMBER THE 21, AROUND 12:30 PM THE ADMINISTRATOR HAD A CONTRACTOR INSTALL A HOOK LATCH WITH THE EXISTING MAGNETIC LOCK TO INSURE THE RESIDENCE PRIVACY.

Immediately and weekly thereafter: A designated staff person will check the home to ensure all common restroom doors have a functional locking mechanism to provide for resident privacy. *g.v. 12/6/17*

On 11/22/17, staff persons were educated on the resident's right to privacy during bathing, dressing, changing and medical procedures. Documentation of the education shall be kept. *12/6/17*

Repeat Violation: Yes	Date(s) of Previous Violation(s):	07/22/2016		
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Signature of Legal Entity Representative  
(Required on EVERY Page) *Leighann Amittage*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Leighann Amittage Administrator* Date **NOVEMBER 19 2017**

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

The above plan of correction is approved as of 12/6/17  
(Date)

Plan of correction implementation status as of 12/6/17  
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *g.v.*
- Partially Implemented - Inadequate Progress
- Not Implemented

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

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NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

DEPARTMENT OF COMMUNITY DEVELOPMENT  
PHILADELPHIA

1. REGULATION 55 Pa.Code §2600

2600.105(g)(1) - To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

2a. DESCRIPTION OF VIOLATION

There was an accumulation of approximately 1/4 inch lint in the lint trap of the dryer located in the first floor laundry room.

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

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

THE ADMINISTRATORS ON SEPTEMBER 21, 2017 EDUCATED STAFF ON CLEARING THE LINT TRAP AFTER EACH USE. ADMINISTRATOR ALSO POSTED ABOVE EACH DRYER "CLEAN OUT AFTER EACH AND EVERY USE" ADMINSTRATORS CHECK DAILY

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Leighann Armitage*

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

Leighann Armitage Administrator

Date NOVEMBER 19TH  
2017

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

The above plan of correction is approved as of 12/6/17  
(Date)

Plan of correction implementation status as of 12/1/17  
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress *pd.*
- Partially Implemented - Inadequate Progress
- Not Implemented

RECEIVED

NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

WILMINGTON POLICE DEPT  
PROPERTY SECTION

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

The first floor emergency exit door, on the old side of the building, rubs against the lower frame preventing it from opening freely.

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 September the 21st 2017, Administrator called contractor who came on September 21st 2017, who corrected the door to open freely. Administrator educated staff on the importance of informing administrators of any doors in future that which are not functioning properly so that proper maintenance can be performed.

Immediately: A designated staff person will check the home weekly to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed.

pu  
12/6/17

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

Signature of Legal Entity Representative (Required on EVERY Page) *Leighann Armitage*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Leighann Armitage Administrator* Date November 19th 2017

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

The above plan of correction is approved as of 12/6/17 (Date)

Plan of correction implementation status as of 12/6/17 (Date)

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

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

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NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

INDUSTRIAL OFFICE  
1000 ...

1. REGULATION 55 Pa.Code §2600  
2600.125(a) - Combustible and flammable materials may not be located near heat sources or hot water heaters.

2a. DESCRIPTION OF VIOLATION  
A 6 foot bamboo shelving unit was within 6 inches of the furnace on the second floor on the new side of the building.

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

Administrators on September 21, 2017 removed questionable object. Administrator also educated staff about the importance of insuring no other objects which are flammable, or combustible are close to furnaces or hot water tanks in facility.

Immediately: A designated staff person will check the home weekly to ensure combustible and flammable materials are not located near heat sources, including furnaces, or hot water heaters.

*g.u.* 12/6/17

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

Signature of Legal Entity Representative  
(Required on EVERY Page) *Leighann Amstutz*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Leighann Amstutz Administrator*

Date November 19 2017

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

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(Date)

Plan of correction implementation status as of 12/6/17  
(Date)

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- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by *g.u.*  
(Initials)

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NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

PHOTOGRAPHIC EVIDENCE  
PROPERTY OF PHOTOGRAFER

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 home had a fire inspection and fire drill conducted by a fire safety expert on 4/19/16. However, the next fire inspection and fire drill conducted by a fire safety expert was not completed until 5/7/17.

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.

ADMINISTRATOR WILL HAVE A FIRE SAFETY INSPECTION 1 MONTH IN ADVACNE OF THE EXPIRATORY DATE. THE FIRE SAFETY INSPECITON IS SCHEDULED FOR THE FIRST WEEK IN APRIL TO ENSURE COMPLIANCE.

Within 15 days of receipt of the plan of correction: The administrator or designee will develop and implement a tracking system to ensure a fire safety inspection and fire drill conducted by a fire safety expert are completed annually.

g.u. 12/6/17

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Leighann Armitage*

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

Leighann Armitage Administrator

Date NOV 19 2017

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(Date)

Plan of correction implementation status as of 12/6/17  
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *g.u.*
- Partially Implemented - Inadequate Progress
- Not Implemented

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

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

PHOTOGRAPHIC EVIDENCE  
Photographing

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

The home conducted a fire drill on 12/13/16. However, the fire drill record indicates the time of that fire drill was 11:48 and does not indicate if this was in the a.m. or p.m.

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

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

ADMINISTRATOR'S WILL CHECK AND RECHECK EACH OTHER DOCUMENTATION TO INSURE AM AND PM TIMES ARE IDENTIFIED PROPERLY FOR FIRE DRILL RECORDS.

The fire drill records for the drills conducted on 9/28/17, 10/27/17 and 11/19/17 include the AM/PM designation by the time of the drill. *9/28/17*

Immediately and monthly thereafter: The administrator or designee will review the fire drill record monthly to ensure it contains all required information, including the time of the drill with an AM or PM designation, in accordance with 2600.132c. *9/28/17*

Repeat Violation: Yes      Date(s) of Previous Violation(s): 07/22/2016

Signature of Legal Entity Representative  
(Required on EVERY Page) *Leigh Ann Armstrong*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Leigh Ann Armstrong Administrator*      Date: NOV 19TH 2017

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The above plan of correction is approved as of 12/1/17  
(Date)

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

Plan of correction implementation status as of 12/6/17  
(Date)

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

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NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

WESTPHALIA FIRE OFFICE  
1000 W. 10th Street  
Pottsville, PA 17870

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

Staff interviews indicate residents did not evacuate the home during the fire drill conducted on 1/22/17 at 3:16 PM. Staff person B indicated that residents only touched the exit door but did not exit the home. The home does not have any internal fire safe areas designated by a fire safety expert.

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 EDUCATED STAFF & RESIDENCE "IMMEDIATELY ON NOV 17TH ON THE IMPORTANCE OF ALL PEOPLE TO DEMONSTRATE THE ABILITY TO EGRESS THIS BUILDING DURING A FIRE DRILL. ALL STAFF AND RESIDENCE PERFORMED THIS ON NOV THE 19TH 2017 AT 3:01 PM AND WILL CONTINUE TO DO SO MONTHLY DURING EVERY FIRE DRILL DEPSITE INCLIMATE WHEATHER TO A DESIGNATED FIRE SAFE AREA.

All residents were evacuated to the outside designated meeting area for the fire drills conducted on 9/28/17, 10/27/17 and 11/19/17.

ps. 12/6/17

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

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Leighann Armitage Administrator* Date **NOV 19 2017**

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

The above plan of correction is approved as of <u>12/6/17</u> (Date)	Plan of correction implementation status as of <u>12/6/17</u> (Date)
The above plan of correction was approved by <u>ps</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>ps</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

RECEIVED

NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

1. REGULATION 55 Pa.Code §2600

2600.133(a)(1) - If the home serves nine or more residents, signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

2a. DESCRIPTION OF VIOLATION

There was no exit sign above the main exit door on the old side of the building. The home currently serves 29 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.

ADMINISTRATORS ON SEPTEMBER 21 2017 ATTAINED AND EXIT SIGN WHICH WAS HUNG IMMEDIATELY BEFORE INSPECTORS LEFT. ADMINISTRATORS ALSO CHECKED ALL OTHER EXITS FOR PROPER SIGNS. ALL 9 EXITS IN RIVERCLIFF TERRACE HAVE EXIT SIGNS.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Leighann Armitage*

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

*Leighann Armitage* Administrator

Date NOV 19TH 2017

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The above plan of correction is approved as of 12/6/17  
(Date)

Plan of correction implementation status as of 12/6/17  
(Date)

The above plan of correction was approved by J.M.  
(initials)

- Fully Implemented *J.M.*
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

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  
Resident #3's current container of Genteal ophthalmic solution is not marked with the date it was opened. The manufacturer's instructions indicate to discard the unused portion after 28 days. The eye drops were originally filled on 3/6/17.

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.

AS OF SEPTEMBER 21ST 2017 AT 4:30 PM ADMINISTRATOR ORDERED NEW EYE DROPS FOR RESIDENT #3 WHICH CAME AT 5:30 PM. THE EYE DROPS WERE DATED AND WILL BE CONTINUED TO BE DATED UPON OPENING AND WILL HAVE NEW DROPS ORDERED FROM PHARMACY EVERY 28 DAYS. ADMINISTRATOR SPOKE WITH PHARMASIST FOR REORDERING EVERY 28 DAYS TO INSURE INSTRUCTIONS OF EYEDROPS. RIVERCLIFF TERRACE WILL DISCARD RESIDENT 3 EYEDROPS EVERY 28 DAYS.

Immediately and monthly thereafter: A designated staff person who is qualified to administer medications will check medication storage areas to ensure all medication is stored in accordance with manufacturer's instructions, including dating eye drops once opened.

*g.w. 12/6/17*

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

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Leighann Armitage, Administrator* Date *11-21-17*

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The above plan of correction is approved as of 12/6/17  
(Date)

Plan of correction implementation status as of 12/6/17  
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *g.w.*
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by *g.w.*  
(Initials)

NOV 29 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
 PCH Name: RIVERCLIFF TERRACE

WEST VIRGINIA UNIVERSITY  
 Human Services Licensing

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

Resident #1 and #3's glucometers and glucometer cases are not marked with the residents' names.

Resident #1's blood sugar readings on his/her glucometer did not match the readings documented on the resident's September 2017 blood sugar log for the following dates and times:

Date and Time	Glucometer reading	Blood sugar log
9/20/17 at 8:00 AM	208	201
9/20/17 at 8:00 AM	242	252
9/17/17 at 8:00 AM	193	191

Resident #3's blood sugar readings on his/her glucometer did not match the readings documented on the resident's September 2017 blood sugar log for the following dates and times:

Date and Time	Glucometer reading	Blood sugar log
9/20/17 at 8:00 AM	98	92
9/4/17 at 8:00 AM	130	132

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

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

RESIDENT 1# AND RESIDENT 3# WERE ORDERED NEW GLUCOMETERS AND CASES ON SEPTEMBER 21ST, 2017. GLUCOMETERS AND GLUCOMETER CASES WERE BOTH MARKED AND TAG WITH RESIDENTS NAMES. ADMINISTRATOR WILL CONTINUE TO CHECK CASES AND METERS TO ENSURE RESIDENTS NAMES ARE MARKED AND TAGGED.

RESIDENT #1 AND RESIDENT #3 GLUCOMETER READINGS WILL BE MATCHED WITH THEIR BLOOD SUGAR LOGS DAILY. ADMINISTRATOR MET WITH STAFF ON SEPTEMBER 22ND 2017, AND EDUCATED ALL STAFF ON THE IMPORTANCE OF ACURATLEY LOGGING READINGS PROPERLY. ALSO, ALL STAFF WAS EDUCATED ON CHECKING AND RECORDING GLUCMETER MACHINES, IF RESIDNETS LEFT THE BUILDING WITH GLUCOMETER MACHINES.

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

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Leighann Armstrong Administrator Date 11-21-2017

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

The above plan of correction is approved as of <u>12/1/17</u> (Date)	Plan of correction implementation status as of <u>12/6/17</u> (Date)
The above plan of correction was approved by <u>JW.</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress JW. <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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NOV 27 2017

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

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 #1's initial assessment, dated [redacted] 17, does not include the diagnoses of hypertension, chronic kidney disease or impairment in cognitive function and alteration in self-care ability that are indicated on the medical evaluation, dated 4/28/17.

Resident #5's initial assessment, dated [redacted] 16, was not updated to include the diagnoses of Parkinson's Disease and Hypercholesterolemia as indicated on the medical evaluation, dated 5/22/17.

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

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

RESIDENT 1# AND RESIDENT 5# BOTH ADMINISTRATORS WILL CHECK AND RECHECK ALL DME DIAGNOSIS WITH THE RASP TO ENSURE PROPER DUPLICATION OF ALL DIAGNOSIS BE TRAFERED FROM DME TO RASP. THIS WAS CORRECTED ON NOVEMBER 21ST 2017. ADMINISTRATORS [redacted] AND [redacted] WILL CONTINUE TO CHECK ALL RESIDENT'S DME MATERIAL IS TRANSFERED TO RESIDENTS RASPS.

Resident #1 no longer lives in the home. *gm 12/6/17*

Resident #5's assessment was updated with current diagnoses. *gm 12/6/17*

Within 15 days of receipt of the plan of correction: A designated staff person will review all current resident assessments for accuracy and completion, including all current diagnoses. Any assessments with inaccurate or incomplete information will be immediately corrected. *gm 12/6/17*

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

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Leighann Prouty Administrator* Date **NOV 21ST 2017**

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

The above plan of correction is approved as of 12/6/17  
(Date)

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

Plan of correction implementation status as of 12/6/17  
(Date)

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

Violation Report: 42661 - 09/21/2017 - Summers, Vicky  
PCH Name: RIVERCLIFF TERRACE

WEST VIRGINIA STATE OFFICE  
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:

- (1) Annually.
- (2) If the condition of the resident significantly changes prior to the annual assessment.
- (3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

Resident #2's annual assessment, dated 7/31/17, does not include the diagnosis of hypothyroidism that is indicated on the medical evaluation, dated 6/29/17.

Resident #4's annual assessment, dated 7/31/17, does not include the diagnoses of anxiety, Insomnia and frequent urinary tract infections that are indicated on the medical evaluation, dated 5/16/17.

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

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

RESIDENT 1# AND RESIDENT 5# BOTH ADMINISTRATORS WILL CHECK AND RECHECK ALL DME DIAGONIS WITH THE RASP TO ENSURE PROPER DUPLICATION OF ALL DIGANGONOS BE TRAFERED FROM DME TO RASP. THIS WAS CORRECTED ON NOVEMBER 21ST 2017. ADMINISTRATORS [REDACTED] AND [REDACTED] WILL CONTINUE TO CHECK ALL RESIDENTS DME MATERIAL IS TRANSFERED TO RESIDENTS RASPS

BOTH ADMINISTRATORS AS OF November 21, 2017, CORRECTED RESIDENTS 2# AND RESIDENT 4# ANNUAL ASSESSMENT TO CORRASPOND WITH RESIDENTS MEDICAL EVALUATION. BOTH ADMINISTRATORS WILL CHECK ALL FUTURE RESIDENTS DME'S DIAGNOISIS BE TRANSFERRED TO RESIDENCE RASPS AND CHECKING ALL CURRENT RESIDENCE IN FUTURE.

Within 15 days of receipt of the plan of correction: A designated staff person will review all current resident assessments for accuracy and completion, including all current diagnoses. Any assessments with inaccurate or incomplete information will be immediately corrected. *JM. 12/6/17*

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Leighann Amadio*

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

*Leighann Amadio Administrator*

Date 11-21-2017

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

The above plan of correction is approved as of 12/6/17  
(Date)

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

Plan of correction implementation status as of 12/6/17  
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *JM.*
- Partially Implemented - Inadequate Progress
- Not Implemented