



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 30 2018

Mr. Ben Willner
Owner
Melody Manor PCH, LLC
413 North McKean Street
Kittanning, Pennsylvania 16201

RE: Melody Manor
Certificate #: 446760

Dear Mr. Willner:

As a result of the Department of Human Services' Licensing annual licensing inspection November 16, 2017 and December 1, 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,

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

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
 PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
 Human Services Licensing

1. REGULATION 55 Pa.Code §2600
 2600.3(c) - The personal care home shall post the current license, a copy of the current licensing inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

2a. DESCRIPTION OF VIOLATION
 The home's most recent Licensing Inspection Summary, dated 12/7/16, was located behind the home's Certificate of Compliance in a frame hanging on the dining room wall. Cardboard backing had to be removed to access the License Inspection Summary.

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 on the day of inspection the current license and copy of the current license inspection summary was removed from the frame and put in a plastic sleeve for easy access. It was then hung back up in a conspicuous location. Inspectors were present and witnessed. In the future all license and inspection reports will be posted the same way to be in compliance.

Immediately: The administrator or a designated staff person shall check the home weekly to ensure a copy of the current license inspection summary issued by the Department and is posted in a public and conspicuous place in the home. *446764*

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Caroline Dunn - Executive Director</i>	Date <i>4-12-18</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u><i>4-16-18</i></u> (Date)	Plan of correction implementation status as of <u><i>4-17-18</i></u> (Date)
The above plan of correction was approved by <u><i>y</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress ✓ <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

APR 17 2018

Violation Report: 44878 - 11/18/2017 - Pfaff, Vicki
PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.15(b) - If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

2a. DESCRIPTION OF VIOLATION

On 11/9/17, staff person E, the home's administrator, was made aware of an allegation by the Armstrong County Area Agency that staff person A kicked resident #1 in the head. The home did not suspend staff person A or submit a plan of supervision to the Department.

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 11-9-2017 the Home received a visit from a Representative from the local Protective Abuse Agency, [REDACTED] He was at the Home to investigate an alleged allegation that Staff Person E had kicked Resident #1 in the head. After much investigation and questioning many people in and out of the Facility, he informed the Administrator that there was no merit to the allegation and it was unfounded. At that time, he did not request an abuse report be filed. The Resident was not residing in the Home at the time of the investigation.

Even though the local Agency did not require a report, according to regulation 2600.15 (b) it is required to report the allegation to DHS and develop a plan of supervision or suspension for the Staff person involved. On the day of inspection, the proper report was filed and DHS Representatives investigated the allegations at length. They determined no action was needed and the report was unsubstantiated. The policies and procedures for regulation 2600.15 (b) and 2600.16 (c) were updated and posted for all Staff to review. A Representative from Protection from Abuse will be doing an upcoming training on April 26, 2018 at 1:30pm. This violation was also discussed at the Quality management meeting on Feb 1, 2018. In the future any allegations will be monitored until the allegation has been settled to the satisfaction of all parties to ensure all of the correct steps are taken.

Immediately: If any suspected abuse or allegations of abuse occur, the home will immediately place the accused staff person on a plan of supervision pre-approval of the Department, or suspend the staff person or persons involved.

H-17452

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *4-12-18*

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The above plan of correction was approved by [Signature] (Initials)
Plan of correction implementation status as of 4-17-18 (Date)
 Fully Implemented
 Partially Implemented - Adequate Progress
 Partially Implemented - Inadequate Progress
 Not Implemented

APR 17 2018

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 65 Pa.Code §2600

2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 11/9/17, staff person E, the home's administrator, was made aware of an allegation by the Armstrong County Area Agency that staff person A kicked resident #1 in the head. The home did not report the allegation to the Department until 12/1/17 at the direction of Department representatives.

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 11-9-2017 the Home received a visit from a Representative from the local Protective Abuse Agency, [redacted]. He was at the Home to investigate an alleged allegation that Staff Person E had kicked Resident #1 in the head. The Resident did not reside in the Home at that time. After much investigation and questioning many people in and out of the Facility, he informed the Administrator that there was no merit to the allegation and it was unfounded. At that time a report should have been filed with DHS as per 2600.16 (12), even if the report is determined unfounded by the local Agencies. A report was filed on the day of inspection and the inspectors did their own investigation and also determined the allegation to be unsubstantiated.

To avoid a reporting issue in the future, the topic of reporting any incidents indicated in 2600.16 was discussed after the inspection and then discussed and reviewed at the Quality Management meeting on Feb. 1, 2018. Documentation attached. The current policies & procedures for incident reporting and abuse reporting were updated and a copy posted for all staff to review. (copies attached). The Executive Director spoke with a Protection from Abuse representative (Carrie), on 4-16, 2018 to set up a training for all staff on the importance of always reporting all incidents to the proper required agencies. The training is scheduled for April 26, 2018 at 1:30pm. Any future allegations will be monitored until the allegation has been settled to the satisfaction of all parties to ensure all of the correct steps are taken

Immediately: The administrator or designee shall review all reportable incidents and conditions at least weekly to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16c

Repeat Violation: No Date(s) of Previous Violation(s): 4-11-18

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *4-12-18*

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Plan of correction implementation status as of 4-17-18 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress ✓
- Partially Implemented - Inadequate Progress
- Not Implemented

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

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
 PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
 Adult Services Licensing

1. REGULATION 66 Pa.Code §2600

2600.51 - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (relating to protective services for older adults).

2a. DESCRIPTION OF VIOLATION

Staff person B started working for the home on 4/7/17. A Pennsylvania State Police criminal history check was not requested until 5/15/17.

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 all the files were checked by Administration to be sure they had a criminal record check done and that it was done in the time required. Moving forward it will be required that all background checks be done before the first day of work. Each file has a file checklist that will be followed for all future Staff.

Attachment 5A

Immediately: The administrator ro designated staff person shall review the records for all newly hired staff persons to ensure the home has requested a Pennsylvania State Police Patch Background Check within 30 days of being hired.

4-16-18

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Quinn - Executive Director* Date *4-12-18*

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The above plan of correction was approved by <u>[Signature]</u> (Initials)	

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
PCH Name: MELODY 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 person C, who started working for the home on 9/9/14, did not receive training in safe management techniques during the staff training year 1/1/16 through 12/31/16.

Direct care staff person D, who started working for the home on 9/3/14, did not receive training in safe management techniques during the 1/1/16 through 12/31/16 staff training year.

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 beginning the day after inspection, all Staff files were reviewed to be sure everything required was present in the file. Staff Persons C & D trainings were accounted for. All other files have the Annual Training plans with certificates and each was checked to be sure all trainings were accounted for.

This violation is being disputed due to the required trainings for Staff Persons C & D being done and accounted for. (copies attached)

Immediately: The administrator or designated staff person shall develop and implement a system to ensure all required staff training is documented in accordance with regulation 2600.65(j), the record of training is kept in the staff records, and available to the Department upon request. 4-16-18.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *4-12-18*

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The above plan of correction is approved as of 4-16-18
(Date)

The above plan of correction was approved by [Signature]
(Initials)

Plan of correction implementation status as of 4-17-18
(Date)

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

APR 13 2018

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
 PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

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 person D, who started working for the home on 9/3/14, did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 1/1/16 through 12/31/16 staff training year.

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 beginning the day after inspection, all Staff files were reviewed to be sure everything required was present in the file. The fire safety training for 2016 for Staff Person D was present and is attached. All files have the required annual fire safety training.

This violation is being disputed due to the required training for Staff Person D being in her file and keeping her within regulation.

Immediately: The administrator or designated staff person shall develop and implement a system to ensure all required staff training is documented in accordance with regulation 2600.65(i), the record of training is kept in the staff records, and available to the Department upon request. 4-16-18

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

Caroline Dunn

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Caroline Dunn - Executive Director</i>	<i>4-12-18</i>

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The above plan of correction was approved by <u>[Signature]</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress Y <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 44678 - 11/16/2017 - Pfaff, Vicki
PCH Name: MELODY MANOR

APR 13 2018

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.86(b) - A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

2a. DESCRIPTION OF VIOLATION
On 11/16/17 at 11:22 a.m., the exhaust fan in the common bathroom of the Melody side basement level was inoperable. This bathroom does not have a window.

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 after inspection on 11-17-2017 an Electrician was contacted and came to assess the inoperable exhaust fan. He returned on 11-19-2017 and replaced the fixture. Pictures and invoice attached.

Moving forward, between Administration and the Head Housekeeper, weekly checks with documentation will be done for a 6 month period and then periodically to check for any non-working exhaust fan in bathrooms required by regulation. Documentation attached

Attachments

8A, 8B, 8C, 8E, 8F

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *4-12-18*

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The above plan of correction is approved as of <u>7-16-18</u> (Date)	Plan of correction implementation status as of <u>4-17-18</u> (Date)
The above plan of correction was approved by <u>[Signature]</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress ✓ <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

APR 13 2018

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.123(b) - Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

2a. DESCRIPTION OF VIOLATION

On 11/16/17 at 12:08 p.m., the emergency preparedness plans for the home and for the municipality in which the home is located were not posted in a conspicuous and public place in the home.

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

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

Immediately on the day of inspection with the Inspectors witnessing, the Emergency Preparedness Plans were moved from the bulletin board in the med room to the front bulletin board which is in a conspicuous public place.

Moving forward any renewals or changes to the plan will be posted in the same place.

Immediately: The administrator or designated staff person shall check the home monthly to ensure that both the personal care home's emergency procedures and the local municipal emergency plans are posted in a conspicuous and public place. *4-16-18*

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *4-12-18*

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The above plan of correction was approved by [Signature] (Initials)

Plan of correction implementation status as of 4-12-18 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress ✓
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

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

2a. DESCRIPTION OF VIOLATION

On 11/16/17 at 2:20 p.m., there was a bottle of Azopt 1% eye drops in the medication cart belonging to resident #2. The bottle label indicated an opened date of 7/21/17. The manufacturer's medicine information indicates that the bottle should be discarded 28 days after opening.

On 11/16/17 at 2:25 p.m., there was a package of Naproxen 375mg tablets in the medication cart, with a prescription label for resident #1, indicating take 1 tablet by mouth twice a day as needed for pain relief. However, the medication was discontinued on 11/14/17.

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 on the day of inspection the eye drops for Resident #2 and the Naproxen for Resident #1 (which was just discontinued 2 days prior) were removed from the medication cart and discarded. New eye drops were ordered for Resident # 2 and delivered immediately.

Immediately Administration implemented a process to review changes in Resident medication orders. To ensure the changes are accounted for, a daily redline report is available through the medication program. This report lists all changes and is printed, reviewed and signed everyday by the Administration or designated Med Tech. Weekly med cart audits with documentation is being done and kept to account for any non-current medications

*Attachments 10A, 10B,
10C, 10D, 10E*

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

Signature of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Caroline Dunn - Executive Director* Date *4-12-18*

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The above plan of correction is approved as of 4-16-18 (Date)

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

Plan of correction implementation status as of 4-17-18 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress ✓
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
 PCH Name: MELODY MANOR

1. REGULATION 55 Pa.Code §2600

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

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

2a. DESCRIPTION OF VIOLATION

Resident #4 is prescribed Albuterol 0.083% nebulizer solution - Administer 1 unit dose via nebulizer every 4-6 hours as needed. On 11/16/17 at 2:30 p.m., the medication pharmacy label indicated: administer 1 unit dose via nebulizer every 6 hours while awake. A second pharmacy label on the medication indicated: administer 1 unit dose via nebulizer daily as needed for SOB.

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 on the day of inspection, Resident #4's order was checked for the correct dosage. Resident #4 was getting the correct dosage as prescribed by her Physician and ordered on her MAR. A direction change sticker was added to the prescription label to account for the change.

Immediately Administration implemented a process to review changes in Resident medication orders. To ensure the changes are accounted for, a daily redline report is available through the medication program. This report lists all changes and is printed, reviewed, and signed everyday by the Administration or Designated Med Tech. Weekly med cart audits with documentation is being done and kept to account for any direction changes. Documentation attached

Attachments 11A, 11B

Also previous violation shows red line report

Repeat Violation: No	Date(s) of Previous Violation(s):	<i>as 10 A-10E</i>
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Caroline Dunn - Executive Director*

Date *4-12-18*

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The above plan of correction is approved as of *4-16-18*
 (Date)

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

Plan of correction implementation status as of *4-17-18*
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress ✓
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
 PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
 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 #4's November 2017 MAR indicated blood glucose readings. However, the resident's glucometer did not indicate the resident's blood glucose was measured as follows:
 * On 11/13/17 at 5:50 a.m., the MAR indicated 91
 * On 11/11/17 at 4:24 a.m., the MAR indicated 87
 * On 11/10/17 at 4:57 a.m., the MAR indicated 89
 * On 11/9/17 at 4:51 a.m., the MAR indicated 87

The blood glucose readings on resident #4's MAR did not coincide with the blood glucose readings indicated on the resident's glucometer as follows:
 * On 11/16/17 at 4:55 a.m., the MAR indicated 98 - Glucometer indicated 93
 * On 11/07/17 at 5:18 a.m., the MAR indicated 77 - Glucometer indicated 77
 * On 10/27/17 at 5:23 a.m., the MAR indicated 86 - Glucometer indicated 83

Resident #6's November 2017 MAR indicated blood glucose readings. However, the resident's glucometer did not indicate the resident's blood glucose was measured as follows:
 * On 11/11/17 at 11:43 a.m., MAR indicated 159
 * On 11/13/17 at 7:43 a.m., MAR indicated 98

The blood glucose readings on resident #6's MAR did not coincide with the blood glucose readings indicated on the resident's glucometer as follows:
 * On 11/16/17 at 7:26 a.m., the MAR indicated 138 - Glucometer indicated 128
 * On 11/12/17 at 7:14 p.m., the MAR indicated 172 - Glucometer indicated 173
 * On 11/12/17 at 4:52 p.m., the MAR indicated 208 - Glucometer indicated 209
 * On 11/12/17 at 7:19 a.m., the MAR indicated 157 - Glucometer indicated 159

Resident #7's November 2017 MAR indicated blood glucose readings. However, the resident's glucometer did not indicate the resident's blood glucose was measured as follows:
 * On 11/16/17 at 7:51 a.m., MAR indicated 102
 * On 11/13/17 at 8:08 a.m., MAR indicated 108
 * On 11/12/17 at 8:01 a.m., MAR indicated 101
 * On 11/11/17 at 8:21 a.m., MAR indicated 111
 * On 11/2/17 at 7:54 a.m., MAR indicated 111

The blood glucose readings on resident #8's MAR did not coincide with the blood glucose readings indicated on the resident's glucometer as follows:
 * On 11/16/17 at 7:33 a.m., the MAR indicated 108 - Glucometer indicated 105
 * On 11/12/17 at 11:34 a.m., the MAR indicated 107 - Glucometer indicated 104
 * On 11/12/17 at 7:36 a.m., the MAR indicated 98 - Glucometer indicated 94

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.

Next Page

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Signature of Legal Entity Representative
 (Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Caroline Dunn - Executive Director</i>	Date <i>4-12-18</i>
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The above plan of correction is approved as of <u>4-16-18</u> (Date)	Plan of correction implementation status as of <u>4-17-18</u> (Date)
/	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki		WEST REGION FIELD OFFICE	
PCH Name: MELODY MANOR		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.			
The above plan of correction was approved by _____ (Initials)		<input type="checkbox"/>	Partially Implemented - Inadequate Progress
		<input type="checkbox"/>	Not Implemented

Immediately after inspection new glucometers were ordered for all Residents that use them. They were delivered the following day at the Homes expense. Every Med Tech was individually re-trained and educated on the importance of following all guidelines for correct glucometer usage and recording. All glucometers were not only marked with the Residents name on both the case and glucometer, but also their picture was attached to the glucometer and glucometer case to avoid using the wrong glucometers on Residents. Weekly reviews of all glucometers with comparison to the MARS are being conducted by the Administration for a 6-month period to ensure the glucometers are being used appropriately. Documentation is kept and some of it is attached for reference. Extra glucometers and batteries are always available in the case of a glucometer malfunction

Immediately: A designated staff person qualified to administer medications shall audit all resident glucometers, MARS, and blood glucose testing records daily to ensure the glucometers are indicated in each resident's glucometer and the correct blood glucose reading is recorded. 4-16-18 ✓

Attachments As

13 A

through

13 P

4-17-18 ✓

Violation Report: 44676 - 11/16/2017 - Pfaff, Vicki
PCH Name: MELODY MANOR

WEST REGION FIELD OFFICE
Human Services Licensing

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 #2's initial assessment, completed on [redacted] 17, does not include an assessment of the resident's needs related to a wrist brace on left wrist as needed, a 2-handled mug for drinking, a compression fracture T11 and L4, fracture left distal radius, spinal stenosis, ambulatory dysfunction with falls, Alzheimer's dementia, degenerative joint disease both knees, and hypertension which were indicated on the resident's medical evaluation completed on 5/25/17.

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.

On 11-22-2017 (the earliest date following inspection that the Dr. could see her), Resident # 2 was taken to the Dr. to be re-evaluated. Her DME was done within the 60-day required time prior to admission, but Family stated Resident #2 had not been using the wrist brace or 2 handled cup because she did not need them. The Dr. did a new DME and a new RASP was completed by the Administrator with all items from the DME accounted for on the RASP. The Administrator has reviewed all DME's and RASPS to be sure that all items on the DME's were accounted for on the RASP. Documentation kept. Moving forward all RASPS will be reviewed and compared for accuracy by the Executive Director or Designated Administration. No RASP will be signed by the second person until the comparison is done and correct.

*Dr. did DC items in question.
Documentation Attached as 14A - 14D*

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Caroline Dunn - Executive Director*

Date *4-12-18*

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

The above plan of correction is approved as of 4-16-18
(Date)

Plan of correction implementation status as of 4-17-18
(Date)

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

The above plan of correction was approved by [Signature]
(Initials)