pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAR 13 2019

Ms. Robyn Burns
Administrator
Hayes Manor, Inc.
2210 Belmont Avenue
Philadelphia, Pennsylvania 19131

RE: Hayes Manor
License #: 142230

Dear Ms. Burns:

As a result of the Department's Bureau of Human Services Licensing annual inspection on December 7, 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 (relating to Personal Care Homes) 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
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: HAYES MANOR	License Number: 14223
Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA 19131	County: Philadelphia
Administrator: Robyn Burns	Region: SOUTHEAST
Legal Entity Name: HAYES MANOR INC	
Legal Entity Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA 19131	

RECEIVED
FEB 01 2019
By

Certificate(s) of Occupancy
I-2
04/12/1985
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Staffing Hours
Resident Support: 72 | Total Daily Staff: 122 | Waking Staff: 92

Type of Inspection: Full | BHA Docket Number: | Notice: Unannounced

Reason(s) for Inspection(s)
Renewal, Complaint

On-Site Inspections Dates and Department Representatives On-Site
12/07/2018: Freeman, Sabrina; Gillespie, Denise

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: 65	Number of Residents who:
Number of Residents Served: 41	Receive Supplemental Security Income: 3
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 41
Area:	Have Mental Illness: 10
Secured Dementia Unit Capacity, If Applicable:	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, If applicable:	Have a Mobility Need: 9
Number of Current Hospice Residents: 1	Have a Physical Disability: 2
Number of Hospice Residents in past year: 1	

Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600
2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION
On 12/7/18, during resident interviews at least two residents confirmed that resident #1 violently and physically attacked them on the elevator. Staff persons also confirmed during staff interviews that resident #1 has physically attacked residents. Based on a review of the home's internal incident/accident report, it was documented that resident #3 was hit by resident #1. The home failed to report these incidents to the Department.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident #2's reportable incident report was completed within 24 hours on Oct 7, 2018 and sent to the department. A copy of the fax and conformation is included.
Resident #3's was omitted by staff in the administrator's absence. To correct the violation an incident was completed upon receiving the violation on December 7th and is attached and kept on file.
All direct care staff employees have been in-serviced on abuse and incident reporting, the regulation, and proper reporting of all incidents. This was completed by 12-21-18.
All employees have been instructed to contact administrator immediately regarding all incidents regardless of the circumstances.
Moving forward all incident will be properly reported to the department or required agencies according to the regulation within 24 hours.
The administrator will personally handle all incident and abuse reporting. In her absence this will be done by the director of nursing.

The Administrator will ensure all reportable incidents are reported to the Departments regional office within 24 hours. SP 02-20-19

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Mebyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Mebyn Burns - Administrator	Date	1/31/19	

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

The above plan of correction is approved as of 02-20-19 (Date)

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

Plan of correction implementation status as of 02-01-19 (Date)

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

Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600
2600.16(f) - The home shall keep a copy of the report of the reportable incident or condition.

2a. DESCRIPTION OF VIOLATION
The home has not retained a copy of the 9/12/18 incident in which resident #1 violently and physically attacked resident #3 on the elevator.

The home did not document, report, or keep a copy of this incident in resident #3's record.

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.

To correct the violation an incident report was completed for resident #3 on December 7, 2019 and is attached to the violation report. The report was omitted by the staff in the administrator's absence.
All direct care staff employees have been in-serviced on abuse and incident reporting, the regulation, and proper reporting of all incidents. This was completed by 12-21-18. A copy of the in-service is attached.
All employees have been instructed to contact administrator immediately regarding all incidents regardless of the circumstances.

Moving forward all incident will be properly reported to the department or required agencies according to the regulation within 24 hours.
A detailed incident report will be completed by the administrator or director of nursing in her absence. The incident will be called in and sent to the department according to the regulations, and a copy will be kept on file.

The Administrator will ensure the home has a policy for keeping track of reportable incidents that were sent to the Department. SP 02-20-19

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Robyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1/31/19	

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Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600
2600.18 - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2a. DESCRIPTION OF VIOLATION
Personal care homes must post the required influenza information in a public place in the home year - round according to the Influenza Awareness Act (HB 1785). The home did not have an influenza poster anywhere.

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.

At the time of the inspection the influenza poster was posted in the front and security office, and when the inspector stated that it needed to be posted where it could be easily seen. To correct the violation copies or the poster was made and immediately display in several places throughout the building including the information board, nursing station, and employee time clock.
All front office staff and department heads have been made aware of the violation and will observed for posters when making rounds.

Moving forward upon making daily rounds the administrator will monitor for the Influenza Awareness Act Poster to ensure that it can be well viewed year-round in public places in the building.
The administrator will periodically check for updates from the CDC and department.

The Administrator will ensure the influenza poster is always visible in a conspicuous place in the home.
SP 02-20-19

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Signature of Legal Entity Representative (Required on EVERY Page)	Robyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1 | 30 | 19	

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Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600
2600.42(c) - A resident shall be treated with dignity and respect.

2a. DESCRIPTION OF VIOLATION
On 12/7/18, during resident interviews at least two residents confirmed that resident #1 violently and physically assaulted them on the elevator. Staff persons also confirmed during staff interviews that resident #1 has physically attacked residents.

Resident #2 stated he will not ride the elevator with resident #1. He stated that resident #1 is an unpredictable racist. Resident #2 said resident #1 was trying to get on the elevator when he was already on the elevator. He said resident #1 stated, "get out my way N word" and then punched him in the face. Resident #2 stated two staff persons were present and separated the two. Resident #2 stated he went to his room and called the police. He was attacking me the whole ride down from the 2nd floor to the 1st floor. Resident #2 is in a wheel chair and resident #1 was ambulatory at the time of the attack.

Resident #3 resides on the 2nd floor, she stated she got on the elevator on the 2nd floor and pushed the button to go down to the 1st floor. She stated if someone on the 3rd floor pushes the elevator button the elevator will go up before it goes down. Resident #1 use to reside on the 3rd floor. Resident #3 pushed the elevator button to go down to the first floor, but the elevator went to the 3rd floor as resident #3 pushed the button to also go down to the 1st floor. Resident #3 is in a wheel chair and resident #1 was ambulatory at the time of the attack. Resident #3 stated as soon as resident #1 got on the elevator he started verbally abusing her, cursing and calling her racial epithets and was violently and physically attacking her. She stated he hit her in the face and head multiple times, from the time he got on the elevator on the 3rd floor until the elevator got to the 1st floor. She stated she had a small bruise on her face.

Per nurse's note, on 9/17/18, "resident #3 spoke to administrator regarding the incident. The Administrator suggested that resident not use the elevator when this resident is on the elevator she also offered to have an RA escort her on the elevator. She refused stated, 'that's not necessary.'"

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.

Please see attached

Residents to be treated with dignity and respect, and protected in home at all times. Staff will be trained on resident's rights. All Documentation will be available for Department review.
SP 02-20-19

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Nakeya Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Nakeya Burns - Administrator	Date	1/31/19	

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Plan of correction implementation status as of 02-01-19 (Date)

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- ☐ Not Implemented

Plan of Correction for 2600.42(c)

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Fix the immediate problem

- Resident #1 was moved to the 1st floor to prevent any further interactions or altercations with residents # 2 & 3.
- The mobile crisis unit has been out to evaluate resident for a 302 and has stated that the resident does not meet the criteria for inpatient admission.
- The resident has been taken to Mercy Crisis Center to be evaluated for a 302 and has been denied.
- Resident #1 has declined and is ambulatory only via wheelchair with assistance of a staff member.
- The resident #1 is closely monitored by all staff on all shifts.
- Resident #2 is escorted via wheelchair by staff.
- Resident #3 self-propels in a wheelchair and was offered an escort when using the elevator and she refused and stated, "that's not necessary".
- New Heaven Behavioral Center was contacted and will not accept resident#1 because resident will not sign in voluntarily.

Step 4 – Plan to ensure compliance

- PCA has been contacted to evaluate resident #1 for more suitable placement psychiatric or skilled nursing.
- All staff continue to monitor all residents for their safety.

Signature of Legal Entity Representative - Robyn Burns

Printed Name and Title of Legal Entity Representative- Robyn Burns - Administrator

Date- 1/31/19

Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600

2600.54(a) - Direct care staff persons shall have the following qualifications:
(1) Be 18 years of age or older, except as permitted in § 2600.54(b).
(2) Have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry.
(3) Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

2a. DESCRIPTION OF VIOLATION

Direct care staff person B, hired on 4/7/16, does not have a high school diploma, GED diploma or active registration status on the Pennsylvania nurse aide registry.

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.

At the time of inspection Friday December 7, 2018 none of employee B's qualifications were not in her file. A receipt for her diploma was received while the inspectors were here, and it was shown to them. The employee had left for the day before the exit interview, she was off for the weekend and returned on Monday.

The employee stated that she successfully completed the nurse aide training program with the American Red Cross and presented it when she was hired in April of 2015.

The employee was instructed to complete the on-line direct care staff training provided by the department on Monday December 10, 2018 and passed this action was done to comply.

Human Resources completed an audit of all employee files. The audit was completed by Jan. 10th.

Upon completing the audit employee B's qualifications were located and placed in her file.

Included is employee B's high school diploma, training certificate for nurse aide training program, and direct care training course and competency.

HR will monitor all employee files monthly to prevent reoccurrence.
The administrator will periodically complete and audit to verify compliance.

The Administrator will ensure all direct care staff persons meet qualifications to work in home. Qualifications will be maintained for Department review. SP 02-20-19

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

Signature of Legal Entity Representative (Required on EVERY Page) Tabrina Burns

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

Date 1/31/19

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- ☐ Not Implemented

Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600

2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:
(1) Training that includes a demonstration of job duties, followed by supervised practice.
(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
(3) Initial direct care staff person training to include the following:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan.
(vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person B, hired on 4/7/16, began providing unsupervised ADL services on 4/7/16. Staff person B, has not completed the Department-approved direct care training course and competency test since employment.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Please see attached

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Nahum Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Nahum Burns - Administrator	Date	1/31/19	

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- ☐ Not Implemented

Plan of Correction for 2600.65(d)

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Fix the immediate problem

- Employee B's qualification documents were not present during inspection.
- The employee stated that she successfully completed the nurse aide training program with the American Red Cross and presented it when she was hired in April of 2015.
- The employee was instructed to complete the on-line direct care staff training provided by the department on Monday December 10, 2018 and passed. This action was done to comply.
- Human Resources completed an audit of all employee files. The audit was completed by Jan. 10th.
- A new updated employee check off list was developed to improve accuracy for employee audits.
- Included is employee B's high school diploma, training certificate for nurse aide training program, and direct care training course and competency.
- Copies of all new direct care staff qualifications will be kept in their files and monitored for completion by HR.

Step 4 – Plan to ensure compliance

- HR will complete monthly audits to prevent the reoccurrence of this violation.
- The administrator will periodically complete and audit to verify compliance.

Signature of Legal Entity Representative - Robyn Burns

Printed Name and Title of Legal Entity Representative- Robyn Burns - Administrator

Date- 1/31/19

Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

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

The annual training provided to direct care staff person B in training year 2017 did not include medication self-administration training.

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.

To correct the violation medication self-administration training has been provided to employee B. This was completed by Jan. 31, 2019.

Medication self- administration training has been provided to all direct care staff.

Human Resources completed an audit of all employee files. The audit was completed by Jan. 10th.

Medication self -administration is now included in our annual training and orientation for compliance.

HR will complete monthly audits to prevent the reoccurrence of this violation. The administrator will periodically complete and audit to verify compliance.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Robyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1 | 31 | 19	

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Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600
2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION
The 325mg Acetaminophen that was prescribed to resident # 4 was discontinued; however on 12/7/18 the medication was still on the med-cart.

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 nursing staff review all medications against every MAR to make sure that no medication that was discontinued was on the medication cart. This audit was completed on December 12, 2018.
When medication orders are discontinued the charge nurse on duty will immediately after transcribing the orders, remove the medication from the med-cart and follow protocol of discarding medication.
All discontinued medication orders will be placed on the 24- hour nursing report.
The director of nursing or charge nurse on duty will check daily to make sure that the medication has been removed from the medication cart.
All medication dispensing staff have been in-service regarding the new procedures of discarding discontinued medications. This was completed by Jan. 31, 2019.

The director of nursing or charge nurse on duty will check daily to make sure that the medication has been removed from the medication cart.
The director of nursing will check the medication cart weekly to ensure compliance.

Repeat Violation: No	Date(s) of Previous Violation(s)			
Signature of Legal Entity Representative (Required on EVERY Page)	Robyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1/31/19	

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Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

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 #2 was prescribed Novolog 100ml/ flex pen which was to be injected subcutaneously per sliding scale. On 12/7/18, the home did not have the medication on hand.

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.

At the time of inspection, the VAMC had not delivered resident's medication.
The residents blood sugars were monitored, and the resident had not required insulin.
The staff was instructed by the director of nurses that if residents blood sugar level required insulin to call the doctor and send resident out to the VAMC ER.
The resident has been offered the opportunity to establish an account with Medcare Pharmacy so that medications will be on hand at all times.
Enclosed is a copy of the medication request from the pharmacy.

The resident has been informed that in order to comply with regulations an account will have to be established with another pharmacy if the VA meds do not arrive in a reasonable amount of time.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Robyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1/30/19	

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Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

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

2a. DESCRIPTION OF VIOLATION
Resident #2 was prescribed 20mg Omperazole which is to be taken once daily at 6:30AM. Resident #2 did not receive the medication on 12/1/18, 12/2/18, 12/3/18, 12/4/18, 12/5/18, 12/6/18 and 12/7/18.

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.

The resident was returned without prescriptions or medications from Rosemont Rehabilitation and Nursing Home on Nov 28th, a call was placed to the VAMC doctors for medication orders a message was left and they did not respond.
The director of nursing called again on Nov 29th, the doctor was made aware of the need for the resident's medication and the medications were ordered from the VAMC.
The VA medications takes 7 – 10 days to receive.
The medication was not received until December 8th and was given to the resident.
Enclosed is a copy of the medication request from the VA pharmacy and nursing notes.

The resident has been informed that in order to comply with regulations an account will have to be established with another pharmacy if the VA meds do not arrive in a reasonable amount of time.

The Administrator will ensure medication for residents are always on-site and available. Administrator understands residents have the right to choose their own doctors and pharmacies and can't be forced to pick one of the homes choosing. SP 02-20-19

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1/30/19	

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Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

1. REGULATION 55 Pa.Code §2600
2600.201 - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself/herself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

2a. DESCRIPTION OF VIOLATION
The home did not implement positive interventions to modify or eliminate resident #1's behavior.

On 12/7/18, during resident interviews at least two residents confirmed that resident #1 violently and physically attacked them on the elevator. Staff persons also confirmed during staff interviews that resident #1 has physically attacked 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.

Please see attached

The Administrator will ensure positive interventions are used on difficult residents who exhibit dangerous behaviors. The home will train staff on identifying behaviors and utilizing positive interventions. SP 02-20-19

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Thebun Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Thebun Burns - Administrator	Date	1/31/19	

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

The above plan of correction is approved as of 02-20-19 (Date)

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

Plan of correction implementation status as of 02-01-19 (Date)

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

Plan of Correction for 2600.201

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – I do not agree with this violation.

- Resident has a psych diagnosis who is a veteran and is his own responsible party.
- There have numerous attempts to get resident #1 help with his behaviors.
- Resident refuses to go to the doctor, or to be committed to address his behaviors.
- The home has contacted several psych doctors none are willing to come to the home.
- We attempted to have him treated at Haven Behavioral Hosp. and he refuses to sign himself in.
- The mobile Crisis unit has been here several time to evaluate resident for a 302 and has stated that the resident does not meet the criteria for inpatient admission.
- He has been taken to Mercy Crisis Center to be evaluated for behaviors due to violence toward other residents and a 302 admission was denied on more than one occasion.
- He refuses to go to the VA or any other hospital, when the ambulance arrives, he refuses to go.
- The PCP has been notified and has changed medication to assist with behaviors multiple times. PCP has also stated that resident requires a hospitalization to critique his medication.
- Resident is constantly redirected to encourage positive behaviors by the staff.
- Resident spends most of his time alternating from the nursing station where the director of nursing and charge nurse spend hours providing him with one on one interaction and applauding him for positive behavior.
- They use various techniques and rewards such as soda's and snacks which he enjoys.
- To the front office staff who also provide him with positive feedback to encourage good behaviors and praise him when we can deescalate his negative behaviors and help him with conflict resolutions.
- The activity department always includes him in activities that he enjoys such as musical therapy and entertainment as alternative techniques for his aggressive behaviors.
- We also allow him to express his feeling and make choices concerning his care.

Step 4 – Plan to ensure compliance

- The staff will continue to closely monitor resident and redirect resident when required.
- We will continue to seek ways to address his behavior and look for alternative techniques to defuse situations.
- The home will contact PCA to have resident evaluated for more suitable placement.

Signature of Legal Entity Representative - Robyn Burns

Printed Name and Title of Legal Entity Representative- Robyn Burns – Administrator

Date- 1/31/19

Violation Report: 14223 - 12/07/2018 - Freeman, Sabrina
PCH Name: HAYES MANOR

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 #4's pre-admission screening form dated 7/24/18 was incomplete.Part 3 or the determination that the resident needs can be met at the home was not documented; If the resident could safely use and avoid poisonous materials; medical, psychological and behavioral diagnoses were not listed or history of problematic behavior; nor the residents personal care and medical needs.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The resident #4 pre-admission screen was started and not completed on July 24, 2018.
Resident # 4's pre-admission screen was completed on the day of inspection to correct the violation.
An audit of all resident pre-admission screenings has been completed by the director or nursing on January 31, 2019.
A monthly review of resident's documentation will be maintained by the director of nursing.
Attached is a copy of the resident #4 pre-admission.

The director of nursing will monitor the due dates for all pre-admission screens.
The administrator will periodically complete an audit for compliance.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Robyn Burns			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Robyn Burns - Administrator	Date	1/31/19	

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The above plan of correction is approved as of 02-20-19 (Date)

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

Plan of correction implementation status as of 02-01-19 (Date)

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