pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 02 2018

Ms. Rebecca L. Brady
Chief Operating Officer
Reformed Presbyterian Women's Association
2344 Perrysville Avenue
Pittsburgh, Pennsylvania 15214

RE: Reformed Presbyterian Home
Certificate #: 429660

Dear Ms. Brady:

As a result of the Department of Human Services' Licensing annual licensing inspection on February 12, 2018 and February 13, 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

PCH Name: REFORMED PRESBYTERIAN HOME	License Number: 42966
Address: 2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214	County: Allegheny
Administrator: Patricia Wilson	Region: WEST
Legal Entity Name: REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION	
Legal Entity Address: 2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214	

Certificate(s) of Occupancy
C-2 I,P
10/10/1983
City of Pittsburgh

Staffing Hours

Resident Support: 0	Total Daily Staff: 18	Waking Staff: 14
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Renewal

On-Site Inspections Dates and Department Representatives On-Site
02/12/2018: Garrigan, Laurie; Barry, Courtney
02/13/2018: Garrigan, Laurie

Off-Site Inspection Dates and Inspectors, If Applicable

Other Details

Partial or Full Triggers:	Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 56	Number of Residents who:
Number of Residents Served: 18	Receive Supplemental Security Income: 1
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 17
Area:	Have Mental Illness: 2
Secured Dementia Unit Capacity, If Applicable:	Have an Intellectual Disability: 1
Number of Residents Served in Secured Dementia Care Unit, If applicable:	Have a Mobility Need: 0
Number of Current Hospice Residents: 0	Have a Physical Disability: 0
Number of Hospice Residents in past year: 0	

Violation Report: 42960 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.25(b) - The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

2a. DESCRIPTION OF VIOLATION
Resident #1's resident-home contract, dated [redacted]17, is not signed by the administrator or designee, the resident, or the payer, if applicable.

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.

2600.25(b)

Immediate Correction: On March 8, 2018 the resident home contract was signed by the Administrator, resident #1 and the agent responsible for payment. (See attached copy)

Continued Compliance:

- By March 31, 2018 all admission agreements will be audited to ensure admission documents are in compliance with regulation 25(b). Audit will be conducted by Administrator or designee.
- Any agreements not in compliance with 25(b) during auditing will have an action item assigned to bring that agreement into compliance with the regulation. Responsible party is the Administrator or designee.
- Admission agreement auditing will be added to monthly Quality Indicator report. (see attached)
- 50% of all admission agreements will be audited monthly by Administrator or designee to ensure compliance with regulation.
- Results of monthly auditing will be reported at QAPI meeting quarterly by Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42866 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

MAR 22 2018

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.25(c)(4) - The contract shall specify the party responsible for payment.

2a. DESCRIPTION OF VIOLATION
Resident #1's resident-home contract, dated [redacted]17, does not indicate who is the party responsible for payment.

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.

2600.25(c)(4)

Immediate Correction: The POA is identified as the payer for the resident. On March 8, 2018 the POA signed the admission agreement as the party responsible for payment. (See attached copy)

Continued Compliance:

- By March 31, 2018 all admission agreements will be audited to ensure admission documents are in compliance with regulation 25(c)(4). Audit will be conducted by Administrator or designee.
- Any agreements not in compliance with 25(c)(4) during auditing will have an action item assigned to bring that agreement into compliance with the regulation. Responsible party is the Administrator or designee.
- Admission agreement auditing will be added to monthly Quality indicator report. (see attached)
- 50% of all admission agreements will be audited monthly by Administrator or designee to ensure compliance with regulation.
- Results of monthly auditing will be reported at QAPI meeting quarterly by Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Saccio, PCHA

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

Date 3-20-18

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Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

2600.63(a) - At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

2a. DESCRIPTION OF VIOLATION

On 2/2/18 from approximately 8:00 p.m. to 11:00 p.m., direct care staff person A worked alone in the home; however, staff person A is not trained in first aid and certified in obstructed airway techniques and CPR. During this time, at least 18 residents were present 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.

2600.63(a)

Immediate Correction: Staff person "A" received training in First Aid and CPR on March 8, 2018 (See attached copy)

Continued Compliance:

- Staff persons who do not have current First Aid and CPR will not be scheduled to work without a peer who has current certification in First Aid and CPR. Scheduling responsible party is Administrator, Human Resources or designee.
- All staff files were audited on 3-13-18 to ensure compliance with this regulation by Human Resources. All staff is now in compliance with regulation 63(a).
- Monthly auditing of all staff files to ensure staff is up to date with First Aid and CPR will be conducted by Administrator or designee. This audit will be added to the monthly Quality Indicator report.
- During monthly auditing, any staff due for recertification in the next 3 months will be scheduled to recertify prior to the expiration of their current certification. The responsible party is the Administrator or designee.
- Compliance from monthly indicator reports will be reported quarterly at QAPI meeting by Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page): Kim Salvio, PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Kim Salvio, PCHA — Date: 3-20-18

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Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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

Direct care staff person A, hired on 1/23/18, and direct care staff person B, hired on 11/14/17, did not receive training on the following topics:

* Evacuation procedures
* Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable
* The designated meeting place outside the building or within the fire-safe area in the event of an actual fire
* The location and use of fire extinguishers
* Smoke detectors and fire alarms
* Telephone use and notification of emergency services

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 for plan of correction.

See page 5A of 24

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Savio, PCHA

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

Date 3-20-18

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Plan of correction implementation status as of 3/23/18 (Date)

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

2600.65(a)

Immediate Correction: Staff person "A" and "B" received training pertaining to 2600.65(a) utilizing the annual fire safety expert report for RP Home, the Fire Response Policy and smoking policy. Staff person "B" has been trained and is certified as a Fire Safety Expert.(See attached copy)

Continued Compliance:

- All staff will have training related to 65(a) prior to the first day of work. Responsible Party is Administrator or designee.
- Fire training pertaining to 65(a) will include Fire Response Policy and review of the latest annual fire safety expert report summarized at the annual drill conducted by the expert. Responsible party includes the Administrator, Director of Maintenance (who is a trained Fire Expert/certification attached) or designee.
- All staff files will be audited monthly by the Administrator or designee for compliance with the 65(a) required training as part of the monthly Quality Indicator Report.
- Compliance with regulation 65(a) will be reported at QAPI quarterly by Administrator or designee.

Kim Saccio, PCHA
Kim Savio, PCHA 3-20-18

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

2600.65(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 (35 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.

2a. DESCRIPTION OF VIOLATION

Direct care staff person A, hired on 1/23/18, and direct care staff person B, hired on 11/14/17, did not receive training on reportable incidents and conditions within 40 working hours of hire.

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.

2600.65(b)

Immediate Correction: Staff person "A" and "B" received training pertaining to 2600.65(b) reportable incidents and conditions.(See attached copy) staff person "B" is not direct care staff but director of Maintenance.

Continued Compliance:

- All staff will have training related to 65(b) within 40 working hours of hire. Responsible Party is Administrator or designee.
- All staff files will be audited monthly by the Administrator or designee for compliance with the 65(b) required training as part of the monthly Quality Indicator Report. Initial audit will take place prior to March 31, 2018.
- Compliance with regulation 65(b) will be reported at QAPI quarterly by Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42956 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.65(e) - Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

2a. DESCRIPTION OF VIOLATION
Direct care staff person C, hired on 12/20/08, received only 7.75 hours of annual training during the 2017 training year.

Direct care staff person D, hired on 8/2/11, received only 7 hours of annual training during the 2017 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.

See attached plan of correction.

See Page 7A of 24

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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

Plan of correction implementation status as of 3/23/18 (Date)

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

2600.65(e)

Immediate Correction:

Direct Care staff persons "C" and "D" have received an additional 5 hours of training on the following education topics related also to the violation on page 8 and in accordance with 65 (f). Please see attachment. Training Topics included: Personal Care Service Needs of the Resident/ pre admission/dme/rasp, Care of Residents with Dementia and Cognitive Impairment, Safe Management Techniques, Medication Self Administration Training, Care of the Residents Personal Needs,

Ongoing Compliance Plan: Staff persons C and D completed an additional 5 hours of training in March 2018. ℓ 3/23/18

- Folders of education materials containing the required training of at least 12 hours for each employee (and new hires) have been created to comply with regulation 65 (e)(f)(g). Education contained in the folders is in accordance with 2600.65(e) (f) and (g). Education folders have already been created by Administrator and Human Resources. See attachment indicating training topics of folders.
- Education folders will be available for all staff to begin 2018 education prior to March 31, 2018. Responsible Party: Administrator or designee.
- Folders will be maintained in the Administrator's office. Responsible Party is Administrator or designee.
- Administrator or designee will be responsible party to ensure that staff education is completed each calendar year by all staff.
- Monitoring of staff progress/completion of education will be conducted by Administrator or designee monthly on Quality Indicator audit.
- Reporting of education compliance will be conducted quarterly by Administrator or designee at quarterly QAPI meeting.

Kim Salvio, PCHA
Kim Salvio, PCHA 3-30-18

Violation Report: 42986 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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, hired on 12/20/08, did not receive annual training on the following training topics during the 2017 training year:
* Medication self-administration training
* Safe management techniques
* Care for residents with mental illness or intellectual disability. Currently, the home serves residents with mental illness and intellectual disabilities.

Direct care staff person D, hired on 8/2/11, did not receive annual training on the following training topics during the 2017 training year:
* Medication self-administration training
* Instruction on meeting the needs of the residents as outlined in preadmission screening form, assessment tool, medical evaluation and support plan
* Safe management techniques
* Care for residents with mental illness or intellectual disability. Currently, the home serves residents with mental illness and intellectual disabilities.

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 plan of correction.

See Page 8A of 24

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/16/2017 et al		

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA — Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

2600.65(f)

Immediate Correction:

Direct Care staff persons "C" and "D" have received an additional 5 hours of training on the following education topics related also to the violation on page 8 and in accordance with 65 (f). Please see attachment related to previous violation on page 7 (the education topics below were satisfied). Fulfillment of education in this violation was met along with the completion of required hours of training cited on page 7.

- Safe management techniques
- Medication self administration
- Care for resident with mental illness or intellectual disability (care of residents with dementia/cognitive impairment)
- Meeting the needs of residents as outline in the preadmission screening form, assessment tool, medical evaluation and support plan.
- Care of residents personal care needs.

Ongoing Compliance Plan:

- Folders of education materials for each employee (and new hires) have been created by Administrator and Human Resources.
- Education contained in the folders is in accordance with 2600.65 (f) and (g). Responsible Party is Administrator or designee.
- Folders will be maintained in the Administrators office: Responsible Party Administrator or designee.
- Administrator or designee will be responsible party to ensure that staff education is completed each calendar year.
- Monitoring of staff progress/completion of education will be conducted by Administrator or designee monthly on Quality Indicator audit.
- Reporting of education compliance will be conducted quarterly by Administrator or designee at QAPI meeting.

Kim Saccio, PCHA
Kim Savio, PCHA 3-20-18

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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 C, hired on 12/20/08, and direct care staff person D, hired on 8/2/11, did not receive annual training on fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 2017 training year.

3. 2600.65(g)

Immediate Correction: Staff person "C" and "D" received training pertaining to 2600.65(g) by a fire safety expert. See attached record of training. Staff person "C" had the training on 3-14-18 and staff person "D" had the training on 3-15-18.

Continued Compliance:

- All staff will be scheduled for annual training by a fire safety expert and other requirements related to 65(g). Responsible Party is Administrator or designee.
- Fire training pertaining to 65(g) will include Fire Response Policy and review of the latest annual fire safety expert report summarized at the annual drill conducted by the expert, Resident Rights, OAPSA, Falls and Accident Prevention, New Population Groups that are being served at the home that were not previously served, Emergency Preparedness procdures and recognition and response to crises and emergency situations. Responsible party includes the Administrator, Director of Maintenance (who is a trained Fire Expert/certification attached) or designee.
- All staff files will be audited monthly by the Administrator or designee for compliance with the 65(g) required training as part of the monthly Quality Indicator Report.
- Compliance with regulation 65(g) will be reported at QAPI quarterly by Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42866 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.66(a) - A staff training plan shall be developed annually.

2a. DESCRIPTION OF VIOLATION
The home does not have a 2018 staff training plan.

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

2600.66(a)

Immediate Correction: A staff training plan was created for 2018. See attachment.

Continued Compliance:

- New staff training plans will be created annually, prior to the beginning of the next calendar year, by the Administrator or designee. Goal is to have plan created each year in December. Will note as an appointment reminder on calendar.
- Education folders created for each employee by Administrator and Human Resources containing all required education.
- Education folders will be made available to staff prior to March 31, 2018. Responsible Party: Administrator or designee.
- Auditing of staff compliance with required education will be conducted by Administrator or designee monthly as indicated on monthly Quality Indicator Audit.
- Reporting of education compliance will be quarterly at QAPI meeting and responsible party will be Administrator or designee.

By 12/1/18: A designated staff person shall develop a 2019 staff training plan, which includes all trainings specified in 2600.65f and 2600.65g. L 3/23/18

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Savio, PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kim Savio, PCHA — Date 3-20-18

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.82(c) - Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

2a. DESCRIPTION OF VIOLATION
On 2/12/18, the following poisonous materials, with manufacturer's labels indicating, "If swallowed, get medical help or contact poison control center", were unlocked and accessible in the following locations:
* (3) 3.57 liter bottles of Clorox Bleach, located in the laundry room closet
* (1) 2 quart bottle of bleach, approximately 1/8 full, located on the dresser in bedroom #232
Resident #3, who resides in bedroom #232, has not been assessed within the past year as capable of recognizing and using poisons safely.

2b. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
2600.82(c) *rect the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed*

Immediate Correction: the Clorox bottle(s) from the laundry room and the resident's dresser in her bedroom were removed and locked in the laundry room closet that is inaccessible to residents. Resident #3 was assessed by her physician and a new DME was completed on 3-15-18 stating that the resident can safely use or avoid poisonous materials. Until all residents charts have been assessed for ability to use or avoid poisonous materials, Clorox will remain locked in laundry cabinet. Resident will have ability to use her own bottle of Clorox when washing by having the staff unlock the cabinet.

Continued Compliance:

- All resident charts will be audited to ensure DME is current and indicates if they can safely use or avoid poisons. All charts will be audited by March 31, 2018. Responsible Party is Administrator or designee.
- Monthly auditing of resident rooms for poisonous chemicals will be added to the Quality Indicator Report by Administrator.
- 50% of resident rooms and common areas will be audited monthly using Quality Indicator report to assess for poisonous chemicals on the personal care floor. Monthly audit will be responsibility of the Administrator or designee.
- Compliance will be reported at the quarterly QAPI meeting by the Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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

2a. DESCRIPTION OF VIOLATION
On 2/12/18, the following unsanitary conditions were present:
* An accumulation of dust was covering the fresh air ceiling vent in the shower room across from bedroom #212, blocking air flow holes.
* Approximately 1/8" accumulation of dust was covering the fresh air ceiling vent in the private bathroom of bedroom #209, blocking air flow holes.

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.

2600.85(a)

Immediate Correction:

Room(s) 209 and bathroom across from 212 have had the air intake vents removed and cleaned as of 3-15-18 by RP Home Maintenance Department.

Ongoing Compliance Plan:

- A vent cleaning scheduled was developed to have all air intake vents cleaned weekly by housekeeping. See attachment.
- Housekeeper educated on vent cleaning schedule on 3-15-18. See attachment.
- Weekly vent cleaning schedule to be submitted to Administrator weekly to confirm compliance. Responsible Party Administrator, Director of Maintenance or designee.
- Weekly vent cleaning compliance added to monthly indicator report for QI to be assessed monthly by Administrator or designee.
- Administrator or designee will report on compliance with vent cleaning quarterly at QAPI.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salerno, PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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 12/29/17 at 6:30 a.m. does not include the number of residents in the home at the time of the drill or the number of residents evacuated.

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.

2600.132(c)

Immediate Correction: the fire drill record for 12-29-17 was amended to include the number of residents in the home at the time. The number of residents was 16 as one resident was on a Leave of Absence with their family for the holiday. That person does show up on the census documents but it is noted that they were at home with family. See attachments.

Continued Compliance:

- Fire drill records documentation training conducted on 3-15-18.see attached.
- Monthly drills to be reviewed by Administrator and Director of Maintenance to ensure 132 (c) is in compliance.
- Monthly drill audit is now added to the Quality Indicator report and will be assessed monthly by Administrator or designee to ensure compliance with regulation 132(c).
- Administrator or designee will report on compliance quarterly at QAPI meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42960 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

WEST REGION FIELD OFFICE
~~Human Services Licensing~~

1. REGULATION 55 Pa.Code §2600
2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

2a. DESCRIPTION OF VIOLATION
According to the home's fire drill records, 15 residents were present in the home during the fire drill conducted on 9/28/17 at 9:30 a.m.; however, only 14 residents were evacuated.

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 plan of correction.

See Page 14A of 24

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Silvio, PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

2600.132(h)

Immediate Correction:

- Resident who did not evacuate was identified by staff.
- Root cause analysis determined that cause of failure to evacuate resident was due to the resident was newly admitted and did not know evacuation procedure.
- Resident who did not evacuate has since discharged from personal care.
- Fire Response education give to all staff of Personal Care on a new procedure: Occupied room list has been placed in each fire extinguisher box (3) indicating which rooms are occupied by residents.
- This list will be updated weekly by Administrator or designee
- Fire evacuation tags also located in each extinguisher box (3) to place on room doors indicating room has been evacuated. When alarm sounds, staff respond to fire extinguisher box and take occupied room list and evacuation tags. Tag each room checked during evacuation.
- All rooms (occupied/unoccupied) to be checked during alarm.
- See attached training and related forms.

Continued Compliance:

- New residents will be educated on fire evacuation procedures upon admission to Personal Care by Administrator or Designee.
- Form will be added to the admission paperwork for resident to sign that they have received training on fire evacuation procedure. This form will be maintained in the resident record. Responsible Party is Administrator or designee.
- Copy of Monthly drills and any alarms will be reviewed by Administrator or designee to ensure proper evacuation of all residents.
- Review of Monthly drill added to monthly Quality Indicator audit to be reviewed by Administrator or designee.
- Compliance will be reported quarterly by Administrator or designee.

Kim Salvio, PCHA
Kim Salvio, PCHA 3-20-18

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION
Resident #2's most recent medical evaluation, signed by the physician on 6/15/17, does not include the resident's height, weight, pulse rate, blood pressure, temperature, special health needs, immunization history, allergies, ability to self-administer medications, body positioning, health status, cognitive function, mobility needs assessment, diet, the date resident was evaluated or date the form was completed. These sections of the medical evaluation are blank.

Resident #3's most recent medical evaluation was completed on 2/6/18; however, the previous medical evaluation was completed on 12/7/17.

Resident #3's most recent medical evaluation, dated 2/6/18, does not include the resident's temperature. This section of the form is blank. Also, the resident's medical evaluation indicates, "see attached" for a list of current medications; however, nothing is attached.

Resident #4's most recent medical evaluation, dated 12/7/17, does not include any allergy information. This section of the form is blank.

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

See attached plan of correction.

See Page 15A of 24

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Kim Salerno, PCHA			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Kim Salerno, PCHA	Date 3-20-18		

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

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MAR 20 2018

WEST REGION FIELD OFFICE
Human Services Licensing

2600.141(b)(1)

Immediate Correction:

- Resident #2 was seen by her physician and had a new DME completed today on 3-20-18. All sections cited as blank on VR report page 15 have been completed.
- Resident #3 was seen by her physician and had a new DME completed on 3-15-18.all sections cited blank have been completed and a full list of medications have been included on the DME.
- Resident #4 was seen by his physician and had a new DME completed on 3-15-18. His allergy information has been included on this new DME.
- See attached for copies of new DME's supporting corrections.
- Staff given education on regulation 141 (b)(1). See attached

Continued Compliance:

- A schedule of monthly audits was created by the administrator to assess who is due to a regularly scheduled physician visit with new DME based on the physician preference for frequency of physician visits when more often than annually.
- All resident charts will be audited before March 31, 2018 to identify which residents need seen by their physician. Responsible Party: Administrator or designee.
- Monthly audit for Quality Indicator report to review/audit 50% of charts to ensure DME is properly completed and resident has had their physician visit based on physician preference (if more often than annually) as required in 141 (b)(1).

Kim Salcido, PCHA
Kim Salcido, PCHA 3-20-18

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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 #3 is prescribed Ipratropium/Albuterol 0.5mg/3mg solution-Inhale contents of 1 unit dose vial via nebulizer every 2 hours as needed; however, on 2/12/18, this medication was not available 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.

2600.185(a)

Immediate Correction:

- Pharmacy for resident #3 notified that medication ordered was not available in the home.
- Pharmacy sent medication for resident on 3-14-18. See attached copy of medication now in medication cart.

Continued Compliance:

- Medication cart audit created for staff to assess 1(or more) resident orders/medications per shift to ensure compliance with 185(a). see attached.
- Staff educated on conducting a medication audit on 3-15-18. See attached.
- Administrator or designee to follow up within 24 hours on any discrepancies cited during medication audit.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Kim Salvio, PCHA			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Kim Salvio, PCHA	Date 3-20-18		

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42986 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

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

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

2a. DESCRIPTION OF VIOLATION

Resident #2's February 2018 medication administration record (MAR) does not include a diagnosis or purpose for the following medications:

* Mirtazapine 15 mg tablet
* Baclofen 10 mg tablet

Resident #3's February 2018 MAR does not include a diagnosis or purpose for Lisinopril 40 mg tablet.

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 plan of correction.

See Page 17A of 24

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/16/2017 et al		

Signature of Legal Entity Representative (Required on EVERY Page) Kim Savio PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

2600.187(a)

Immediate Correction:

- Medication Administration Record (MAR) for resident #2 has been amended to include the diagnosis for Mirtazapine or Baclofen.
- Medication Administration Record (MAR) for resident #3 has been amended to include the diagnosis for Lisinopril.
- See attached records to support compliance with regulation 187(a).

Continued Compliance:

- Medication cart audits in place in order to ensure that regulation is met. Staff performing medication cart audits will identify if medication does not have a diagnosis. See copy of attached audit with bullet points underneath.
- Monthly Quality Indicator audit for assessing MAR to ensure that there is a diagnosis with each medication orders. 50% of charts to be assessed monthly by Administrator or designee.
- Administrator or designee will report at quarterly QI on compliance with monthly audits, daily audits pertaining to 187(a).

Kim Salvio, PCHA
Kim Salvio, PCHA 3-20-18

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

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 #1's February 2018 MAR does not include the initials of the staff person who administered the following medications to the resident during the evening of 2/11/18:
* Irbesartan 75 mg tablet-Give 1 tablet by mouth at bedtime
* Olanzapine 15 mg tablet-Give 2 tablets by mouth at bedtime
* Cholestyram powder 4 mg-Dissolve 1 packet in water and give by mouth twice a day

Resident #2's February 2018 MAR does not include the initials of the staff person who administered the following medications to the resident during the evening of 2/11/18:
* Mirtazapine 15 mg tablet-Give 1 tablet by mouth at bedtime
* Acetamin 500 mg tablet-Give 1 tablet by mouth twice a day
* Baclofen 10 mg tablet-Give ½ tablet by mouth twice a day
* Metoprol Tar 25 mg tablet-Give ½ tablet by mouth twice a day
* Omeprazole 20 mg capsule-Give 1 capsule by mouth twice a day
* Alprazolam 0.5 mg tablet-Give 1 tablet by mouth twice a day
* Tramadol HCL 50 mg tablet-Give 1 tablet by mouth every evening

Resident #3's February 2018 MAR does not include the initials of the staff person who administered Atorvastatin 20 mg tablet-Give 1 tablet by mouth at bedtime to the resident during the evening of 2/9/18.

Resident #3's February 2018 MAR does not include the initials of the staff person who administered the following medications to the resident during the evening of 2/11/18:
* Atorvastatin 20 mg tablet-Give 1 tablet by mouth at bedtime
* Lantus injection 100 ml-Inject 40 units sub-q at bedtime
* Robafen 100 mg/5ml syrup-Give 10 ml by mouth at bedtime
* Gabapentin 300 mg capsule-Give 1 capsule by mouth every morning and bedtime
* Glimepiride 1 mg tablet-Give 1 tablet by mouth twice a day
* Metoprol Tar 50 mg tablet-Give 1 tablet by mouth every morning and bedtime

Resident #4's February 2018 MAR does not include the initials of the staff person who administered the following medications to the resident during the evening of 2/10/18:
* Bicalutamide 50 mg tablet-Give 1 tablet by mouth daily
* Quetiapine 25 mg tablet-Give 1 tablet by mouth at bedtime
* Doxazosin 2 mg tablet-Give 1 tablet by mouth twice a day

Resident #4's February 2018 MAR does not include the initials of the staff person who administered the following medications to the resident during the evening of 2/11/18:
* Quetiapine 25 mg tablet-Give 1 tablet by mouth at bedtime
* Doxazosin 2 mg tablet-Give 1 tablet by mouth twice a day
* Oxbutynin 5 mg tablet-Give 1 tablet by mouth twice a day

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 Plan of Correction See Page 19A of 24

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

Signature of Legal Entity Representative (Required on EVERY Page): Kim Salvio, PCHA

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

Date: 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

Plan of correction implementation status as of 3/23/18 (Date)

☐ Fully Implemented

☒ Partially Implemented - Adequate Progress P

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie PCH Name: REFORMED PRESBYTERIAN HOME	WEST REGION FIELD OFFICE Human Services Licensing
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.	
The above plan of correction was approved by _____ (Initials)	☐ Partially Implemented - Inadequate Progress ☐ Not Implemented

Kim Salvio, PCHA

Kim Salvio, PCHA 3-20-18

RECEIVED

MAR 20 2018

WEST REGION FIELD OFFICE
Human Services Licensing

2600.187(b)

Immediate Correction:

- The MAR's cited in VR page 18 187(b) have been amended to show initials of staff who administered medications during the evening shift on 2-10-18 and 2-11-18 for residents #1,#2,#3,#4.
- See attached documents.

Continued Compliance:

- Staff will be educated on 187(b) by March 31, 2018 Responsible Party is Administrator or designee.
- Monthly Indicator for Quality Indicator report to have Administrator or designee select 50% of MAR's to review to ensure compliance with 187(b).
- Administrator or designee will report quarterly at QAPI on compliance with 187(b).

Kim Salcedo, PCHA
Kim Salcedo, PCHA 3-20-18

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:
(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

Resident #2's most recent assessment is undated; however, was signed by assessor as completed on 7/15/16.

Resident #3's most recent assessment was completed on 1/3/17.

Resident #4's most recent assessment was completed on 12/20/16.

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

2600.225(c) *Correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed*

Immediate Correction:

- A new support plan was completed for resident #2, #3 and #4 .
- Resident #2, #3 and #4 have all had new DME's completed and are located under page 15.
- Please see attached copies of support plans.

Continued Compliance:

- Audit has been created to identify when support plans are due for residents on a regular schedule. This does not include a significant change. Audit will be managed by Administrator or designee.
- See copy of attached audit form.
- Monthly Quality Indicator for RASP audits will be conducted monthly by Administrator or designee to ensure continued compliance. Approximately 50% of charts will be assessed on monthly audits.
- Quarterly compliance of regulation 225(c) will be reported by Administrator or designee at QAPI meeting.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/16/2017 et al		

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salerno, PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.227(a) - A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

2a. DESCRIPTION OF VIOLATION
Resident #1 was admitted to the home on [redacted]17; however, the resident's support plan was completed on 5/1/17.

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.

2600.227(a)

Immediate Correction:

- A new support plan was completed for resident #1 on 3-16-18 as a DHS request as result of this annual inspection.
- Resident #1 has a pcp appointment on 4-10-18 and will have a new DME completed at the appointment.
- Once DME is received, we will complete a new RASP and send to DHS.

Continued Compliance:

- Audit has been created to identify when support plans are due for residents on a regular schedule. This does not include a significant change. Audit will be managed by Administrator or designee.
- See copy of attached audit form.
- Monthly Quality Indicator for RASP audits will be conducted monthly by Administrator or designee to ensure continued compliance. Approximately 50% of charts will be assessed on monthly audits.
- Quarterly compliance of regulation 227(a) will be reported by Administrator or designee at QAPI meeting.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/16/2017 et al		

Signature of Legal Entity Representative (Required on EVERY Page): Kim Salvio, RCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Kim Salvio, RCHA — Date: 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.

2a. DESCRIPTION OF VIOLATION
Resident #1's support plan, dated 5/1/17, is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

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 [illegible] which the steps will be completed.

2600.227(g)

Immediate Correction:

- A new RASP was completed for resident #1 on 3-16-18 as a result of our annual DHS survey and VR.
- Resident was unable to sign newly completed RASP and this is indicated on the RASP.
- Resident does have a PCP appointment on 4-10-18 and will have a new DME completed and we will complete another RASP and review with POA and resident and attempt to have resident sign RASP after 4-10-18.

Continued Compliance:

- Audit has been created to identify when support plans are due for residents on a regular schedule. This does not include a significant change. Audit will be managed by Administrator or designee.
- Monthly Quality Indicator for RASP audits will be conducted monthly by Administrator or designee to ensure continued compliance. Approximately 50% of charts will be assessed on monthly audits.
- Quarterly compliance of regulation 227(g) will be reported by Administrator or designee at QAPI meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA — Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42966 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.251(c) - The home shall use standardized forms to record information in the resident's record.

2a. DESCRIPTION OF VIOLATION
Resident #2's medical evaluation, signed by the physician on 6/15/17, is not on the Department's current medical evaluation form, dated 6/2012.

Resident #3's medical evaluation,dated 2/6/18, is not on the Department's current medical evaluation form, dated 6/2012.

3. I 2600.251 (c) [illegible] 'oled

Immediate Correction:

- Resident #2 and Resident #3 both had new DME's completed on the current DME form dated 6/2012.
- See attached copies under page 15 violation report.
- Resident #2 completed 3-20-18
- Resident #3 completed 3-15-18

Continued Compliance:

- Discarded old printed DME forms. Completed 3-15-18.
- New DME forms printed from DHS website.3-15-18.
- When DHS notifies providers of new forms, will immediately institute new forms as required. Responsible Party: Administrator or designee.
- All resident charts will be audited for correct DME forms by 4-30-18. Responsible party is administrator or designee.
- If any resident DME is identified as being on an outdated form, a medical appointment with the resident physician will be scheduled in order to have a updated DME on correct documentation. Responsible Party: Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Salvio, PCHA

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

Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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

Plan of correction implementation status as of 3/23/18 (Date)

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

Violation Report: 42988 - 02/12/2018 - Garrigan, Laurie
PCH Name: REFORMED PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.252 - Each resident's record must include the following information: (1) through (26)

2a. DESCRIPTION OF VIOLATION
Resident #1's record does not include an inventory of the resident's belongings.

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.

2600.252

Immediate Correction:

- Staff completed an inventory sheet for Resident #1 on 3-14-18 and placed in resident record.
- See attached.

Continued Compliance:

- Audit of resident charts to assess for completed inventory sheets will be completed by 4-30-18.Responsible Party Administrator or designee.
- Blank inventory sheets will be added to the back of each resident door to allow residents/staff to document new items as they receive them by 4-30-18.Responsbile Party Administrator or designee.
- Monthly Indicator report to include updating inventory forms if new items were added or acquired by resident. Responsible Party Administrator or designee.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kim Selucio, RHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kim Selucio, RHA — Date 3-20-18

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

The above plan of correction is approved as of 3/23/18 (Date)

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