pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 13 2019

Ms. Stephanie R. Short, RN
Owner/Administrator
TLC Adult Care Center, Inc.
9 Rio Vista Drive
West Newton, Pennsylvania 15089

RE: T.L.C. Adult Care Center
Certificate #: 428200

Dear Ms. Short:

As a result of the Department's Bureau of Human Services Licensing annual inspection on February 26, 2019, 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
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: T L C ADULT CARE CENTER	License Number: 42620
Address: 9 RIO VISTA DRIVE, WEST NEWTON, PA 15089	County: Westmoreland
Administrator: Stephanie Short	Region: WEST
Legal Entity Name: TLC ADULT CARE CENTER INC	
Legal Entity Address: 9 RIO VISTA DRIVE, WEST NEWTON, PA 15089	

Certificate(s) of Occupancy

C-2 LP
01/23/1996
Labor and Industry

Staffing Hours

Resident Support: 0 | Total Daily Staff: 34 | Waking Staff: 26

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

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

02/26/2019: Roser, Ashley; Eveges, Joseph

RECEIVED
4/17/2019
Western Region Field Office
Bureau of Human Services Licensing

On-Site Inspection Dates and Inspectors, If Applicable

Other Details

Partial or Full Triggers: | Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 30	Number of Residents who:
Number of Residents Served: 29	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 29
Area:	Have Mental Illness: 0
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: 5
Number of Current Hospice Residents: 9	Have a Physical Disability: 0
Number of Hospice Residents in past year: 9	

RN

Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

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

2a. DESCRIPTION OF VIOLATION
Staff person B, hired on 4/24/12, only received 10 hours of annual training during the 2018 training year.

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

Staff peesan B did receive 12hrs of annual training but did not sign in to 2 trainings. Admin in future will Account for number of staff present to sign in sheet before Course begins. This will ensure compliance so that A re-print violation does not occue in the future.

(See Attached Course held 2/26/19)

By 12/31/19 - staff person B will receive at least 14 hours of annual training to make up for the hours not received in 2018. BB 4/25/19

Immediately - The administrator will implement procedures that ensure training records include all of the requirements in accordance with Chapter 2600.65(i). The procedures will include, at a minimum, monthly reviews of training records. BB 4/25/19

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): Stephanie R Short Curee/Admin/RN/CEO — Date: 4/16/19

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

The above plan of correction is approved as of 4/25/19 (Date)

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

Plan of correction implementation status as of 4/25/19 (Date)

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

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

Staff person A, hired on 9/27/10, and staff person B, hired on 4/24/12, did not receive annual training on medication self-administration during the 2018 training year.

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

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

Admin was not aware medication Self Administration training needed provided to employees as no one at TLC self medicates and hasn't in the past. Now that Admin aware it will be implemented yearly to adhere to compliance team this point forward

Class held by Admin 3/15 included Medication Self Administration (see Attached)

Immediately at least monthly thereafter – The administrator will review the home's staff training plan required by Chapter 2600.66(a) – (c). BB 4/25/19

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): Stephanie R Street Owner/Admin/RN/CEO — Date 4/26/19

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Plan of correction implementation status as of 4/25/19 (Date)

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Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

1. REGULATION 55 Pa.Code §2600
2600.86(b) - A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

2a. DESCRIPTION OF VIOLATION
The exhaust fans in the shared bathroom of residents #1 and #2 and the shared bathroom of residents #3 and 4 are inoperable. No operable windows are present in either bathroom.

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.

Co Owner ordered 2 fans while inspectors on site 2/26. Fans were received and installed by Co owner within A week. Admin Advised Staff At meeting on 3/15, when Review of Violations were Reviewed, to document in Communication book when A fan is noted to be inoperable. Admin + Co owner Read Communication book daily when on site. Also Co Owner will check for himself monthly when Air filters Are changed. This process will Allow for Compliance and Avoid A Repeat Violation in the future. (See Attached Receipt & Review. Previously Attached staff meeting Signatures from 3/15)

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

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Stephanie R Street Owner/Admin/RN/CEO

Date: 4/16/19

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Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

1. REGULATION 55 Pa.Code §2600
2600.91 - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

2a. DESCRIPTION OF VIOLATION
There are no emergency phone numbers posted on or near resident #5's bedroom telephone.

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 was given ER numbers upon Admission which was by his phone? Counsel Rectified violation while inspectors on site. Numbers placed on his wall by the phone so there's no chance of it being lost or misplaced in the future. Resident educated on the importance of leaving them posted @ All times. He verbalized understanding.

All Residents who have a phone in the future will have laminated ER number list posted & hung by their phone to adhere to Compliance & Avoid A Repeated Violation

(See Attached)

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) Stephanie R Short owner/Admin/RN/CEO — Date 4/16/19

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Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

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 #5 does not have an operable lamp or other source of lighting which can be turned on/off at 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.

Residents daughter moved lamp over to roommates side when she brought him in to stand in. Roommate already had a push light on his side of the dresser (As seen in Attached photo) #1. CoOwner placed light source beside bed on wall while inspectors on site. (See Attached) #2

Admin Reeducated All staff At 3/15 meeting, Reviewing violations about notifying Admin or CoOwner when a resident does not have a source of lighting in reach at bedside. This is to be written in communication book & reviewed by CoOwner or Admin daily. Written Communication will allow adherence to compliance & decreased chance of repeated violation in the future.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/27/2018		

Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Stephanie R Street Owner/Admin/RN/CEO — Date 4/16/19

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Plan of correction implementation status as of 4/25/19 (Date)

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Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

1. REGULATION 55 Pa.Code §2600
2600.130(d) - If the home serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the home or an automatic fire alarm system that is interconnected and audible throughout the home.

2a. DESCRIPTION OF VIOLATION
The home currently serves 29 residents; however, there is no smoke detector located in the home's attic.

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.

Co-Owner Contacted Rampart Security while inspectors on site 2/26. Violation was brought to Compliance on 3/18/19. (See Attached) Violation will not be Repeated As Rectification is a permanent fix. Rampart Security inspects entire system yearly.

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): Stephanie R Street Owner/Admin/RN/CEO — Date 4/16/19

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- ☐ Not Implemented

Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

1. REGULATION 55 Pa.Code §2600
2600.131(a) - There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

2a. DESCRIPTION OF VIOLATION
There is no operable fire extinguisher in the home's attic.

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 extinguisher has always been hung outside door leading to Attic. CoOwner called Abco while inspectors on site 2/26. Abco delivered 3/1/19 & CoOwner installed up in the Attic. Violation will not be repeated now that it's installed. Abco Services TLC's extinguishers twice yearly.
(See Attached)

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): Stephanie R Strat Owner/Admin/RN/CEO — Date 4/16/19

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

Plan of correction implementation status as of 4/25/19 (Date)

- ☐ Fully Implemented
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- ☐ Not Implemented

Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

1. REGULATION 55 Pa.Code §2600
2600.131(f) - Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

2a. DESCRIPTION OF VIOLATION
The fire extinguisher located in the home's basement has not been inspected by a fire safety expert since July 2012.

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.

Abco has serviced TLC for over 15 years & Fire Safety expert inspects yearly. Abco installed new fire extinguisher in basement 3/1/19 After Service CALL made 2/26 while inspectors on Site.

Admin or Co Owner, in future, will inspect ALL AREAS prior to signing work order twice yearly when they are on site inspecting. This dual check will decrease the risk of a Repeated violation. (See Attached Invoice)

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): Stephanie K Shaw Owner/Admin/RN/CEO — Date 4/16/19

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Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

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 #6's One Touch glucometer was not calibrated to current date and time

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.

Admin will check calibration of glucometers weekly to every 2 weeks when documentation of blood sugars are reviewed for QM. Admin will sign of document on blood Glucose log Showing it was completed. This new implemented process will allow for continuous compliance & Avoid Repeated violation in the future.

Within 30 days of receipt of the plan of correction (See Attached) - All staff persons involved with glucometers will be educated on the home's procedures in accordance with Chapter 2600.185(a) and manufacturer's instructions of glucometers. BB 4/25/19

Immediately - Resident #6's glucometer will be calibrated accurately to date and time. BB 4/25/19

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)	Stephanie Schaat Owner/Admin/EM/CEO		Date	4/16/19

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Violation Report: 42820 - 02/26/2019 - Roser, Ashley
PCH Name: T L C ADULT CARE CENTER

1. REGULATION 55 Pa.Code §2600
2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION
Resident #6 is prescribed Novolog Flexpen 3 ml-Inject 4 times a day subcutaneously in accordance with the following sliding scale: 150-200=4 units, 201-250=6 units, 251-300=8 units, 301-350=10 units, 351-400=12 units, >401=15 units and call MD. The resident's February 2019 medication administration record (MAR) indicates 4 units of insulin was administered on 2/22/19 at 8 a.m.; however, does not include the initials of the staff person who administered the 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.

Admin will Review All Resident MARs At the end of each month for proper documentation. Each Staff member on each shift to do QM on peer shift for Adherence to documentation. If there's A missed documented initial Admin to be notified to Address the individual. This new Implemented Process was Reviewed At Staff meeting on 3/15 previously Addressed. The Added Critique to documentation will Allow for less errors. Increased Compliance, & decreased Chance of A Repeated Violation.

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): Stephanie K Sheet Owner/Admin/RN/CEO — Date 4/16/19

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Plan of correction implementation status as of 4/25/19 (Date)

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