



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 09 2019

Ms. Lori Lasosky
Owner/Administrator
Lasosky's Personal Care Home, Inc.
200 Nobles Road
Brownsville, Pennsylvania 15417

RE: Lasosky's Personal Care Home
23 Main Street
Clarksville, Pennsylvania 15322
Certificate #: 418580

Dear Ms. Lasosky:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 6, 2018, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report 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
Violation Report

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

2600.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2a. DESCRIPTION OF VIOLATION

At 9:00 AM, confidential information for several residents to include the following was unlocked, unattended and accessible in the opened office:

- * Physician prescriptions for residents #1 and #2
- * Billing status for residents #3 and #4
- * Denied approval of refills for resident #5's Lithium and Doxepin
- * Resident #6's diagnoses of stage 3 lung/brain cancer and congestive heart failure

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.

New lock was purchased that uses thumb print. making it easier to lock and re lock door. All supervisors were educated on the importance of locking the office door.

_____ of all areas of the home *SE* 4/17/19

Supervisor will make random checks throughout the day to ensure compliance.

On 4/17/19, the administrator conducted a staff meeting and re-educated staff regarding the importance of confidentiality of resident records and the procedures for maintaining resident records in a secure location.

SE 4/17/19

Lori Lasosky
Administrator

4/17/19

Repeat Violation: Yes | Date(s) of Previous Violation(s): 07/06/2017 |

Signature of Legal Entity Representative
(Required on EVERY Page)

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

Date

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

The above plan of correction is approved as of 4/17/19
(Date)

Plan of correction implementation status as of 4/17/19
(Date)

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

The above plan of correction was approved by _____

SE
(Initials)

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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

2a. DESCRIPTION OF VIOLATION
 A quality management review has not been completed since 4/6/17.

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.

The home has a quality management plan. Please see attached plan and meetings. The administrator had to leave prior to inspection completed.

Supervisors educated regarding the location of plan and meeting minutes.

The home conducted an annual Quality Management Meeting on 4/2/18.

 4/17/19


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

Signature of Legal Entity Representative (Required on EVERY Page)	
--	---

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Administrator	4/11/19

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

The above plan of correction is approved as of 4/17/19
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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

2a. DESCRIPTION OF VIOLATION

On 7/1/18 at 7:30 AM, resident #13's glucometer was used to measure resident #11's blood glucose level.
 On 7/3/18 at 9:00 AM, a glucometer labeled "Spare Kit" was used to measure resident #12's blood glucose level.
 On 7/5/18 at 9:00 AM, resident #11's glucometer was used to measure resident #12's blood glucose level.

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 staff educated on the importance of using the correct glucometer. Supervisor to check glucometers 1x per week to ensure compliance.

The home replaced glucometers for resident #11, resident #12 and resident #13 on 7/6/18.

SE 4/17/19

Immediately, the home shall review all glucometers to ensure each is labeled to identify the specific resident it is to be used upon. If a spare glucometer is maintained by the home for emergencies, it shall become the glucometer of the resident it was used upon and not used on any other residents.

SE 4/17/19

On 7/10/18, resident #11, resident #12 and resident #13's physician was notified of the possibility of shared glucometer use. The physician did not require any additional testing.

SE 4/17/19

Immediately, then at least once per week for 3 months, the administrator or designated staff person qualified to administer medication shall observe each staff person responsible for diabetic care perform blood glucose checks to ensure each resident glucometer is used only for the resident to whom it belongs. Documentation of the observations shall be maintained by the home for Department review.

SE 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *Jaw Lasosky*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Administrator* Date *4/11/19*

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

The above plan of correction is approved as of 4/17/19
 (Date)

Plan of correction implementation status as of 4/17/19
 (Date)

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

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600
 2600.89(b) - Hot water temperature in areas accessible to the resident may not exceed 120°F.

2a. DESCRIPTION OF VIOLATION

At 10:50 AM, the hot water temperature, at the sink in the first floor common restroom near the office, was 126.5 degrees Fahrenheit.
 At approximately 12:05 PM, the hot water temperature, at the sink in the common restroom past the dining room in the rear addition, was 122.9 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.

Water temperature was turned down and to 117 degrees. Staff will monitor water temperatures weekly to ensure compliance.

The home developed a "Supervisor Weekly Checklist", to be completed every Monday. The checklist includes glucometers, water temperature, insulin given correctly, first aid kit, and a location for staff to initial and date when completed.

 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons regarding safe water temperatures and the risk of unsafe water temperatures to residents. Any unsafe water temperature discovered shall immediately be reported to the administrator.

 4/17/19

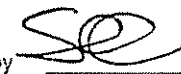
Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Administrator Date 4/11/19

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

The above plan of correction is approved as of 4/17/19
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

2600.92 - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

2a. DESCRIPTION OF VIOLATION

There was no screen in the operable window of the first floor common restroom near the office. The restroom did not have an exhaust fan.

There was no screen in the opened window of resident #14's bedroom which is located in the rear addition of the first floor.

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.

Screen will be added by 04/17/2019. Maintenance will check screens monthly to ensure compliance.

Due to a delay in delivery of materials, an extension has been granted until 4/24/19 to install the screen.

 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that all windows, including doors with windows must be in good repair, and all operable windows must have screens that are securely attached and in good repair. Any deficiencies discovered shall immediately be reported to the administrator and repaired or replaced.

 4/17/19

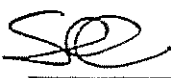
Repeat Violation: No	Date(s) of Previous Violation(s):			
----------------------	-----------------------------------	--	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Administrator	Date 4/11/19
---	--------------

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

The above plan of correction is approved as of 4/17/19
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600
 2600.94(b) - Interior stairs, exterior steps and ramps must have nonskid surfaces.

2a. DESCRIPTION OF VIOLATION
 There were either no nonskid surfaces or the nonskid strips were not well-secured on the top 12 steps of the fire escape.

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.

Non slip strips will be added by 04/17/2019. Maintenance will check outside building monthly to ensure good repair.

Due to a delay in delivery of materials, an extension has been granted until 4/24/19 to install non slip strips.

 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that interior stairs, exterior steps and ramps must have nonskid surfaces. Any hazards found shall immediately be reported to the administrator and repaired or replaced.

 4/17/19


Repeat Violation: Yes	Date(s) of Previous Violation(s):	07/06/2017		
-----------------------	-----------------------------------	------------	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Administrator Date 4/11/19

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

The above plan of correction is approved as of 4/17/19
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600


2600.96(a) - The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

2a. DESCRIPTION OF VIOLATION

There were no scissors, thermometer or tweezers in the first aid kit in the medication 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.

on 7/6/18  4/17/19
 Scissors, thermometer and tweezers were added. The kit is sealed so that items are not removed.
 Supervisor will check the kit weekly to ensure compliance if opened.

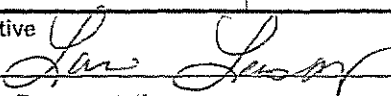
On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons on the need to maintain proper first aid kit contents and the uses for each item in the event of an emergency.

 4/17/19

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)



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

Administrators

Date

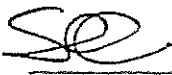
4/17/19

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

The above plan of correction is approved as of 4/17/19
 (Date)

Plan of correction implementation status as of 4/17/19
 (Date)

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

The above plan of correction was approved by 
 (Initials)

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600
 2600.101(j)(7) - Each resident shall have the following in the bedroom: An operable lamp or other source of lighting that can be turned on at bedside.

2a. DESCRIPTION OF VIOLATION
 Resident #10 did not have a source of lighting that can be turned on/off from bedside.

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

on 7/6/18 *SE* 4/17/19
 Lamp was placed at bedside. Supervisor will make rounds monthly to ensure appropriate room equipment in place.

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that each resident shall have an operable lamp or other source of lighting that can be turned on at bedside. Any damaged or missing light sources shall immediately be reported to the administrator and repaired or replaced.

SE 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *Jim Lasosky*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Administrator* Date *4/11/19*

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

The above plan of correction is approved as of 4/17/19
 (Date)

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

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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
 At 11:00 AM, there was no thermometer in the Frigidaire refrigerator or the chest freezer in the basement.

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.

Thermometer added. Supervisor will check for thermometer weekly when putting food order away.

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that 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. The administrator shall be notified immediately if any thermometers are missing or if refrigerator temperatures are above 40°F or freezer temperatures are above 0°F.


 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Admunes trator Date 4-11-19

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

The above plan of correction is approved as of <u>4/17/19</u> (Date) The above plan of correction was approved by  (Initials)	Plan of correction implementation status as of <u>4/17/19</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
---	--

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

2a. DESCRIPTION OF VIOLATION

There was a chair placed upside down and covering 18" of the bottom step of the fire escape.

There was a bed partially blocking the emergency exit in resident #7's bedroom.

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.

Bed removed from room. Housekeeper to monitor fire escapes during routine cleaning.
 The chair at the bottom of the fire escape was removed 7/6/18.

 4/17/19


A new resident was admitted to the home on 4/17/19 and has been assigned the bed in room #7 that was previously removed. The bed is positioned in such a way as to not block the emergency exit.

 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Any obstructions found shall be immediately reported to the administrator and removed.

 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) 


Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Administrator Date 4-11-19

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

The above plan of correction is approved as of 4/17/19
 (Date)

Plan of correction implementation status as of 4/17/19
 (Date)

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

The above plan of correction was approved by 
 (Initials)

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

The emergency preparedness plan for the municipality was not posted in a conspicuous and public place in the home. It was kept in the office.

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.

Emergency plan posted. See photo attached. Administrator to check weekly to ensure it isn't removed.

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept. Staff shall notify the administrator immediately if the emergency preparedness plan for the home or the municipality is found to be missing, at which time the administrator will immediately re-post the missing plan(s).

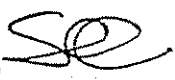
 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Administrative</i>	Date <i>4-11-19</i>
---	---------------------

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

The above plan of correction is approved as of <u>4/17/19</u> (Date) The above plan of correction was approved by  (Initials)	Plan of correction implementation status as of <u>4/17/19</u> (Date) <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: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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 does not include the exit route(s) used, the number of residents in the home at the time of the drill or the number of residents evacuated during the following fire drills:

- * 1/21/18 at 5:00 AM
- * 2/17/18 at 2:00 PM
- * 3/15/18 at 8:00 AM
- * 4/19/18 at 3:00 PM
- * 5/20/18 at 7:00 PM
- * 6/10/18 at 5:00 AM

Also, the fire drill log does not designate AM or PM for the fire drill held on 11/10/17 at 1:15.

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.

Supervisors educated regarding fire drills and exit routes. Administrator will monitor monthly drills for compliance.

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that 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.

 4/17/19

Immediately, the administrator or designated staff person shall audit the fire drill log directly after each fire drill to ensure 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 is documented on the log.

 4/17/19

Repeat Violation: Yes	Date(s) of Previous Violation(s):	07/06/2017
-----------------------	-----------------------------------	------------

Signature of Legal Entity Representative
 (Required on EVERY Page) 


Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Administrative</i>	Date <i>4-11-19</i>
---	---------------------

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

The above plan of correction is approved as of 4/17/19
 (Date)

Plan of correction implementation status as of 4/17/19
 (Date)

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

The above plan of correction was approved by 
 (Initials)

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600
 2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant, or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

2a. DESCRIPTION OF VIOLATION
 Resident #13 was admitted on 8/31/17; however, the resident's medical evaluation was completed on 5/31/17 which is greater than 60 days prior to admission.
 Resident #12 was admitted on 1/5/18; however, a medical evaluation has not been completed.

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.

for resident #12 on 6/15/18. *SE* 4/17/19
 Medical evaluations have been completed. An extra staff person has been added to the schedule weekly to permit supervisors time to audit residents files.

Between 7/6/18 and 8/31/18, the administrator reviewed all resident records to ensure all residents had a current medical evaluation form completed and present in each resident file.

SE 4/17/19

Repeat Violation: Yes	Date(s) of Previous Violation(s):	11/21/2017
-----------------------	-----------------------------------	------------

Signature of Legal Entity Representative
 (Required on EVERY Page) *Lou Lord*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Administrator</i>	Date <i>4-11-19</i>
--	---------------------

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

The above plan of correction is approved as of <u>4/17/19</u> (Date)	Plan of correction implementation status as of <u>4/17/19</u> (Date)
The above plan of correction was approved by <u><i>SE</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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 #11's current medical evaluation was completed on 3/1/17.

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.

Resident 11's medical evaluation has been completed. An additional staff added to schedule 1x week to permit supervisors time to audit records.

*All Supervisors Educated Regarding
 timelines for Resident Records.*

Between 7/6/18 and 8/31/18, the administrator reviewed all resident records to ensure all residents had a current medical evaluation form completed and present in each resident file.

SE 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *Lari Lesor*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Administrative</i>	Date <i>4-11-19</i>
---	---------------------

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

The above plan of correction is approved as of <u>4/17/19</u> (Date) The above plan of correction was approved by <u><i>SE</i></u> (Initials)	Plan of correction implementation status as of <u>4/17/19</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
--	--

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

2600.162(c) - Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

2a. DESCRIPTION OF VIOLATION

The menu for the current week of July 2nd to July 8th was posted. However, the following week's menu was not posted.

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

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

Staff responsible for menus has been re-educated regarding posting menus. Administrator will check weekly to ensure compliance.


On 7/6/18, the administrator posted the menu for the week of 7/9/18 to 7/15/18.

 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons that weekly menus shall be posted 1 week in advance in a public and conspicuous place. Staff shall notify the administrator immediately if a menu is found to be missing, at which time the administrator will immediately re-post the menu.

 4/7/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	07/06/2017
-----------------------	-----------------------------------	------------

Signature of Legal Entity Representative
 (Required on EVERY Page) 


Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Admin Whelan Date 4-11-19

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

The above plan of correction is approved as of 4/17/19
 (Date)

Plan of correction implementation status as of 4/17/19
 (Date)

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

The above plan of correction was approved by 
 (Initials)

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

2600.171(b)(5) - If staff persons or volunteers of the home provide transportation for the residents, the vehicle must have a first aid kit with the contents in § 2600.96 (relating to first aid kit).

2a. DESCRIPTION OF VIOLATION

There were no nonporous disposable gloves, eye coverings or thermometer in the car used to transport residents.

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

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

on 7/6/18. *SE* 4/17/19
 These items were added to the car. Administrator will check monthly to ensure compliance.

The home developed a "Supervisor Weekly Checklist", to be completed every Monday. The checklist includes glucometers, water temperature, insulin given correctly, first aid kit, and a location for staff to initial and date when completed.

SE 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated all staff persons transporting residents regarding the requirements of a first aid kit in the vehicle that includes all of the required contents in accordance with regulation 2600.96.

SE 4/17/19

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Jai Lasosky

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

Administrator

Date *4-11-19*

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

The above plan of correction is approved as of 4/17/19
 (Date)

Plan of correction implementation status as of 4/17/19
 (Date)

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

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600
 2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
 (1) The resident's name.
 (2) The name of the medication.
 (3) The date the prescription was issued.
 (4) The prescribed dosage and instructions for administration.
 (5) The name and title of the prescriber.

2a. DESCRIPTION OF VIOLATION
 The bag containing resident #13's Victoza insulin pen did not include instructions for administration and the original container with a pharmacy label was not available.

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.

Pharmacy sending labels for insulin pens so they may be kept in a bag. Supervisors will monitor this weekly along with glucometers.

On 7/6/18, the pharmacy provided labels for insulin pens so they could be kept in a bag.

 4/17/19


Immediately, then at least monthly, a designated staff person qualified to administer medications shall audit prescription medications to ensure they are stored in their original container and labeled with a pharmacy label that includes the resident's name, the name of the medication, the date the prescription was issued, the prescribed dosage, instructions for administration and the name and title of the prescriber. The pharmacy label and the MAR shall be compared to the prescriber's order. Any discrepancies shall be verified with the prescriber and immediately corrected.

 4/17/19

On 4/17/19, the administrator conducted a staff meeting and re-educated staff that the original container for prescription medications shall be labeled with a pharmacy label in accordance with regulation 2600.184(a).

 4/17/19


Repeat Violation: Yes	Date(s) of Previous Violation(s):	07/06/2017	
-----------------------	-----------------------------------	------------	--

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Administrator	Date 4-11-19
---	-----------------

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

The above plan of correction is approved as of 4/17/19
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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 #11's glucometer was not calibrated to the correct time.

Resident #13's glucometer was not calibrated to the correct time.

Resident #12's glucometer was not calibrated to the correct date and time.

Resident #12's July 2018 medication administration record (MAR) included multiple blood glucose levels that did not correspond to the blood glucose readings in the resident's glucometer to include the following:

- * On 7/4 at 9:00 PM, the MAR indicated 280; however, the glucometer indicated 230.
- * On 7/3 at 5:00 PM, the MAR indicated 129; however, the glucometer indicated 139
- * On 7/2 at 12:00 PM, the MAR indicated 86; however, the glucometer indicated 84.
- * On 7/1 at 9:00 PM, the MAR indicated 218; however, the glucometer indicated 216.
- * On 7/1 at 12:00 PM, the MAR indicated 121; however, the glucometer indicated 125.
- * On 7/1 at 9:00 AM, the MAR indicated 115; however, the glucometer indicated 105.

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 staff re-trained regarding appropriate documentation of glucometers. Supervisors will check the glucometers weekly.

The home developed a "Supervisor Weekly Checklist", to be completed every Monday. The checklist includes glucometers, water temperature, insulin given correctly, first aid kit, and a location for staff to initial and date when completed.

 4/17/19

Immediately, then at least once per week for 3 months, the administrator or designated staff person qualified to administer medication shall observe each staff person responsible for diabetic care perform blood glucose checks to ensure each resident glucometer is calibrated to the correct date and time, used only for the resident to whom it belongs, and the blood glucose reading is accurately documented in the resident's MAR. Documentation of the observations shall be maintained by the home for Department review.

 4/17/19

Repeat Violation: Yes	Date(s) of Previous Violation(s):	11/21/2017	
-----------------------	-----------------------------------	------------	--

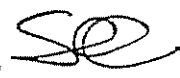
Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <u>Administrator</u>	Date <u>4-11-19</u>
---	---------------------

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

The above plan of correction is approved as of 4/17/19
(Date)

Plan of correction implementation status as of 4/17/19
(Date)

The above plan of correction was approved by 
(Initials)

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

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600
 2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #13 is prescribed blood glucose levels before meals with Novolog insulin sliding scale coverage as follows (U=Units): <70 = 0U, 80-100 = 2U, 101-120 = 4U, 121-150 = 8U, 151-200 = 11U, 201-250 = 15U, 251-300=18U, 301-350=22U, 351-400=26U, 401-450=29U.

On 7/2/18 at 7:30 AM, resident #13's blood glucose level was 202 and 11 units of Novolog were administered; however, 15 units should have been administered.

Resident #12 is prescribed blood glucose levels 4 times a day with Novolog insulin sliding scale coverage as follows (U=Units): 70-130=0U, 131-180=2U, 181-240=4U, 241-300=6U, 301-350=8U, 351-400=10U, >400=12U and call physician.

On 7/5/18 at 12:00 PM, resident #12's blood glucose level was 273 and 4 units of Novolog were administered; however, 6 units should have been administered.

On 7/4/18 at 9:00 PM, resident #12's MAR indicated a blood glucose level of 280 with 6 units of Novolog administered; however, the glucometer reading indicated a blood glucose level of 230 requiring 4 units of insulin.

On 7/3/18 at 5:00 PM, resident #12's MAR indicated a blood glucose level of 129 with no insulin administered; however, the glucometer reading indicated a blood glucose level of 139 requiring 2 units of insulin.

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.

Sliding scales have been added to the e-mar. All staff re-educated regarding proper documentation and administration of insulin.


The home developed a "Supervisor Weekly Checklist", to be completed every Monday. The checklist includes glucometers, water temperature, insulin given correctly, first aid kit, and a location for staff to initial and date when completed.

 4/17/19

Immediately, then at least once per week for 3 months, the administrator or designated staff person qualified to administer medication shall observe each staff person responsible for diabetic care perform blood glucose checks to ensure the glucometer is used only for the resident to whom it belongs, and the blood glucose reading is accurately documented in the resident's MAR. The observer shall also check the amount of insulin distributed based on sliding scale to ensure the prescriber's orders are followed. Documentation of the observations shall be maintained by the home for Department review.

 4/17/19


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

Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Administrator	Date 4-11-19
---	--------------

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

The above plan of correction is approved as of 4/17/19
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 4/17/19
 (Date)

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

Violation Report: 41858 - 07/06/2018 - Barons, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

1. REGULATION 55 Pa.Code §2600

2600.224(a) - A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

2a. DESCRIPTION OF VIOLATION

Resident #12 was admitted on 1/5/18; however, a preadmission screening form has not been completed.

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.

for resident #12 on 6/11/18. *SE* 4/17/19

Preadmission screening was completed. An additional staff has been added weekly to permit supervisors time to complete proper paperwork and audit records.

Between 7/6/18 and 8/31/18, the administrator reviewed all resident records to ensure all residents had a preadmission screening form completed and present in each resident file.

SE 4/17/19

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Administrator</i>	Date <i>4-11-19</i>
--	---------------------

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

The above plan of correction is approved as of <u>4/17/19</u> (Date) The above plan of correction was approved by <u><i>SE</i></u> (Initials)	Plan of correction implementation status as of <u>4/17/19</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
--	--

Violation Report: 41858 - 07/06/2018 - Barone, Barbara
 PCH Name: LASOSKY S PERSONAL CARE HOME INC

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 #11's current assessment was completed on 3/1/17.

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.

Residents assessment was completed. An additional staff member has been added 1x week to ensure proper Documentation is completed and records will be ordered.

*Supervisors Educated regarding
 time lines for Resident Records.*

Between 7/6/18 and 8/31/18, the administrator reviewed all resident records to ensure all residents had a current assessment form completed and present in each resident file.

SE 4/17/19

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *Lan Lasoy*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Administratrix* Date *4-11-19*

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

The above plan of correction is approved as of 4/17/19
 (Date)

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

Plan of correction implementation status as of 4/17/19
 (Date)

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