



pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUL 3 1 2018

Ms. Trisha L. Johnson, LPN
Personal Care Home Administrator
Senior Care – OLM South LLC
6157 28th Street 7
Grand Rapids, Michigan 49546

RE: Oak Leaf Manor Personal Care
Retirement Home
2101 Wabank Road
Millersville, Pennsylvania 17551
Certificate #: 333260

Dear Ms. Johnson:

As a result of the Department of Human Services' annual licensing inspection on May 30 and 31, 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,

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

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

PCH Name: OAK LEAF MANOR PERSONAL CARE RETIREMENT 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 5/30/18, the following containers were found unlocked and accessible in Room D13 of the Secured Dementia Care Unit:
- An 8 ounce bottle of "Secura Personal Cleanse Spray" with a manufacturer's label indicating, "If accidentally ingested, call Poison Control"
- A 3 ounce stick of "Old Spice Pure Sport Antiperspirant Deodorant" with a manufacturer's label indicating, "If swallowed, get medical help or call Poison Control"
- A 2.9 ounce tube of "Crest Tartar Protection Toothpaste, with a manufacturer's label indicating, "If accidentally swallowed get medical help or contact medical help or call Poison Control"

Residents of the Secured Dementia Care Unit have not been assessed capable of recognizing and using poisons safely.

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.

All residents in Secured Dementia Unit have a locked cabinet under their sink in each bathroom. All poisonous materials or potentially poisonous materials are to be locked in these cabinets at all times unless supervised by a staff or family member. Staff have been re-educated and will be continuously reminded of the importance of this regulation at each staff meeting. Friendship Place Unit Coordinator will complete monthly audit to ensure compliance. Please review attached audit (Attachment #1)

These actions will begin immediately. Unit coordinator has gone through each resident room to ensure all poisonous materials are properly locked up.

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

Signature of Legal Entity Representative (Required on EVERY Page) *Trisha Johnson*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Trisha K. Johnson LPA RCHA* Date *7/6/18*

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

The above plan of correction is approved as of 7-19-18 (Date)

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

Plan of correction implementation status as of 7-19-18 (Date)

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

Violation Report: 33328 - 06/30/2018 - OPake, Hope
 PCH Name: OAK LEAF MANOR PERSONAL CARE RETIREMENT HOME

1. REGULATION 55 Pa.Code §2800
 2600.107(c) - The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

2a. DESCRIPTION OF VIOLATION
 On 5/30/18, the home had 57 residents, but only 22 gallons of emergency drinking water.

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.

An adequate amount of water supply (22 gallons) has been placed in our climate controlled shed which remains on property. Director of maintenance will monitor water supply and replace as supply expires. Please review attachment #2 (Picture of supply)
 This was completed on 7/1/18.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Trisha L. Johnson LPN PCHA</i>	Date <i>7/6/18</i>
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The above plan of correction is approved as of 7-19-18
 (Date)

Plan of correction implementation status as of 7-19-18
 (Date)

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

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

Violation Report: 33326 - 05/30/2018 - O'Pake, Hope
 PCH Name: OAK LEAF MANOR PERSONAL CARE RETIREMENT HOME

1. REGULATION 55 Pa.Code §2600
 2600.127(a) - Portable space heaters are prohibited.

2a. DESCRIPTION OF VIOLATION

On 5/30/18, a decorative fireplace which produces heat, was located in the lobby area. The space heater plugs into the wall and was not hard-wired.

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 heating element on this fireplace has been disabled. The fireplace can no longer produce heat. Please review attached product manual as reference. Attachment #3
 This was disabled on 7/1/18.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Trisha L. Johnson*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Trisha L. Johnson LPA/PCA* Date *7/6/18*

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

The above plan of correction is approved as of <u>7-19-18</u> (Date)	Plan of correction implementation status as of <u>7-19-18</u> (Date)
The above plan of correction was approved by <u>BE</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

Violation Report: 33326 - 05/30/2018 - O'Pake, Hope
 PCH Name: OAK LEAF MANOR PERSONAL CARE RETIREMENT HOME

1. REGULATION 55 Pa.Code §2600
 2600.132(b) - A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

2a. DESCRIPTION OF VIOLATION
 The last fire safety inspection was conducted in 2016.

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.

Fire Safety inspection was completed in August³ 2017 by Blue Rock Fire Department. Proper documentation of inspection was not available at time of inspection. Documentation has been requested & received by Administrator. Administrator to audit DHS survey ready binder to ensure proper inspections have been completed and documentation provided.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Tasha L. Johnson LPN RCHHA</i>	Date <i>7/6/18</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 7-19-18
 (Date)

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

Plan of correction implementation status as of 7-19-18
 (Date)

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

Violation Report: 33326 - 05/30/2018 - O'Pake, Hope
 PCH Name: OAK LEAF MANOR PERSONAL CARE RETIREMENT HOME

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

The home has procedures for the safe use of medications and medical equipment, but not all staff implement them, as evidenced by glucometer readings and documentation that do not match, for multiple residents on multiple dates.

- Resident #1's 5/15/18 blood sugar readings of 141, 131, and 110 don't appear on the Medication Administration Record (MAR). An additional number of 131 on the glucometer doesn't appear on the MAR for Resident #1, but does appear on Resident #2's MAR.

- Resident #2's 5/23/18 glucometer reading of 160 appears as 170 on MAR. The 5/22/18 reading of 92 doesn't appear on the MAR. The 5/12/18 reading of 126 appears as 119 on the MAR, and the 5/7/18 reading of 254 does not appear on the MAR.

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.

All medication technicians and licensed practical nurses have been re-educated on the proper procedures for conducting peak checks, safety precautions to be used and proper documentation. Weekly glucometer audits will be conducted by Director of Nursing for 2 months then to be completed monthly if compliant in previous weeks. Please review attached audit sheet (Attachment #4 & #5)

Training was completed on 7/1/18 & 7/2/18. Audits will begin immediately. Documentation will be kept by the home. - BE

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Trisha L. Johnson*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Trisha L. Johnson LPN RCH* Date *7/6/18*

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

The above plan of correction is approved as of 7-9-18 (Date)

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

Plan of correction implementation status as of 7-19-18 (Date)

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