



pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUN 21 2018

Ms. Terri King
Executive Director
Barnes Aid OPCO LLC
2021 James Street
Latrobe, Pennsylvania 15650

RE: Barnes Place
Certificate #: 444880

Dear Ms. King:

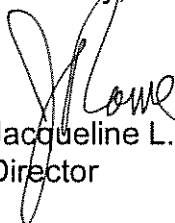
As a result of the Department's Bureau of Human Services Licensing annual inspection on January 4, 2018; January 5, 2018 and April 5, 2018, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

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

PCI Name: BARNES PLACE		License Number: 44400
Address: 2021 JAMES STREET, LATROBE, PA 15050		County: Westmoreland
Administrator: Peggy Konacny		Region: WEST
Legal Entity Name: BARNES AID OPCO LLC		
Legal Entity Address: 2021 JAMES STREET, LATROBE, PA 15050		RECEIVED
Certificate(s) of Occupancy C-2 LP 06/26/1997 L & I		MAR 16 2018 WEST REGION FIELD OFFICE Human Services Licensing
Staffing Hours		
Resident Support: 0	Total Daily Staff: 69	Working Staff: 52
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
Reason(s) for inspection(s) Renewal, Complaint		
On-Site Inspection Dates and Department Representatives On-Site 01/04/2018: McConnell, Deb; Grace, Deemond 01/05/2018: McConnell, Deb; Grace, Deemond		
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: 68 Number of Residents Served: 50 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: 5 Number of Hospice Residents in past year: 12	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 47 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 19 Have a Physical Disability: 1	

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Violation Report: 44488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 56 Pa. Code §2800

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

On 1/4/18, the current licensing inspection summary, dated 1/4/17, was 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.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Immediate remediation: The Executive Director (ED) added on 1/4/2018 the licensing inspection summary to public binder located at the resident mail boxes.

With each inspection by DHS, the inspection summary will be added to the public binder by the ED or designee

The ED/designee will review the public binder monthly to confirm 1 year of inspection summaries remain in the public binder

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

Signature of Legal Entity Representative (Required on EVERY Page) *Terry King*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Terry King Executive Director* Date *3-16-18*

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

The above plan of correction is approved as of 5/17/18
(Date)

Plan of correction implementation status as of 5/17/18
(Date)

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

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

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MAR 16 2018

WEST REGION FIELD OFFICE Page 3 of 25
Human Services Licensing

Violation Report: 44480 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 85 Pa.Code §2600
2600.18 - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2a. DESCRIPTION OF VIOLATION
The Care Facility Carbon Monoxide Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The two carbon monoxide detectors in the home were placed too close to the devices: One was approximately 3 feet from the gas fireplace in the main lobby area, and the other was approximately 6 feet from the gas furnace in room #6.

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 Maintenance Tech (MT) relocated the carbon monoxide alarms outside 15 feet of the gas fire place in the main lobby an outside 15 feet away from the gas furnace in room #6 on 1/17/2018
Current residents have the potential to be affected by this alleged deficient practice.
See attached

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Harry King Executive Director* Date *3-16-18*

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

The above plan of correction is approved as of 5/12/18 (Date)

Plan of correction implementation status as of 5/17/18 (Date)

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

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

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MAR 16 2018

Violation Report: 44488 - 01/04/2018 - McConnell, Don
PCH Name: BARNES PLACE

1. REGULATION 55 Pa.Code §2600
2600.26(a) - The home shall establish and implement a quality management plan.

2a. DESCRIPTION OF VIOLATION
The home's quality management plan does not indicate the home will complete a periodic review and evaluation of staff person training and licensing violations and plans of correction.

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 Quality Management plan includes an addendum to review and evaluate staff training, licensing violations and plans of correction which will be reviewed monthly.

The addendum will be part of the monthly quality assurance process completed by the assigned department for the monthly QA meeting.

Targeted compliance date of 4/30/2018.

Repeat Violation: No	Date(s) of Previous Violation(s):		
Signature of Legal Entity Representative (Required on EVERY Page)			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)			Date
Trey King Executive Director			3-16-18

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The above plan of correction is approved as of <u>3/17/18</u> (Date)	Plan of correction implementation status as of <u>3/17/18</u> (Date)
The above plan of correction was approved by <u>[Signature]</u> (Initials)	<input checked="" type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

MAR 16 2018

Violation Report: 44788 - 01042018 - McConnell, Deb
 PCH Name: BARNES PLACE

1. REGULATION 65 Pa.Code §2600
 2600.41(e) - A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in § 2600.41(d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

2a. DESCRIPTION OF VIOLATION
 The records of residents #1, #2 and #3 do not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

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.

Residents #1, #2 and #3 signed a statement acknowledging receipt of a copy of the resident rights and complaint procedures on 2/15/2018.

Current residents have the potential to be affected by this alleged deficient practice.

An audit of current resident files will be completed by the ED/designee by 3/30/18 to ensure that there are signed statements by the resident acknowledging receipt of a copy of the resident rights and complaint procedures on file.

Based upon the results of the audit, current resident files without the required signature will be obtained and a copy of the signed acknowledgment will be placed in the resident file and dated.

ED/designee will review newly admitted residents within 72 hours to ensure that there is a signed resident statement acknowledging receipt of a copy of resident rights and complaint procedure in their file.

Targeted compliance date of 4/30/2018.

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

[Handwritten Signature]

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

Polly King Executive Director Date *3-16-18*

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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 <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44400 - 01/04/2018 - McConnell, Bob
PCH Name: BARNES PLACE

1. REGULATION 65 Pn.Code §2600
2600.57(c) - Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

2a. DESCRIPTION OF VIOLATION

The home is required to provide a minimum of 2 hours per day of personal care services for each resident with mobility needs.

On 12/3/17, there were 49 residents residing in the home, including 18 residents with mobility needs, requiring a total minimum of 67 direct care staffing hours. However, on this day, only 55 hours of direct care staffing were provided.

On 12/23/17, there were 60 residents residing in the home, including 19 residents with mobility needs, requiring a total minimum of 69 direct care staffing hours. However, on this day, only 64.3 hours of direct care staffing were provided.

On 12/25/17, there were 60 residents residing in the home, including 19 residents with mobility needs, requiring a total minimum of 69 direct care staffing hours. However, on this day, only 49.5 hours of direct care staffing were provided.

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.

Barnes Place will provide 2 hours minimum of personal care services to each resident identified with mobility needs. Community has been providing the minimum of 2 hours of personal care services for each resident identified with mobility needs since 2/1/2018.

Current residents with mobility needs have the potential to be affected by this alleged deficient practice.

The Care Services Manager (CSM)/designee will keep a current list of residents identified with mobility needs, with minimum required hours of personal care to meet those needs. ED and CSM will be responsible to verify daily staffing needs to meet the minimum requirement of 2 hours of personal care services for each resident identified with mobility needs.

Targeted compliance by 4/30/2018.

Repeat Violation: Yes Date(s) of Previous Violation(s):

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Tracy King Executive Director* Date *3-16-18*

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The above plan of correction is approved as of 5/17/18 (Date)

Plan of correction implementation status as of 5/17/18 (Date)

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

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

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MAR 16 2018

Violation Report: 44408 - 01/04/2018 - McConnell, Dab
PCH Name: BARNES PLACE

1. REGULATION 56 Pa. Code §2000
2600.57(d) - At least 75% of the personal care service hours specified in § 2600.57(b) and § 2600.57(c) shall be available during waking hours.

2a. DESCRIPTION OF VIOLATION

The home is required a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs. At least 75% of these hours shall be available during waking hours.

On 12/3/17, there were 49 residents residing in the home, including 18 residents with mobility needs, requiring a total minimum of 60.25 direct care staffing during waking hours. However, on this day, only 40 hours of direct care staffing were provided during waking hours.

On 12/23/17, there were 60 residents residing in the home, including 18 residents with mobility needs, requiring a total minimum of 51.75 direct care staffing during waking hours. However, on this day, only 50.1 hours of direct care staffing were provided during waking hours.

On 12/25/17, there were 60 residents residing in the home, including 18 residents with mobility needs, requiring a total minimum of 51.75 direct care staffing during waking hours. However, on this day, only 35.5 hours of direct care staffing were provided during waking hours.

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.

Barnes place will provide at least 75% of personal care service hours during waking hour: 1 hour per mobile resident and 2 hours per resident with mobility needs.

Current residents with mobility needs have the potential to be affected by this alleged deficient practice.

Care Service Manager (CSM) or designee will keep a current list of residents identified with mobility needs, with minimum required hours of personal care to meet those needs.

The ED and CSM, or designee's, will verify staffing daily to confirm staffing is meeting the minimum of personal care hours per day. This will be logged to reflect tracking for each day.

Targeted compliance by 4/30/2018

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *TERRELL KING, EXECUTIVE DIRECTOR* Date *3-16-18*

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

The above plan of correction is approved as of 5/17/18 (Date)

Plan of correction implementation status as of 5/17/18 (Date)

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

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

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 55 Pa.Code §2600
2000.60(a) - Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION

The home's staffing schedule indicates that only 2 staff persons work on the 10:00 p.m.- 6:00 a.m. shift. In the event of an emergency evacuation, the home's night staffing is inadequate to meet the needs of the residents. The home serves 50 residents and has identified 16 residents as physically immobile, including residents #3, #4 and #5 needing 2-person assistance in transferring, and residents #6, #7 and #8 as cognitively immobile, using the wander guard services for safety.

During an emergency evaluation resident #6, #7 and #8 would be unsupervised while residents #3, #4 and #5 are assisted in transferring by the only 2 staff persons 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.

Barnes place will provide staffing to meet the resident needs per the specified needs indicated in the resident assessment support plan (RASP)

Current residents with mobility needs have the potential to be affected by this alleged deficient practice.

A minimum of 3 direct care staff will be scheduled on the 10pm to 6am shift to meet resident needs per the RASP assessment

The ED and the CSM, or designee's, will check the schedule daily to confirm staffing is reflecting resident needs and that there are 3 direct care staff scheduled on the 10pm to 6 am shift.

Staffing started on 2/15/2018.

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

Signature of Legal Entity Representative (Required on EVERY Page) *Debra King, Executive Dir*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Debra King, Executive Dir* Date: *3/16/18*

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

The above plan of correction is approved as of 3/12/18 (Date)

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

Plan of correction implementation status as of 3/12/18 (Date)

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

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MAR 16 2018

Violation Report: 44488 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

WEST-FLORIDA FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.65(a) - Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

2a. DESCRIPTION OF VIOLATION

Staff person A, hired 10/2/17, did not receive orientation training in general fire safety and emergency preparedness until 11/16/17.

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

Prior to or on the first day of work direct care staff and ancillary staff, substitute personnel and volunteers will have an orientation including items 1-7 in the identified regulation.

The ED/designee will audit current employee files on or by 3/30/2018 to ensure proper orientation training in emergency preparedness and fire safety, including items 1-7 in the identified regulation, to ensure that staff have received this orientation training.

The ED or designee will audit newly hired employee files after completion of new hire paperwork for compliance in fire safety and emergency preparedness, including items 1-7 in the identified regulation, to ensure that staff have received this orientation training.

The Audit will be reviewed at the monthly QA meeting until compliance is achieved.

Targeted compliance by 4/30/18

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Terly King Executive Director

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

Terly King Executive Director

Date *3-16-18*

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The above plan of correction is approved as of

3/17/18
(Date)

Plan of correction implementation status as of

3/17/18
(Date)

The above plan of correction was approved by

[Signature]
(Initials)

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

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MAR 16 2018

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Violation Report: 44488 - 01/04/2018 - McConnell, Deb
POH Name: BARNES PLACE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa. Code §2600
2600.06(b) - Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (36 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.

2a. DESCRIPTION OF VIOLATION
Staff person A, hired 10/2/17, and staff person D, hired 3/13/17, completed 40 scheduled working hours; however, they have not received an orientation to include the emergency medical plan and reporting of reportable incidents and conditions.

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

Staff person A and staff person D will receive additional orientation to include the emergency medical plan and reporting of reportable incidents and conditions on by 3/30/2018

The ED or designee will audit current employee files on or by 3/30/2018 to ensure orientation of the emergency medical plan, and reporting of reportable incidents and conditions are completed within the first 40 scheduled working hours.

The ED or designee will audit new employee files within 72 hours for correct education covering the emergency medical plan and the reporting of reportable incidents and conditions within the first 40 working hours. An employee file found to be lacking the orientation required will be addressed immediately and completed within the 40 worked hours.

The results of the audits will be discussed in monthly QA meeting until compliance is achieved

Targeted compliance by 4/30/2018

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

Signature of Legal Entity Representative (Required on EVERY Page) *Terry King, Executive Director*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Terry King, Executive Director* Date *3/16/18*

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

The above plan of correction is approved as of 5/17/18
(Date)

Plan of correction implementation status as of 5/17/18
(Date)

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

- Fully Implemented
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- Not Implemented

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Page 11 of 25

Violation Report: 44488 - 01/04/2018 - McCormick, Del
PCH Name: BARNES PLACE

1. REGULATION 65 Pa.Code §2800

2800.65(d) - Direct care staff persons hired after April 24, 2008 may not provide unsupervised ADL services until completion of the following:

- (1) Training that includes a demonstration of job duties, followed by supervised practice.
- (2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
- (3) Initial direct care staff person training to include the following:
 - (i) Safe management techniques.
 - (ii) ADLs and IADLs.
 - (iii) Personal hygiene.
 - (iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
 - (v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - (vi) Implementation of the initial assessment, annual assessment and support plan.
 - (vii) Nutrition, food handling and sanitation.
 - (viii) Recreation, socialization, community resources, social services and activities in the community.
 - (ix) Gerontology.
 - (x) Staff person supervision, if applicable.
 - (xi) Care and needs of residents with special emphasis on the residents being served in the home.
 - (xii) Safety management and hazard prevention.
 - (xiii) Universal precautions.
 - (xiv) The requirements of this chapter.
 - (xv) Infection control.
 - (xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person A, hired on 10/2/17, did not successfully complete the Department-approved direct care training course and passing of the competency test. However, the staff person has been providing unsupervised ADL services since 10/2/17.

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

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

See attached Page 11A of 25

Repeat Violation: No	Date(s) of Previous Violation(s):	
Signature of Legal Entity Representative (Required on EVERY Page)		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)		Date
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!		
The above plan of correction is approved as of	<u>5/17/18</u> (Date)	Plan of correction implementation status as of <u>5/17/18</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

Page 4A of 25

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MAR 16 2018
WEST VALLEY FIELD OFFICE
Human Services Licensing

- Direct care staff person A completed the Department approved direct care training course and achieved a passing score on the competency test on 11/17/14.
- The ED or designee will audit current employee files, on or by 3/30/2018 to ensure completion of the Department approved direct care training course and competency test with a passing score.
- The ED or designee will audit each newly hired direct care staff person, within 72 hours to ensure completion of the Department approved direct care training course and competency test with a passing score, prior to providing ADL services.
- The results of the audits will be discussed in the QA meeting monthly until compliance is achieved.
- Targeted compliance by 4/30/18.

2/12/18

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44488 - 01/04/2018 - McCannell, Deb
PCH Name: BARNES PLACE

1. REGULATION 65 Pa.Code §2600
2600.65(l) - 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
Staff person B, hired 6/1/13, did not receive annual training in the following topics during training year 2017:
*Meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
*Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
*Personal care service needs of the residents.

Staff person C, hired 8/11/16, did not receive annual training in the following topics during training year 2017:
*Meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
*Personal care service needs of the 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.

- Staff person B - will receive training in topics identified by 3/30/2018
- Staff person C - will receive training in topics identified by 3/30/2018

The ED or designee will audit current employee files, on or by 3/30/2018 to ensure completion of the identified training topics for annual training for direct care staff.

The ED or designee will audit employee file after in house educational session to track attendance, those not in attendance will be expected to complete required training as soon as possible and completion will be recorded by designee.
Results of the audit will be discussed at monthly QA meeting until compliance is achieved.

Targeted compliance by 4/30/2018

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Ferry Kurz Executive Director*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Ferry Kurz Executive Director* Date *3-16-18*

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

The above plan of correction is approved as of 5/17/18
(Date)

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

Plan of correction implementation status as of 5/17/18
(Date)

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

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44488 - 01/01/2018 - McConnell, Dub
PCH Name: BARNES PLACE

1. REGULATION 68 Pa.Code §2600
2600.65(l) - A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

2a. DESCRIPTION OF VIOLATION
The home's staff training record does not include the length of all courses.

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 ED/designee will utilize record of training that will include the name of the staff person, date, source, content, length of each course and any certifications.

The ED/designee will review training records monthly until compliance is achieved.

Targeted compliance by 4/30/18

Repeat Violation: No	Date(s) of Previous Violation(s):	
Signature of Legal Entity Representative (Required on EVERY Page) <i>T. L. King, Executive Director</i>		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>T. L. King, Executive Director</i>		Date <i>3-16-18</i>

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

The above plan of correction is approved as of 3/17/18
(Date)

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

Plan of correction implementation status as of 3/17/18
(Date)

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

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Violation Report: 44488 - 03/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

MAR 16 2018

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

WEST REGION FIELD OFFICE
Human Services Licensing

2a. DESCRIPTION OF VIOLATION
On 1/4/18, there was no lid on the 1/4 full garbage can in the "Grandma" kitchenette.
On 1/4/18, there was a hole approximately 8" in diameter, in the lid of the garbage can in the main kitchen.

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

Immediate remediation: Trash can with lid was placed in grandma kitchen on 1/4/2018.
Trash can in the kitchen was replaced with 2 step on lid trash can on 2/15/2018

The ED/designee will monitor kitchen area's to assure proper trash cans with lids are being utilized

Results will be reviewed monthly in the QA meeting until compliance is achieved

Targeted compliance by 4/30/18

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

Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Date 3-16-18

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

The above plan of correction is approved as of 3/17/18 (Date) Plan of correction implementation status as of 3/17/18 (Date)

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

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

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 55 Pa.Code §2600
2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION
On 1/4/17, the enabler bar was loose, and not secured to resident #6's bed in room 103, posing a fall hazard

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.

Immediate remediation: the enabler bar in room 103 was secured to resident bed and stabilized on 1/4/2018 or at the time it was identified during inspection.

The Maintenance Tech/designee will do quarterly checks of enabler bars for correct installation and stability to ensure resident safety.

Quarterly checks will be discussed in the Monthly QA meeting until compliance is achieved.

Targeted compliance by April 30, 2018

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Terry King, EP*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Terry King, Executive Director* Date: *3-16-18*

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The above plan of correction is approved as of 3/17/18
(Date)

Plan of correction implementation status as of 3/16/18
(Date)

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

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

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MAR 16 2018

Page 16 of 26

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44188 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 55 Pa.Code §2600
2600.101(j)(6) - Each resident shall have the following in the bedroom: A bedside table or a shelf

2a. DESCRIPTION OF VIOLATION
There is no bedside table or shelf beside resident #2's bed in room 120.

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.

Immediate remediation: Bedside table was provided by Barnes place on 1/4/2018 in room 120
The Maintenance Tech verified that current resident rooms have a bed side table on 1/4/2018.
Completed on 1/4/2018.

Immediately - Staff will be reeducated on this requirement and directed to monitor resident rooms for a bedside table or shelf as part of their daily duties.

Stiles

Report Violation: Yes Date(s) of Previous Violation(s): 01/04/2017

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Emily King Executive Director* Date: *3-16-18*

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The above plan of correction is approved as of 3/17/18
(Date)

Plan of correction implementation status as of 3/17/18
(Date)

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

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

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MAR 16 2018

Page 17 of 25

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 44488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 56 Pa.Code §2600
2600.103(c) - Food shall be protected from contamination while being stored, prepared, transported and served.

2a. DESCRIPTION OF VIOLATION
On 1/4/18, there were multiple opened and unsealed food items, including a 25 pound box of graham crumbs in the dry foods pantry and two boxes of corn starch in the upper cabinet next to the stove in the kitchen.

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

Immediate remediation. All listed items were discarded 1/4/2018.

Current residents have the potential to be affected by this alleged deficient practice.

New Dietary Service Manager (DSM) will be educated on this by 3/30/2018

The ED and Dietary Service Manager will verify that the dry storage food pantry is protected from contamination while food is being stored, prepared, transported and served by 3/30/2018.

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

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Toby King Executive Director* Date *3-16-18*

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

The above plan of correction is approved as of 5/17/18
(Date)

Plan of correction implementation status as of 5/17/18
(Date)

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

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

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MAR 16 2018

Page 18 of 25

Violation Report: 44408 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE
WEST REGION FIELD OFFICE
Human Services Licensing

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 record for the fire drill conducted on 12/0/17 at 2:04 p.m., does not indicate the number of residents in the home at the time of the fire drill and the number of residents who evacuated during the fire drill.

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 fire drill record will reflect the number of residents in house and the number of residents in house who evacuated during the fire drill.

Current residents have the potential to be affected by this alleged deficient practice.

Maintenance Tech was re-educated that the number of residents in house and the number of residents in house who evacuated during the drill, will be reflected on the fire drill record.

The ED or designee will review the fire drill record monthly to ensure that the number of residents in house and the number of residents in house who evacuated during the fire drill is reflected on the record.

Targeted compliancy by 4/30/2018

1/1

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

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *TERRY KING Executive Director* Date *3/16/18*

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

The above plan of correction is approved as of 5/17/18
(Date)

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

Plan of correction implementation status as of 5/17/18
(Date)
 Fully Implemented
 Partially Implemented - Adequate Progress
 Partially Implemented - Inadequate Progress
 Not Implemented

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MAR 16 2018

Page 20 of 25

Violation Report: 44408 - 01/07/2018 - McConwell, Don		WEST REGION FIELD OFFICE	
PCH Name: BARNES PLACE		Human Services Licensing	
<p>1. REGULATION 66 Pa.Code §2600 2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:</p> <ol style="list-style-type: none"> (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. 			
<p>2a. DESCRIPTION OF VIOLATION Resident #6 is prescribed Novolog Flex Pen on a sliding scale, with blood glucose checks four times daily, before meals and at bedtime. However, the pharmacy label does not indicate the sliding scale, as follows: 150-180= 2 units; 181-200=4 units; 201-250=6 units; 251-300=8 units; 301-350=10 units; 351-400=12 units; 401-450=14 units; >450=call physician</p>			
<p>3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) <i>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.</i></p> <p>The pharmacy corrected the label to indicate the sliding scale instructions with the 2/27/2018 delivery.</p> <p>Current resident receiving insulin have the potential to be affected by this alleged deficient practice. On 2/27/2018 the CSM or designee reviewed residents with orders for insulin administration to ensure that their prescription is pharmacy labeled and indicates direction for use.</p> <p>Licensed nursing staff and medication aides were re-educated by Care Services Specialist (CSS) on 1/25/18 and 1/31/18 about having the original medication container/Flex Pens labeled with a pharmacy label that includes directions.</p> <p>CSM or designee will review until compliance is achieved</p> <p>Targeted compliance by 4/30/2018</p>			
Repeat Violation: No		Date(s) of Previous Violation(s):	
Signature of Legal Entity Representative (Required on EVERY Page)			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)			
		Date 3/16/18	
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!			
The above plan of correction is approved as of		Plan of correction implementation status as of	
5/17/18 (Date)		5/17/18 (Date)	
The above plan of correction was approved by		<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	
[Initials]			

MAR 16 2018

Violation Report: 4488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 56 Pa.Code §2600
2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION
Resident #1 was prescribed Cephalexin 500mg, three times daily for 10 days - 12/19/17 through 12/29/17. On 12/22/17, at 6:00 p.m., and 12/28/17, at 1:00 p.m., the medication administration record (MAR) was not initiated by the staff person(s) who administered the medication.
Resident #1 is prescribed Sinemet 25/100, 1 tablet, three times daily. On 12/14/17, at 8:00 p.m., the MAR was not initiated by the staff person who administered the medication.
Resident #3 is prescribed Quetiapine Fumarate 25mg, at bedtime. On 1/4/18, at 7:30 p.m., the MAR was not initiated by the staff person who administered the medication.
Resident #3 was prescribed Gentamicin, 0.3% eye drops, 2 drops into left eye 4 times daily for 5 days. Administration began on 12/13/17. On 12/14/17, at 12:00 p.m. and 4:00 p.m., the MAR was not initiated by the staff person who administered the medication.

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.

Current residents receiving assistance with medication administration have the potential to be affected by this alleged deficient practice.
Licensed Nursing staff and Medication Techs were re-educated beginning on 1/25/2018 and ending on 1/31/2018 by CSS on correct medication administration process and documentation of medications.
At least 3 days a week the CSS/designee will audit MAR until compliance is achieved
Targeted compliance on 4/30/2018

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

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *TERRY KING, Executive Director* Date *3-16-18*

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

The above plan of correction is approved as of 3/17/18 (Date)
The above plan of correction was approved by [Signature] (Initials)
Plan of correction implementation status as of 3/17/18 (Date)
 Fully Implemented
 Partially Implemented - Adequate Progress
 Partially Implemented - Inadequate Progress
 Not Implemented

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MAR 16 2018

WEST REGION FIELD OFFICE Page 22 of 25
Human Services Licensing

Violation Report: 44400 - 01/04/2018 - McConogh, Del
 PCH Name: BARNES PLACE

1. REGULATION 65 Pa.Code §2600
 2600.107(d) - The home shall follow the directions of the prescriber

2a. DESCRIPTION OF VIOLATION
 Resident #5 is ordered Mycolog Topical to right lower extremity open area daily (10:00 a.m.) and wrap with gauze and ace wraps. However, on 1/4/18, at approximately 4:00 p.m., the resident had not receive the medication as ordered.

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.

Current residents have the potential to be affected by this alleged deficient practice.

Licensed Nursing staff and Medication Techs were re-educated beginning on 1/25/2018 and ending on 1/31/2018 by CSS on correct medication administration process and following the directions of the prescriber.

At least 3 days a week the CSS/ designee will audit treatment record to confirm that treatments are being followed until compliance is achieved.

Targeted compliance by 4/30/2018

Repeat Violation: No	Date(s) of Previous Violation(s):	
Signature of Legal Entity Representative (Required on EVERY Page)		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)		
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE		Date 3-16-18
The above plan of correction is approved as of	5/17/18 (Date)	Plan of correction implementation status as of 5/17/18 (Date)
The above plan of correction was approved by	(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

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MAR 16 2018

Violation Report: 44488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 66 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
The home has not completed an initial assessment for resident #1, admitted 10/16/17.

The initial assessment for resident #3, dated 12/15/17, is blank in the area of turning and repositioning. Also, the assessment indicates the resident is independent with ambulation; however, the support plan indicates the resident is not ambulatory.

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 - an assessment will be completed for this resident by 3/27/2018
Resident #3 - the assessment will be updated to reflect identified area's of discrepancy by 3/27/2018

Current residents have the potential to be affected by this alleged deficient practice.

CSM or designee will audit current residents initial assessments and support plans, on or by 4/13/2018 to ensure that each resident has one completed and that each area has been addressed on the form.

CSM/designee will review new move in within 72 hours

Targeted compliance 4/30/2018

Within 30 days of receipt of plan of correction:
All staff who complete assessments will be reeducated on accurate completion of the document and updating the document if residents condition changes.

[Handwritten Signature]

Repeat Violation: Yes Date(s) of Previous Violation(s): 01/04/2017

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Date 3-16-18
TERRY KIRBY Executive Director

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE

The above plan of correction is approved as of 3/17/18 (Date)

Plan of correction implementation status as of 3/16/18 (Date)

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

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

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Page 24 of 25

Violation Report: 44488 - 01/04/2018 - McConnell, Dair
PCH Name: BARNES PLACE

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

The assessment for resident #2, dated 12/7/17, indicates the resident is on a regular diet. However, the medical evaluation, dated 10/11/17, indicates the resident is ordered a mechanical soft diet. Also, the assessment is blank in the area of ambulation.

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 #2 had assessment updated related to her diet on 2/13/2018.

Current residents have the potential to be affected by this alleged deficient practice.

CSM or designee will audit current residents assessments and support plans, on or by 4/13/2018 to ensure that each resident has one completed and that each area has been addressed and is current to the resident needs.

The ED/CSM or designee will review and verify current resident assessments and DME for continuity of care services needed related to diet and ambulation. The review will be done quarterly for continued compliance.

Targeted compliance by 4/30/2018

*Within 30 days of receipt of plan of correction:
All staff who complete assessments will be reeducated on accurate completion of the documents and updating the document if residents condition changes.*

Repeat Violation: Yes Date(s) of Previous Violation(s): 01/04/2017

Signature of Legal Entity Representative (Required on EVERY Page) *Terry King ED*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Terry King Executive Dir* Date *3/16/18*

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The above plan of correction is approved as of *5/1/18* (Date) Plan of correction implementation status as of *5/12/18* (Date)

This above plan of correction was approved by *[Signature]* (Initials) Fully Implemented
 Partially Implemented - Adequate Progress
 Partially Implemented - Inadequate Progress
 Not Implemented

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MAR 16 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Page 25 of 25

Violation Report: 44488 - 01/04/2018 - McConnell, Deb
PCH Name: BARNES PLACE

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

The support plan, dated 1/4/18, for resident #3, does not indicate how the home will meet the resident's needs relating to total physical assistance for toileting, as indicated in the assessment, dated 12/15/17.

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.

Current residents have the potential to be affected by this alleged deficient practice.

CSM or designee will audit current residents support plans, on or by 4/13/2018 to ensure that how the resident's needs relating to total physical assistance will be met.

Quarterly at the time of re-assessment, with annual or significant change.

Targeted compliance by 4/30/2018

The current interim ED/CSM leadership will be educated on this entire Plan of Correction by the RDO/CSS/designee.

Within 30 days of receipt of plan of correction:
All staff who complete support plans will be reeducated on thorough completion of the document, to include specific description of how the home will meet residents needs.

SP
3/17/18

Repeat Violation: No	Date(s) of Previous Violation(s):	
Signature of Legal Entity Representative (Required on EVERY Page)		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)		Date
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!		
The above plan of correction is approved as of	<u>01/17/18</u> (Date)	Plan of correction implementation status as of <u>01/17/18</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

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

Page 1 of 3

PCH Name: BARNES PLACE		License Number: 44488
Address: 2021 JAMES STREET, LATROBE, PA 16660		County: Westmoreland
Administrator: Terri King		Region: WEST
Legal Entity Name: BARNES AID OPCO LLC		RECEIVED
Legal Entity Address: 2021 JAMES STREET, LATROBE, PA 16650		
Certificate(s) of Occupancy C-2 LP 09/28/1997 I. & I		MAY 03 2018 WEST REGION FIELD OFFICE Human Services Licensing
Staffing Hours		
Resident Support: 0	Total Daily Staff: 68	Waking Staff: 51
Type of Inspection: Interim - POC	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Interim		
On-Site Inspections Dates and Department Representatives On-Site 04/05/2018: McConnell, Deb; Mulick, Cindy		
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: 68 Number of Residents Served: 49 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: 4 Number of Hospice Residents In past year: 12		Number of Residents who: Receive Supplemental Security Income: 0 Are 69 Years of Age or Older: 47 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 19 Have a Physical Disability: 0

MAY 03 2018

WEST REGION FIELD OFFICE Page 2 of 3
Human Services Licensing

Violation Report: 44488 - 04/06/2018 - McConnell, Deb
PCH Name: BARNES PLACE

1. REGULATION 55 Pa.Code §2600
2600.60(a) - Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
The home's staffing schedule indicates that on 4/4/18, only 2 staff persons worked on the 10:00 p.m. - 6:00 a.m. shift. In the event of an emergency evacuation, the home's night staffing is inadequate to meet the needs of the residents.

On 4/4/18, the home served 46 residents and had identified 19 residents as physically immobile, 7 residents needing 2-person assistance in transferring, including resident #1, #2 and #3, and residents #4 and #5 as cognitively immobile, using a wanderguard unit for safety.

During an emergency evacuation resident #4 and #5 would be unsupervised while residents #1, #2 and #3 are assisted with transferring by the only 2 staff persons 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.

See Page 2A of 3

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

Signature of Legal Entity Representative (Required on EVERY Page) *Melissa Hice Executive Director*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Melissa Hice, ED* Date *5/1/18*

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

The above plan of correction is approved as of 5/17/18 (Date)

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

Plan of correction implementation status as of 5/17/18 (Date)
 Fully Implemented
 Partially Implemented - Adequate Progress
 Partially Implemented - Inadequate Progress
 Not Implemented

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Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

2600.187(b)

- Three staff members will be scheduled for the 10p-6a shift daily effective 05/02/2018. (See Attachments A-C)
- Current residents have the potential to be affected by this alleged deficient practice.
- Direct Care Staff educated that call offs need to be communicated to the Executive Director immediately to ensure adequate staffing.
- Executive Director or designee to ensure that staffing shall be present to meet the needs of the residents as indicated by the support plan and assessment.
- Executive Director and Care Service Manager to provide on-call coverage to ensure staffing is maintained.
- All call-offs will be indicated on current schedules and replacement staff members will be indicated on the schedule as well.
- Plan Of Correction completed 05/02/2018

J. Smith

Melissa J. Jace, Executive Director

MAY 03 2018

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Violation Report: 44400 - 04/05/2018 - McConneli, Deb
PCH Name: BARNES PLACE

1. REGULATION 55 Pa.Code §2600
2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION
Resident #8 is prescribed Novolog Flexpen, 100/ML unit sliding scale at 8:30 a.m., 11:30 a.m., 4:30 p.m., and at 8:30 p.m. On 3/9/18, at 11:30 a.m. and 3/11/18, at 4:30 p.m., the medication administration record (MAR) was not initiated by the staff person(s) who administered the medication.
Resident #7 was prescribed Omeprazole, 20 mg, twice daily. On 3/10/18 and 3/17/18, the MAR was initiated by staff person as administering the medication three times.
Resident #7 is prescribed Loratadine, 10 mg, 1 tab every other day. From 4/1/18 through 4/5/18, the MAR was initiated daily by the staff person(s) who administered the medication.
Resident #7 is prescribed Omeprazole, 20 mg twice daily. On 4/2/18, at 4:40 p.m., the MAR was not initiated by the staff person who administered the medication.

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 Page 3A of 3

Repeat Violation: No	Date(s) of Previous Violation(s):
Signature of Legal Entity Representative (Required on EVERY Page) <i>Melissa Hice, Executive Director</i>	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Melissa Hice, ED</i>	Date <i>5/1/18</i>

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

The above plan of correction is approved as of <u>5/17/18</u> (Date)	Plan of correction implementation status as of <u>5/17/18</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

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Human Services Licensing

2600.187(b)

- Staff members identified as having been responsible for the occurrences cited are receiving re-education on documentation of medication administration by the Care Service Manager. Re-education to be completed by 05/04/2018.
- Current residents have the potential to be affected by this alleged deficient practice.
- Current Residents' Medication Administration Record have been audited by the Licensed Practical Nurse on 04/27/2018.
- Medication Techs were re-educated on proper documentation on 04/18/2018 by the Care Service Manager.
- Monthly in-services are to be held by Care Service Manager for Med Techs to improve knowledge base.
- MAR audits are to be completed by Care Service Manager or designee five times a week for 4 weeks then weekly to ensure proper documentation of medications administered. (See Attachment D) Care Service Manager or designee to audit new orders to ensure proper transcription.
- Care Service Manager or designee to conduct Med pass audits for Med Techs quarterly and documented on the Medication Administration Program Annual Recertification forms.
- Plan of Correction to be completed by 06/02/2018.

Banks

*Melissa Arce,
Executive Director*