pennsylvania
DEPARTMENT OF HUMAN SERVICES

AUG 16 2018

Ms. Caroline DeAugustine
Executive Director
Shenango Presbyterian Seniorcare
238 South Market Street
New Wilmington, Pennsylvania 16142

RE: Shenango Presbyterian Home
Certificate #: 440340

Dear Ms. DeAugustine:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 9, 2018 and May 15, 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: SHENANGO PRESBYTERIAN HOME	License Number: 44034
Address: 238 SOUTH MARKET STREET, NEW WILMINGTON, PA 16142	County: Lawrence
Administrator: Shawna Bostaph	Region: WEST
Legal Entity Name: SHENANGO PRESBYTERIAN SENIORCARE	
Legal Entity Address: 238 SOUTH MARKET STREET, NEW WILMINGTON, PA 16142	

Certificate(s) of Occupancy
C-1
11/10/1981
PA Dept L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 43	Waking Staff: 32
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Renewal

On-Site Inspections Dates and Department Representatives On-Site
05/4/2018: Pfaff, Vicki; Garrigan, Laurie
05/15/2018: Pfaff, Vicki

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: 46	Number of Residents who:
Number of Residents Served: 34	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 34
Area: Woodside	Have Mental Illness: 0
Secured Dementia Unit Capacity, if Applicable: 14	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, if applicable: 8	Have a Mobility Need: 9
Number of Current Hospice Residents: 1	Have a Physical Disability: 0
Number of Hospice Residents in past year: 4	

Violation Report: 44034 - 05/15/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

WEST REGIONAL
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.65(i) - 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 annual 2017 training documentation for staff persons A, B, and C does not include the date of the training nor the length of each course for the topics covered.

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.

1. Corrected staff education tracking to include the staff person trained, date, source, content, length of each course and copies of any certificates received. (see attached)
2. Staff education coordinator(s) and human resources educated to regulation 2600.65(i). (see attachments)
3. Policy written regarding staff training. (see attachment)
4. Staff education coordinator(s) and human resources to be educated to policy by August 10, 2018.
5. A new system for tracking staff education began March 2018. (See attachment)
6. Administrator or designee will monitor quarterly to ensure education is being documented per regulation and report results at quarterly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawn M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawn M Bostaph — Date 7-31-18

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

The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

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

[*]

AUG 01 2018

Violation Report: 44034 - 05/16/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

WESTERN REGION FIELD OPS
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.102(i) - A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

2a. DESCRIPTION OF VIOLATION
On 5/9/18 at 11:11 a.m., there was no soap available in the private bathroom in resident room #124.

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.

1. Soap was immediately placed in resident's room the day of survey. (see attachment).
2. Families were notified and educated via email and nursing staff educated via shift report sheet and rounding 1:1 to ensure residents have appropriate nonpoisonous soap available.
3. Administrator or designee will audit 10% of occupied resident rooms in personal care monthly to ensure that soap is being provided and accessible to residents.
4. Administrator or designee will report results at monthly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph — Date 7-31-18

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The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

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

Violation Report: 44034 - 05/[illegible]/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.103(f) - Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

2a. DESCRIPTION OF VIOLATION
On 5/9/18 at 10:10 a.m., the temperature of freezer #6 in the home's kitchen measured 8 degrees Fahrenheit. At 1:00 p.m., the temperature again measured 8 degrees Fahrenheit.

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.

1. The freezer #6 was taken out of service immediately that day of the survey (May 9).
2. A new freezer was ordered on 5-11-18, delivered on May 25 and put into service on May 28, 2018.
3. Dietary staff check freezer temperatures twice a day and record on a log (see attachment). Any inappropriate temperatures are reported to supervisor.
4. Dietary supervisor or designee will report on freezer temperatures at quarterly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl — **Date** 7-31-18

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

The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

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

Violation Report: 44034 - 05/9/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

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

2a. DESCRIPTION OF VIOLATION
On 5/9/18 at 10:06 a.m., there was a white rag setting on top of domestic water heater #5 in the home's boiler room.

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

1. The white rag was immediately removed from the boiler in front of the surveyor.
2. Maintenance staff was educated and have/will sign off on the education regarding regulation 2600.125(a). (see attachment)
3. Maintenance staff will do a daily check of the boiler room to ensure no combustibles are in the area and document on an audit sheet beginning 7-18-18. (see attachment)
4. Maintenance director or designee will report on no combustibles in the boiler area at quarterly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawnee Bostyl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawne M Bostyl — Date 7-31-18

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

The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

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

Violation Report: 44034 - 05/16/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600
2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION
The home's most recent fire drill held during sleeping hours was conducted on 9/21/17 at 1:58 a.m.

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

1. Maintenance staff was educated and have/will sign off on the education regarding regulation 2600.132(e). (see attachment)
2. Fire Drill policy was updated to include that the person conducting the fire drill will ensure that all/most residents are sleeping prior to drill. (see attachment)
3. A fire drill was held on 7-25-18 at 3:02 am and all or most residents were sleeping.
4. Maintenance Director or designee will monitor fire drills and fire drill log to ensure that there are fires drills held during sleeping hours once every 6 months.
5. Maintenance director or designee will report results at monthly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawnem Bostpl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawnem Bostpl — Date 7-31-18

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

The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

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

RECEIVED

Violation Report: 44034 - 05/14/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

AUG 01 2018

WEST REGION FIELD OFFICE
Human Services Licensing

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

2a. DESCRIPTION OF VIOLATION
The home's fire drill records indicate that the "courtyard" was the only exit to evacuate the residents from the SDCU for all of fire drills conducted from 5/30/17 through 4/30/18.

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.

1. Maintenance staff was educated and have/will sign off on the education regarding regulation 2600.132(f). (see attachment)
2. Nursing staff was and will be educated via shift report, rounding 1:1 with staff, and during team meetings regarding regulation 2600.132(f)
3. A fire drill was held on 7-23-18 at 3:14 pm and residents in the SDCU were evacuated via an alternate exit other than the courtyard--out main Woodside door and out through fireside lounge. (see attachment)
4. Administrator or designee will monitor fire drills and fire drill log to ensure that residents in personal care are evacuated via alternate exit routes throughout the year.
5. Maintenance director or designee will report results at monthly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bastyk

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bastyk — **Date** 7-31-18

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

The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

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

Violation Report: 44034 - 06/15/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

The exit door from the SDCU dining room leads to a courtyard that has a gate with a magnetic locking system. There is no exit sign above the dining room door to the courtyard.

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.

1. Exit signs were immediately placed over the doors to the garden in the SDCU. (see attachment)
2. An audit will be completed by the administrator or designee monthly to ensure the exit signs are in place.
3. Administrator or designee will report results at monthly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostapl — Date 7-31-18

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The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 8-7-18 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress 6.
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 44034 - 05/[illegible]/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

WESTERN REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2800

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

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

2a. DESCRIPTION OF VIOLATION

Resident #10 is prescribed Acetaminophen 325mg tablet [Tylenol] take 2 tablets (650mg total) by mouth every 6 hours as needed for pain. However, the pharmacy label for the medication indicates Non-aspirin Pain Relief – take 2 tablets by mouth every 6 hours as needed for pain.

Resident #10 is prescribed Milk of Magnesia 400 mg/5 mL oral suspension [Magnesium hydroxide]; 30 mL by mouth daily as needed for constipation. However, the prescription label for this medication indicates Milk of Magnesia 30cc by mouth if no BM on Day 3 evening shift.

Resident #11 is prescribed Tylenol 325mg tablet [Acetaminophen], take 2 tabs; 650mg by mouth twice daily for pain. However, the prescription label for the medication indicates MAPAP 325mg 2 tabs by mouth twice daily.

Resident #11 is prescribed Tylenol 325mg tablet [Acetaminophen], take 2 tabs; 650mg by mouth every 4 hours as needed for pain. However, the prescription label for the medication indicates MAPAP 325mg 2 tabs by mouth every 4 hours as needed for pain.

Resident #11 is prescribed Doc-Q-Lax 8.6 mg-50 mg tablet [Sennosides-docusate sodium] – take 2 tablets by mouth at bedtime for constipation. However, the prescription label for the medication indicates Senexon 8.6-50 mg tab – take two tablets by mouth at bedtime.

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 9A of 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna Bostaph

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

Date 7-31-18

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

The above plan of correction is approved as of 8-7-18 (Date)

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

Plan of correction implementation status as of 9-7-18 (Date)

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

1. Pharmacy was contacted 5-14 and 5-15, 2018 and the pharmacy is to put alternate/generic names for medications on the label so that the pharmacy label matches the order/eMar. The labels for residents #10 and 11 were corrected.
2. All orders for Tylenol now read, "may substitute acetaminophen, MAPAP or Tactinal".
3. Medications received from pharmacies will be reviewed upon receipt to ensure the label matches the physician's order. If a discrepancy is noted, a sticker titled, "directions changed. Refer to Chart" will be placed on the label to notify staff that the directions are not correct and the pharmacy will be notified of the correct order.
4. Staff to receive education by August 10, 2018 to compare and review medication labels to the physician order of any medications received from the pharmacies, as well as education regarding the regulation. (see attachment)
5. The nurse or MT on night shift verifies when medications are delivered that the medication label matches the order and initial on the order sheet that they are correct.
6. The nurse or MT passing medications follows the 5 Rights and meds are checked against the orders 3 times before giving as per the med tech education. Any errors found are reported to the nurse.
7. Administrator or designee will do a monthly audit of physician orders and medication labels to ensure compliance.
8. Administrator or designee will report results at monthly QA meeting.

Shawna Bostaph 7-31-18
Shawna M Bostaph
8-7-18

Violation Report: 44034 - 05/[illegible]/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.233(a) - Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

2a. DESCRIPTION OF VIOLATION

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority permitting the use of a magnetic locking system.

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.

1. Contacted local and government officials to obtain the written approval for the specific locking system.
2. Will continue working with the contacted officials and local building code official to get the letter within the next 60 days.
3. Administrator or designee will report results at monthly QA meeting.

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

Signature of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Shawna M Bostaph — Date 8-1-18

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

Plan of correction implementation status as of 8-7-18 (Date)

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

Violation Report: 44034 - 05/15/2018 - Pfaff, Vicki
PCH Name: SHENANGO PRESBYTERIAN HOME

1. REGULATION 55 Pa.Code §2600

2600.234(a) - Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

2a. DESCRIPTION OF VIOLATION

Resident #9 was admitted to the home's SDCU on 3/9/18. However, the resident's initial support plan was not completed until 3/13/18.

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.

1. Personal care staff to be educated to Regulation 2600.234(a) by reviewing the Resident Assessment and Service Plan policy (see attached) and the "Preadmission screening, Medical Evaluation, and Assessment-Support Plan: Best Practices from the RCG and review appropriate RASP completion dates by August 10, 2018.
2. Administrator or designee will monitor a sample of support plans for compliance monthly.
3. Administrator or designee will report results at monthly QA meeting.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Dawna M Bostaph			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Dawna M Bostaph	Date	7-31-18	

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

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Plan of correction implementation status as of 8-7-18 (Date)

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