pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TITHONUS MT. LEBANON LP**
LEGAL ENTITY

To operate **THE PINES OF MT. LEBANON**
NAME OF FACILITY OR AGENCY

Located at **1537 WASHINGTON ROAD, PITTSBURGH, PA 15228**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **112**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 18**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 3, 2019** until **June 3, 2020**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **433610**

Robert E. Robinson
ISSUING OFFICER

Carolyn K Ellison
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility

HS 628cke – 2/18

pennsylvania
DEPARTMENT OF HUMAN SERVICES

June 3, 2019

Ms. Loriann Putzier
President/CEO
Tithonus Mt. Lebanon LP
C/O Integracare Group
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: The Pines of Mt. Lebanon
1537 Washington Road
Pittsburgh, Pennsylvania 15228
Certificate #: 433610

Dear Ms. Putzier:

As a result of the Department's Bureau of Human Services Licensing annual inspection on March 26, 2019; March 27, 2019 and May 3, 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.

A regular license is being issued based on the enclosed violation report. Your license is enclosed.

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

Enclosures
License
Violation Report

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: THE PINES OF MT LEBANON	**License Number:** 43361
Address: 1537 WASHINGTON ROAD, PITTSBURGH, PA 15228	**County:** Allegheny
Administrator: Jackie Hainer	**Region:** WEST
Legal Entity Name: TITHONUS MT LEBANON LP	
Legal Entity Address: 6600 BROOKTREE COURT SUITE 1000, WEXFORD, PA 15090	

Certificate(s) of Occupancy
C-2 LP
06/05/1990
L&I

RECEIVED
APRIL 18 2019
WEST REGION FIELD OFFICE
Human Services Licensing

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 63 **Waking Staff:** 47

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

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

On-Site Inspections Dates and Department Representatives On-Site
03/26/2019: Hoover, Josh; Bartlett, Patricia
03/27/2019: Hoover, Josh; Bartlett, Patricia

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: 112

Number of Residents Served: 42

Secured Dementia Care Unit in Home: Yes

Area: Memory Care

Secured Dementia Unit Capacity, if Applicable: 18

Number of Residents Served in Secured Dementia Care Unit, if applicable: 5

Number of Current Hospice Residents: 3

Number of Hospice Residents in past year: 10

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 42

Have Mental Illness: 2

Have an Intellectual Disability: 0

Have a Mobility Need: 21

Have a Physical Disability: 1

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

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
In Allegheny County, a certified food protection safety manager is required to be on-site during all hours of operation in facilities when food preparation and handling take place. However, the following meals were prepared and served without a certified food protection safety manager on-site:
- Breakfast on 3/18/2019 through 3/20/2019 and 3/23/2019 through 3/26/2019
- Breakfast, lunch, and dinner on 3/21/2019 and 3/22/2019

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

See attached Page 2A AND 2B OF 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Heiner

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Heiner PHCA | **Date** 4-17-2019

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

The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. **Violation Review:**

   REGULATION 2600.18: A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2. **Violation Interpretative Statement:**

   Allegheny County, the county in which The Pines of Mount Lebanon is located, requires a certified food protection safety manager to be on site during all hours of operation in facilities when food preparation and handling take place.

3. **Review the benefit of the Regulation, per RCG:**

   The primary benefit of this regulation is to ensure compliance with other applicable health, safety and wellness requirements not incorporated by Chapter 2600.

4. **Description of the Repair of the Immediate Problem:**

   Two individuals have been registered for a Serve Safe Training Course of May 24, 2019.

   During survey the Director of Dining Services provided copies of registrations for two team members to complete the Safe Serve course on May 24,2019. Upon completion of the course all cooks in Dining Services will have required education and corresponding certification.

5. **Determine / document the Root Cause of the Violation:**

   Only one of three cooks currently possess this certification and this team member does not work during all hours of food preparation requiring additional Dining Service team members to also be certified.

Authorized Signature Judith Hamm Date: 4-17-19

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See PAGE 2B of 11

6. **Detail Action Steps / System Developed to prevent future occurrence:**

   a. **Changing practice?**

An Outlook "tickler file" for certifications and licenses has been developed which will alert the PCHA, Human Resources Manager and respective Department Leader 30 days in-advance of a certification and/or licensure expiring and again one week prior to expiration. The PHCA will review with the Department Leader upon receipt of an electronic alert the plan to renew the certification and/or licensure timely. Future cooks hired will have their Serve Safe certification upon hire, or be scheduled for the training within the quarter of their hire, and this will be verified by the Business Office Manager.

   b. **Teaching or Training?**

PHCA will review with the leaders of the departments who have team members with certifications and/or licenses the new process of an Outlook "tickler" file to track upcoming expiration dates.

   c. **On-going Monitoring?**

Issues of non-compliance with licenses and/or certifications will be reported monthly by exception only via SQIRT (quality) meetings, and corrective action will be taken, accordingly.

7. **Designated position responsible and specify target date for correction.**

Two individuals will have their Serve Safe Certification completed on 4/25/19.
PHCA will be responsible to follow up on all alerts for pending licensure and/or certification expirations.
Respective Department Leaders with the assistance of the Business Office Manager will input their departmental licenses and certifications by team member.
The Business Office Manager will ensure that all new hires are inputted into the system along with all renewals of licenses and/or certifications.

Date of Completion: May 25, 2019

Authorized Signature Jackie Hamer Date: 4-17-19

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Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

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
A card containing 4 capsules of Amoxicillin 500mg for resident #1 was in the medication cart; however, resident #1 does not have a current order for this medication.

A card containing approximately 15 capsules of Benzonatate 200mg for resident #2 was in the medication cart; however, resident #2 does not have a current order for this medication.

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

See attached PAGES 3A AND 3B OF 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Hamer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Hamer PCHA | **Date** 4-17-2019

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The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. **Violation Review:**
   REGULATION 2600.183(d): Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

2. **Violation Interpretative Statement:**

   Two of four residents reviewed had medication in the medication cart without a current order for the medication.

3. **Review the benefit of the Regulation, per RCG:**

   The regulation ensures the community will dispose medications that have been discontinued or prescribed for resident who no longer reside in the community.

4. **Description of the Repair of the Immediate Problem:**

   Resident #1, having dental implants which require unanticipated trips for dental procedures, now has a current order for the identified medication obtained and documented in the medical record.

   Resident #2 has had the Benzonatate capsules discontinued per physician order.

5. **Determine / document the Root Cause of the Violation:**

   A deficit in staff education regarding the process to follow when a medication is discontinued has been identified.

Authorized Signature _____ Date: 4-17-2019

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SEE PAGE 3B OF 11

4/22/19

6. **Detail Action Steps / System Developed to prevent future occurrence:**

   a. Changing practice?
   A weekly med cart audit has been implemented. Results of weekly medication cart audits will be given to the Director of Wellness and PCHA for review and follow up action.

   b. **Teaching or Training?**
   Team members who have a role in passing medications, will be educated as to the regulation for having only current prescriptions, OTC, sample and CAM for individuals living in the community in the medication carts as well as the disposition and documentation process for when a medication is discontinued.

   c. **On-going Monitoring?**
   Weekly medication cart audits will be completed by the night shift Medication Assistant and/or LPN and the results given to the Director of Wellness and PCHA. Audit documentation will be maintained. Any issues of non-compliance will be addressed immediately. Contracted Pharmacy Services will complete a quarterly and random audit of the medication carts for any discontinued and/or medications without a current order and the results will be given to the Director of Wellness and PCHA, and documentation will be kept. The results of these audits will be submitted monthly to SQIRT (quality) for three months and then quarterly thereafter.

7. **Designated position responsible and specify target date for correction.**

   Night shift Medication Assistant and/or LPN will complete a weekly medication cart audit which will be provided to the Director of Wellness and up to the PCHA.

   Date of Completion: Training was completed : 4/18/2019
   The Audit was implemented on : 4/18/2019
   Monitoring to occur weekly by DRCS beginning: 4/18/2019

Authorized Signature Jackie Hamm Date: 4-17-19

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4/22/19

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

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

Resident #3 is prescribed a straight order of Humalog 100units/ml 3 times daily - 7 units before breakfast, and 10 units before lunch and supper. In addtion, the resident is prescribed sliding scale coverage prior to each meal and at bedtime. However, the label for this medication did not include the straight order dosages 3 times daily before each meal. The label only indicated the sliding scale directions and dosages.

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

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

See attached PAGES 4A AND 4B OF 11

Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/19/2018		

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Hainer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Hainer PHCA **Date** 4-17-19

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

The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. **Violation Review:**
   REGULATION 2600.184(a)
   The original container for prescription medications shall be labeled with a pharmacy label that includes the follow: 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.

2. **Violation Interpretative Statement:**

   Resident #3 has a straight order and a sliding scale order for Humalog. The pharmacy label only indicated the sliding scale directions and dosages.

3. **Review the benefit of the Regulation, per RCG:**

   A prescription medication label should contain 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. This will reduce the possibility that medication will be administered to the wrong resident or improperly administered.

4. **Description of the Repair of the Immediate Problem:**
   During the survey, upon identification of the incomplete pharmacy label, a new and complete pharmacy label was obtained for Resident #3's Humalog and is in place.

   In addition, a pharmacy label audit will be completed for the community and any issues of non-compliance were identified and remedied at that time. The results of the audit will be reported to the SQIRT (quality) Committee.

Authorized Signature [signature] Date: 4-17-19

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4/22/19

SEE PAGE 4B OF 11

5. **Determine / document the Root Cause of the Violation:**

   A pharmacy error happened and there was a deficit in staff procedural knowledge to ensure the pharmacy label matched the eMAR and the process to follow in the event of a discrepancy.

6. **Detail Action Steps / System Developed to prevent future occurrence:**

   a. **Changing practice?**
   The weekly med cart audit will include a pharmacy label audit. Results of weekly medication cart audits will be given to the Director of Wellness and PCHA for review and follow up action.

   b. **Teaching or Training?**
   Team members who have a role in passing medications, will be educated as to the regulation for having a complete pharmacy label in place, containing the resident's name, name of the medication, date the prescription was issued, prescribed dosage and administration instructions and name of the prescriber.

   c. **On-going Monitoring?**
   Weekly medication cart audits will be completed by the night shift Medication Assistant and/or LPN and the results given to the Director of Wellness and PCHA. Audit documentation will be maintained. Any issues of non-compliance will be addressed immediately. Contracted Pharmacy Services will complete a quarterly and random audit of the medication carts for any discontinued and/or medications without a current order and the results will be given to the Director of Wellness and PCHA, and documentation will be kept. The results of these audits will be submitted monthly to SQIRT (quality) for three months and then quarterly thereafter.

7. **Designated position responsible and specify target date for correction.**

   The Director of Wellness and/or designee and PCHA.

   Date of Completion: 04/19/2019

Authorized Signature Judith Heiner Date: 4-17-19

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4/22/19

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

1. REGULATION 55 Pa.Code §2600

2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

The home's narcotics and controlled substance policy indicates that "when a routine narcotic or controlled substance is administered," staff are to "note the date, time, and quantity used on the Control Sheet" and "calculate the remaining quantity and initial." The policy also indicates that narcotics and controlled substances are to be counted "between 2 authorized, trained team members and reconciled at the beginning and end of each shift."

The Control Sheet for resident #3's Tramadol 50mg tab, give 1 by mouth daily at midnight was not updated during administration on 3/26/2019 and the Control Sheet for resident #3's Zolpidem Tartrate 5mg tab, take 1 at bedtime as needed for insomnia was not updated when the medication was administered on 3/26/2019 and 3:23a.m.

The counts for these medications were not reconciled at the 7:00a.m. shift change on 3/26/2019 and the discrepancies in the counts were discovered by agents of the Department on 3/26/2019 at approximately 2:00p.m.

The March 2019 medication administration record (MAR) for resident #3 contained the following blood glucose testing documentation errors:

- 3/20/2019 at 9:00a.m. MAR indicates 119, glucometer indicates 112
- 3/20/2019 at 12:00p.m. MAR indicates 112, glucometer does not contain a reading
- 3/22/2019 at 12:00p.m. MAR indicates 332, glucometer indicates 271
- 3/23/2019 at 12:00p.m. MAR indicates 284 glucometer indicates 271

Resident #4 is ordered Bisac-Evac 10mg suppository daily as needed for constipation; however, this medication was not available in the home.

The March 2019 MAR for resident #4 indicates that the resident's blood glucose was 211 on 3/22/2019 at 8:00p.m.; however, there is no reading on the resident's glucometer for this 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.

See attached SEE PAGES 5A, 5B AND 5C OF 11

Repeat Violation: Yes	Date(s) of Previous Violation(s):	09/19/2018		

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Heimer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Heimer PCHA **Date** 4-17-19

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The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

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

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. **Violation Review:**
   REGULATION 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.

2. **Violation Interpretative Statement:**

   The Community's trained medication team members failed to have an accurate Control Sheet and record accurate blood glucose testing documentation for Resident #3 on 4 different testing times. In addition, the medication team members did not complete narcotic medication reconciliation at the time of shift change on March 26, 2019. Nor did they ensure prescribed medication was available for Resident #4 and that a blood glucose historical reading was available in the resident's glucometer for March 22, 2019.

3. **Review the benefit of the Regulation, per RCG:**

   In the accountability of medications and controlled substances a community must ensure staff are trained in the use of medical equipment in the same manner as medications to reduce the risk that medications and medical equipment will be misplaced, lost or misused.

4. **Description of the Repair of the Immediate Problem:**

   Resident #3's Control Sheet was updated with a late entry by the night nurse who self-reported the error during the survey. Documentation was provided to the surveyors at that time. Resident #4 Bisac-Evac 10 mg suppository has been ordered and obtained from the pharmacy for continued use.

   With regards to identified blood glucose documentation errors, the medication error for March 22, 2019 was reported to DHS and subsequent errors identified on March 20 and 23, 2019 will likewise be reported as medication errors.

Authorized Signature _____ Date: 4-17-19

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4/22/19

SEE PAGE 5B OF 11

5. **Determine / document the Root Cause of the Violation:**

Medication Team have been trained multiple times, and there have been several transitions within the department. Comprehension of procedural knowledge must be tested and monitored to establish proper habits that ensure compliance.

6. **Detail Action Steps / System Developed to prevent future occurrence:**

a. Changing practice?
The Clinical Director and/or designee who is an authorized and trained team member for medication pass, will audit the narcotic count daily, M-F. The MOD will perform the audit on the weekends. Written documentation of the monitor will be maintained.

The Clinical Director and/or designee who is an authorized and trained team member for medication pass, will audit audit the narcotic count daily, M-F. The MOD will perform the audit on the weekends. E-MARs will be reconciled with blood glucose meters to ensure accuracy of all readings, daily. Written documentation of the monitor will be maintained.

b. Teaching or Training?

Re-Education will be completed with all team members who pass medications with regards to the following:

1. Documentation of the administration of narcotic and controlled substances.
2. Counting and reconciling narcotic and controlled substances at the beginning and end of each shift via an electronic narcotic count/inventory tracking system, which will be implemented June 1, 2019.
3. the 11-7 person reviews the days' orders for fulfillment, and uses EMAR approvals to document: we cannot review a weeks' worth of orders every week.
4. Documentation of blood glucose testing to ensure its accuracy and that documentation in the eMAR and glucometer are identical. This will be achieved via a 2-team member verification. A second person verification will be required to be documented in the eMAR system. In addition, community procedures will now require a progress note be documented if for any reason the glucometer does not reflect the last blood sugar reading i.e. a dropped glucometer, a change in batteries, a new glucometer being put into place for a resident. Weekly battery changes on Sunday night with date/time set during the process. Per-use verification of date/time settings Per use verification of reading plus history of the reading

Authorized Signature Jackie Hamm Date: 4-17-19

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4/22/19

SEE PAGE 5C OF 11

c. On-going Monitoring
Daily and weekly monitoring will be implemented, and documentation will be maintained.

In addition, The Clinical Director and/or designee who is an authorized and trained team member for medication pass, will audit weekly for two weeks to ensure blood glucose testing documentation is being documented accurately. MARs will be reconciled with blood glucose meters to ensure accuracy of all readings. Any discrepancies will be addressed and/or reported as warranted. Any additional education and/or discipline will be done with the involved team members. Audits will be done weekly for two weeks with all results being reported monthly to the SQIRT (quality) committee.

7. Designated position responsible and specify target date for correction.

The Director of Wellness and/or Designee will complete and report findings to the PHCA who will verify additional education and/or discipline is being done as warranted.

Date of Completion: Training was completed : 04/18/2019
The Audit was implemented on : 04/18/2019
Monitoring to occur weekly by DRCS beginning: 04/18/2019

Authorized Signature Jackie Hamm Date: 4-17-19

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4/22/19

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

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
The March 2019 MAR for resident #1 does not include the initials of the staff person(s) who administered the resident's afternoon and evening medications on 3/8/2019, to include Divalproex Sodium DR 500mg, Trazodone 100mg, and Turmeric Curcumin 450mg.

The March 2019 MAR for resident #2 does not include the initials of the staff person(s) who administered multiple medications, including Ceravite Senior Tab, Furosemide 20mg, and Levothyroxine 175 mcg on 3/7/2019, Divalproex Sodium 125mg on 3/7/2019 at 9:00a.m. and 3/19/2019 at 9:00p.m., and Memantine HCL 10mg and Rivastigmine 4.6mg/24hour patch on 3/19/2019 at 9:00p.m.

The March 2019 MAR for resident #3 does not include the initials of the staff person(s) who administered the resident's afternoon and evening medications on 3/8/2019, including Advair 250/50, Atorvastatin 40mg, Humalog 100U/ml, and Lantus 100U/ml. Also, this MAR was initialed by staff person B, as having administered the prescribed Humalog 100Units/ml, inject 7 units subcutaneously before breakfast, on 3/26/2019. However, staff person B indicated the Humalog was not administered because the resident did not eat breakfast.

The March 2019 MAR for resident #4 does not include the initials of the staff person(s) who administered Budesonide .5mg/2ml suspension on 3/8/2019 at 2:00p.m. and 3/14/2019 at 2:00p.m., and Repaglinide .5mg on 3/82019 at 4:30p.m.

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

See attached PAGES 6A AND 6B OF 11

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

Signature of Legal Entity Representative
(Required on EVERY Page) Jackie Hainer

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

Date 4-17-19

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The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of _____ (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. **Violation Review:**
   REGULATION 2600.187(a)(13)
   The date and time of medication administration and the name and initials of the staff person administering the medication shall be kept in the medication record for each resident for whom medication is administered and done so at the time the medication is administered.

2. **Violation Interpretative Statement:**

   The community's medication trained team members failed to initial medications when administered for 4 residents at varying times during the month of March. One medication trained team member initialed a medication was given on the MAR then documented the medication was not administered.

3. **Review the benefit of the Regulation, per RCG:**

   It is vital a community be able to track all medications a resident receives and to ensure all medications are administered as prescribed with MAR accuracy thereby minimizing the chances of a documentation mistake should a resident refuse a medication.

4. **Description of the Repair of the Immediate Problem:**

   It would further violate the rules of medication administration and documentation for medication trained team members to remedy these documentation errors.

5. **Determine / document the Root Cause of the Violation:**

   There have been several transitions within the department. Comprehension of procedural knowledge must be tested and monitored to establish proper habits that ensure compliance.

Authorized Signature Jackie Hamer Date: 4-17-19

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SEE PAGE 6B OF 11

6. **Detail Action Steps / System Developed to prevent future occurrence:**

   a. Changing practice?

   A nightly medication audit review will be completed by the night shift medication trained team member. This medication variance report will identify lack of documentation with resident medication pass. All audit documentation will be maintained. This will allow follow up by Director of Wellness and/or designee to address issues of non-compliance with the respective team member.

   b. Teaching or Training?

   Education will be completed with all team members who are authorized and trained to administer medications regarding:

   1. Documentation of medication administration at the time the medication is given
   2. Ensuring medications are administered per physician's orders
   3. Communication flow for the medication variance report created by the 10p night shift staff and reporting to the Director of Wellness and/or designee for follow up.

   Staff Person B has been education as to her conflicting documentation of medication administration.

   c. On-going Monitoring?

   The results of the Medication Variance Report will be presented monthly to SQIRT (quality) committee. Additional education and/or discipline will be given as warranted. All audit documentation will be maintained.

7. **Designated position responsible and specify target date for correction.**

   Night Shift trained medication team member will complete the audit and the Director of Wellness and/or designee will address all issues of non-compliance

   Training was completed : 04/18/2019
   The Audit was implemented on : 04/18/2019
   Monitoring to occur weekly by DRCS beginning: 04/18/2019

Authorized Signature Jackie Hamm Date: 4-17-19

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4/22/19

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

1. REGULATION 55 Pa.Code §2600
2600.187(c) - If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

2a. DESCRIPTION OF VIOLATION
There were no notifications of the residents' medication refusals to the physicians of residents #1, #2, #3, or #4 for over 200 documented instances of medication refusals between 3/2/2019 and 3/26/2019 to include the following:

*Resident #1:
-Glucerna at 5:00p.m. on 3/11/2019, 3/13/2019 through 3/15/2019, 3/18/2019 through 3/21/2019, and 3/23/2019 through 3/25/2019

*Resident #2:
-Divalproex 125mg at 9:00a.m. on 3/9/2019, 3/13/2019 through 3/15/2019, 3/21/2019 through 3/24/2019, and 3/26/2019
-Furosemide 20mg at 9:00a.m. on 3/9/2019, 3/13/2019 through 3/15/2019, 3/21/2019 through 3/24/2019, and 3/26/2019

*Resident #3:
-Advair 250/50 at 9:00p.m. on 3/2/2019. 3/5/2019, 3/11/2019, 3/13/2019 through 3/15/2019, 3/18/2019 through 3/20/2019, and 3/23/2019 through 3/25/2019.
-Humalog 100u/ml at 5:00p.m. on 3/15/2019, 3/18/2019, 3/20/2019, and 3/24/2019 and 3/25/2019.

*Resident #4:
-Novalog 100U/ml at 5:00p.m. on 3/13/2019, 3/14/2019, and 3/18/2019 through 3/20/2019

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

See attached PAGES 7A AND 7B OF 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Hamer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Hamer PCHA **Date** 4-17-19

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The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

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

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1.Violation Review:

REGULATION 2600.187(c)
If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

2. Violation Interpretative Statement:

There were no notifications of the residents' medication refusals to the physicians for 4 residents reviewed from March 2, 2019 through March 25, 2019.

3.Review the benefit of the Regulation, per RCG:

By keeping documentation of prescriber notification of residents' refusal to take a medication and the prescriber's response a community can ensure resident safety and have supportive documentation history should a refusal of medication lead to health complications.

4.Description of the Repair of the Immediate Problem:

It would further violate the rules of medication administration and documentation for medication trained team members to remedy these documentation errors. However Resident #1, 2, 3, 4 have had their respective refusals of medications reported to the prescriber during time of survey. No new orders were received.

5.Determine / document the Root Cause of the Violation:

A deficit in staff education and accountability has been identified with regards to medication administration documentation and prescriber communication

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6.Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice

Community is currently working to establish a refusal of medications protocol with the Medical Director. Medical Director is in the community on a weekly basis, refusal notification will be weekly per Medical Director unless the resident is in an emergent situation related to an insulin medication event.

In addition, a community-wide audit was completed on all residents of a 30 day look back period to identify the frequency of a resident refusing medications. Physicians will be contacted regarding the results of the audit for his/her specific patients and any changes and/or new physician's orders will be implemented as given. All audit documentation will be maintained.

b.Teaching or Training

Education will be completed with all team members who are authorized and trained to administer medications regarding:

1. Methods to be used to assist in compliance with a resident taking his/her medications as prescribed.
2. Documentation of medication refusals
3. Prescriber communication with regards to medication refusals.

c. On-going Monitoring?

Audits will be done by the Director of Wellness or designee, of medication refusals to ensure their communication to physicians. Audits will identify any contributing trends for the refusal as well as documentation of prescriber communication and follow up documentation. Audits will then be completed on a monthly basis. All results will be communicated to the SQIRT (quality) committee monthly. All audit documentation will be maintained. Any additional education and/or disciplinary education will be completed as warranted.

7.Designated position responsible and specify target date for correction.

Director of Wellness and/or Designee

Training was completed : 04/18/2019
The Audit was implemented on : 04/18/2019
Monitoring to occur weekly by DRCS beginning: 04/18/2019

Authorized Signature Jackie Hamer Date: 4-17-19

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4/22/19

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

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

2a. DESCRIPTION OF VIOLATION
Resident #3 is ordered Humalog 100units/ml, inject 7 units subcutaneously before breakfast and 10 units before lunch and supper, and a sliding scale four times daily as follows: <70= Call MD and protocol; 141-180=2U; 181-220=4U; 221-260=6U; 261-300=8U; 301-340=10U; 341-380=12U; >380=14U and call MD.

On 3/22/2019 at 12:00p.m., resident #3's blood glucose was 271, requiring the administration of 8U of sliding scale insulin; however, 10 units of insulin were administered.

On 3/26/2019, at 8:00a.m., staff person B, LPN, did not administer the resident's ordered 7 units of Humalog.

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

See attached PAGES 8A, 8B AND 8C

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/24/2018 et al		

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Hainer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Hainer PCHA — **Date** 4-17-19

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

Plan of correction implementation status as of 5/30/19 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. **Violation Review:**
   REGULATION 2600.187(d)
   The home shall follow the directions of the prescriber.

2. **Violation Interpretative Statement:**

Resident #3's insulin was administered incorrectly on two occasions identified during the survey process.

3. **Review the benefit of the Regulation, per RCG:**

In order to ensure a resident receives medications and treatments as ordered by a physician it is necessary for a community to follow the directions of the prescriber.

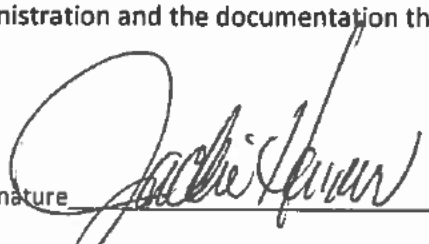
4. **Description of the Repair of the Immediate Problem:**
   Resident #3 had a medication error report completed, at the time of survey, regarding the administration of 10 units when 8 units should have been administered on the 22nd of March 2019 and when the a.m. dose of insulin was omitted on the 26th of March 2019.

   A new and complete pharmacy label was obtained documenting the standing order and sliding scale order for the insulin.

   Staff Person B has been educated as to the 5 Rights of Medication Administration.

5. **Determine / document the Root Cause of the Violation:**

   A deficit in staff education and accountability has been identified with regards to medication administration and the documentation thereof.

Authorized Signature  Date: 4-17-19

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6. **Detail Action Steps / System Developed to prevent future occurrence:**

a. Changing practice

To ensure the highest degree of diligence on medication pass our sliding scale insulin orders will require a two-team member sign off at the time of medication pass. This will ensure the team member will engage a witness to observe sliding scale insulin administration.

A weekly audit will be completed on all insulin orders to ensure they are reconciled with the glucometer reading and the eMAR documentation. Any discrepancies involving the administration of insulin will be recorded as medication errors and reported. Any documentation errors will be addressed with the respective team member for re-education and/or discipline as warranted. All audit documentation will be maintained.

b. Teaching or Training?

Education will be completed on the following:

1. Documentation of blood glucose testing to ensure its accuracy and that documentation in the eMAR and glucometer are identical. This will be achieved via a 2-team member verification. A second person verification will be required to be documented in the eMAR system. In addition, community procedures will now require a progress note be documented if for any reason the glucometer does not reflect the last blood sugar reading i.e. a dropped glucometer, a change in batteries, a new glucometer being put into place for a resident.
2. Weekly glucometer reading audits will remain in place and any medication errors identified will be reported.

c. On-going Monitoring

The Director of Wellness and/or designee who is an authorized and trained team member for medication pass, will audit weekly for two weeks to ensure blood glucose testing documentation is being documented accurately. MARs will be reconciled with blood glucose meters to ensure accuracy of all readings. Any discrepancies will be addressed and/or reported as warranted. Any additional education and/or discipline will be done with the involved team members. Audits will be done weekly for two weeks with all results being reported monthly to the SQIRT (quality) committee. All audit documentation will be maintained.

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4/22/19

7. Designated position responsible and specify target date for correction.

The Director of Wellness and/or designee who is an authorized and trained team member for medication pass.

Training was completed : 04/18/2019
The Audit was implemented on : 04/18/2019
Monitoring to occur weekly by DRCS beginning: 04/18/2019

Authorized Signature _____ Date: 4-17-19

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4/22/19

Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

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 was admitted on 11/28/2018; however, the preadmission screening for resident #4 was not completed until 12/17/2018.

Resident #5 was admitted on 3/5/2019; however, the preadmission screening for resident #5 was not completed until 3/14/2019.

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

See attached PAGES 9A AND 9B OF 11

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

Signature of Legal Entity Representative (Required on EVERY Page) Jackie Hamer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jackie Hamer PCHA — Date 4-17-19

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

Plan of correction implementation status as of 5/30/19 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. Violation Review:
   REGULATION 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.

2. Violation Interpretative Statement:

   Resident #4 and #5's preadmission screening was completed after admission.

3. Review the benefit of the Regulation, per RCG:

The benefit of completing a preadmission screen prior to admission ensures the community can safely meet a resident's needs prior to admission.

4. Description of the Repair of the Immediate Problem:

It would be a further violation of documentation to correct the deficient pre-admission screens identified.

5. Determine / document the Root Cause of the Violation:

A lack of education for a temporary team member has been identified as the cause of this violation. The community had an independent contractor completing this process from September 2018 through March 8, 2019

6. Detail Action Steps / System Developed to prevent future occurrence:

Authorized Signature _____ Date: 4-17-19

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4/22/19

a. Changing practice

Verification will be done by the Director of Wellness and/or designee to ensure a Department Preadmission Screen Form has been completed prior to a new admissions arrival. This information will be placed on a tracking log identifying the resident name, date of the preadmission screen and move-in date. All written audit documentation will be maintained.

The Director of Wellness will review all preadmission screenings after completion to ensure each is timely and completed in full in all areas, including determination that they home can meet the needs of the resident, and date of screening. --JRW 4/22/19

b. Teaching or Training

Education will be completed with the Sales and Marketing Director, the Business Office Manager and the PCHA with regards to this regulation.

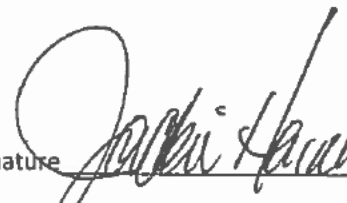
c. On-going Monitoring

The Director of Wellness and/or designee will report by exception to the SQIRT (quality) Committee on a monthly basis any issues of non-compliance. This will be done monthly for 3 months, then quarterly thereafter. All written audit documentation will be maintained.

7. Designated position responsible and specify target date for correction.

The Director of Wellness and/or designee with the PHCA ensuring proper follow up, education and/or discipline is completed as warranted.

Training was completed : 04/18/2019
The Audit was implemented on : 04/18/2019
Monitoring to occur weekly by DRCS beginning: 04/18/2019

Authorized Signature  Date: 4-17-19

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Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

1. REGULATION 55 Pa.Code §2600
2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.

2a. DESCRIPTION OF VIOLATION
The support plan for resident #2, dated 8/21/2018, does not contain any signatures.

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

See attached PAGES 10A AND 10B

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

Signature of Legal Entity Representative (Required on EVERY Page) Millie Hamer

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Millie Hamer PCHA — **Date** 4-17-19

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The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. Violation Review:
   REGULATION 2600.227(g)
   Individuals who participate in the development of the support plan shall sign and date the support plan.

2. Violation Interpretative Statement:

Resident #2's support plan from 8/21/2018 did not have any signatures.

3. Review the benefit of the Regulation, per RCG:

Having individuals who participate in the development of the support plan sign and date the support plan provides a record of who participated in the development of the support plan for future reference purposes.

4. Description of the Repair of the Immediate Problem:
   The Support Plan for Resident #2 will be reviewed for accuracy and ensure appropriate signatures are documented on support plan including indication of a refusal or unable to sign.

5. Determine / document the Root Cause of the Violation:
   There have been several transitions within the department. Comprehension of procedural knowledge has been reviewed.

6. Detail Action Steps / System Developed to prevent future occurrence:

Authorized Signature Debbie Hamm Date: 4-17-19

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a. Changing practice?

PHCA and Director of Wellness and/or designee will review RASPs initially, quarterly, annually and with any significant change so as to ensure all appropriate signatures are documented on the support plan including indication of a refusal or unable to sign at the time of review.

A tickler file of support plan review dates will be developed and as the support plan date approaches, a care plan conference will be scheduled with the resident, responsible party and team member. All written documentation will be maintained.

b. Teaching or Training?

Team members responsible for the development of the support plan shall review the Regulation, Community Policy and the RCG manual with regards to the support plan and reasons for obtaining signatures.

c. On-going Monitoring?

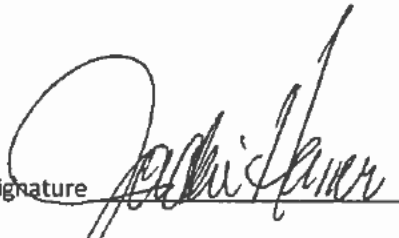
An audit will be completed on all Support Plans for signatures of all individuals who participate in the support plan. Any identified issues of non-compliance will have the Support Plan reviewed for accuracy and will have a Care Plan meeting set up to review the Support Plan, obtain input, and secure signatures. If an individual refuses to sign or is unable to sign and/or participate, then that corresponding information will be documented on the Support Plan as appropriate and a signature obtained of the POA if applicable. All written documentation will be maintained.

Reporting of compliance will be done monthly via SQIRT (quality) Committee and be by exception.

7. Designated position responsible and specify target date for correction.

Director of Wellness and/or designee and PHCA

Training was completed : 04/22/2019
The Audit was implemented on : 04/22/2019
Monitoring to occur weekly by DRCS beginning: 04/22/2019

Authorized Signature  Date: 4-17-19

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Violation Report: 43361 - 03/26/2019 - Hoover, Josh
PCH Name: THE PINES OF MT LEBANON

1. REGULATION 55 Pa.Code §2600
2600.227(h) - If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

2a. DESCRIPTION OF VIOLATION
The support plan for resident #1, dated 8/23/2018 is not signed by the resident. Staff interviews indicate that resident #1 refused to sign the plan; however, his refusal was not indicated on the plan.

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

SEE PAGES 11A AND 11B

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)	Jackie Hainer QCHA		Date 4-17-19	

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The above plan of correction is approved as of 4/22/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

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

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: March 26 & 27 2019

Date of Submission: April 18, 2019

1. Violation Review:

REGULATION 2600.227(h)

If a resident or designated person is unable to or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

2. Violation Interpretative Statement:

Resident #1's support plan from 8/23/2019 was not signed by the resident and staff did not document the refusal on the plan.

3. Review the benefit of the Regulation, per RCG:

If a resident and/or designated person participates in the development of the support plan and is unable or chooses not to sign and date the support plan, noting this in the record provides a record of who participated in the development of the support plan for future reference purposes (even though the persons did not sign).

4. Description of the Repair of the Immediate Problem:
The Support Plan for Resident #1 will be reviewed for accuracy and ensure appropriate signatures are documented on support plan including indication of a refusal or unable to sign.

5. Determine / document the Root Cause of the Violation:
There have been several transitions within the department. Comprehension of procedural knowledge has been reviewed.

Authorized Signature _____ Date: 4-17-19

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6. Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice

PHCA and Director of Wellness and/or designee will review RASPs initially, quarterly, annually and with any significant change so as to ensure all appropriate signatures are documented on the support plan including indication of a refusal or unable to sign at the time of review.

A tickler file of support plan review dates will be developed and as the support plan date approaches, a care plan conference will be scheduled with the resident, responsible party and team member. All tickler files and schedules will be maintained.

b. Teaching or Training

Team members responsible for the development of the support plan shall review the Regulation, Community Policy and the RCG manual with regards to the support plan and reasons for obtaining signatures.

c. On-going Monitoring

An audit will be completed on all Support Plans for signatures of all individuals who participate in the support plan. All audits will be maintained. Any identified issues of non-compliance will have the Support Plan reviewed for accuracy and will have a Care Plan meeting set up to review the Support Plan, obtain input, and secure signatures. If an individual refuses to sign or is unable to sign and/or participate, then that corresponding information will be documented on the Support Plan as appropriate and a signature obtained of the POA if applicable.

Reporting of compliance will be done monthly via SQIRT (quality) Committee and be by exception.

7. Designated position responsible and specify target date for correction.

Director of Wellness and/or designee and PHCA

Training was completed : 04/18/2019
The Audit was implemented on : 04/18/2019
Monitoring to occur weekly by DRCS beginning: 04/18/2019

Authorized Signature Jackie Hamm Date: 4-17-19

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4/22/19

RECEIVED
MAY 22 2019
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report

Facility Information

Name: *THE PINES OF MT LEBANON* License Number: *433611*
Address: *1537 WASHINGTON ROAD, PITTSBURGH, PA 15228*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Jackie Hainer* Phone: *4123414400* Email: *LPUTZIER@INTEGRACARE.COM*

Legal Entity

Name: *TITHONUS MT LEBANON LP*
Address: *C/O INTEGRACARE CORP 6600 BROOKTREE COURT SUITE 1000, PA, 15090*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *71* Waking Staff: *53*

Inspection

Type: *Partial* BHA Docket #: Notice: *Unannounced*
Reason: *Incident,Monitoring*

Inspection Dates and Department Representative

05/03/2019 - On-Site: Josh Hoover, Patricia Bartlett

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* Residents Served: *47*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *18* Residents Served: *6*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *47*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *24*
Have Physical Disability: *0*

16c - Written Incident Report

Regulations

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 § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 4/1/2019, 2 cards containing 30 tabs each of Oxycodone HCL 5mg for resident #1, who self-administers all medications, were delivered to the home. Staff Person A took possession of the medication. Instead of following the home's regular procedures and notifying the resident of the receipt of the medications and having the resident come to the wellness center to take pick it up, staff person A took the medications to resident #1's bedroom, which was unoccupied at the time, placed the medication on the resident's bed, and covered it with an item of clothing.

On 4/6/2019, resident #1 reported that she did not receive the usual number of pills of the Oxycodone HCL 5mg. Upon investigation by the home, it was discovered that 1 card containing 30 tabs of Oxycodone was missing.

This incident was not reported to the Department until 4/11/2019.

Plan of Correction (POC)

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

see attached Page 2A of 3

Legal Entity Representative

Jackie Hamer — Signature

Jackie Hamer Executive Dir. — Printed Name and Title

5/22/2019 — Date

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The above plan of correction is approved as of 5/30/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

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

PLAN OF CORRECTION

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: May 3, 2019

Date of Submission: May 22, 2019

1. Violation Review:
   REGULATION 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.

2. Violation Interpretative Statement:
   Reporting incidents allows the Department to respond promptly to serious situations and offers homes the opportunity to provide information that may reduce the need for the Department to pursue additional information.

3. Review the benefit of the Regulation, per RCG:
   The primary benefit of this regulation is to allow the home the opportunity to provide information that may reduce the assumption of non-compliance with regulatory issues.

4. Description of the Repair of the Immediate Problem:
   The PCHA and licensed nursing staff have been educated to Appendix A i.e. a list of reportable incidents. In addition, education included following the "when in doubt, send it out" rule as outlined in the RCG manual.

   The Medication Assistant involved in this event has been terminated for violation of policy regarding the handling and storage of medications.

5. Determine / document the Root Cause of the Violation:
   The community in an attempt to provide a comprehensive report, delayed to report while compiling all information. Staff delayed reporting event to admionistr4ation due to event occurring on a weekend.

See Page 2B of 3

Authorized Signature Jackie Hamer Date: 5-22-2019

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PLAN OF CORRECTION

6. Detail Action Steps / System Developed to prevent future occurrence:

   a. Changing practice?
   "When in doubt, send it out"
   All questionable events will be reported prior to any investigation being initiated.
   Ensure all contact telephone numbers for administration are readily available.
   The home will submit an inital report and a final report where applicable. -- JRW 5/30/19

   b. Teaching or Training?
   All licensed team members have been educated on reportables per Appendix A, 2600.16c

   c. On-going Monitoring?
   Review of 24 hour documentation, internal communications will be done so as to ensure whether a certain type of event or specific situation needs to be reported.

7. Designated position responsible and specify target date for correction.
   The Personal Care Home Administrator will be responsible to ensure all reportables are submitted timely. Reportable events will continue to be reviewed in monthly Safety and Quality committees on an ongoing basis.
   Date of Completion: May 24, 2019

5/30/19

Authorized Signature Jodi Hamm Date: 5-22-2019

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185a - Implement Storage Procedures

Regulations

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.

Description of Violation

On 4/1/2019, 2 cards containing 30 tabs each of Oxycodone HCL 5mg for resident #1, who self-administers all medications, were delivered to the home. Staff Person A took possession of the medications. Staff person A took the medication to resident #1's bedroom, which was unoccupied at the time, and placed the medications on the resident's bed, covering them with an item of clothing. Staff person A's actions violated the home's policies on self-administration and narcotic storage, which indicate that "medications for self-administering residents will be kept in a locked container in the resident's room and their room door will be locked at all times."

On 4/6/2019, resident #1 reported that she did not have the correct amount of medication. Upon investigation it was discovered that 1 card containing 30 tabs of Oxycodone HCL 5mg was missing. The home investigated the incident, notified the local police, and staff person A was terminated from employment at the home.

Plan of Correction (POC)

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

See attached Page 3a of 3

Legal Entity Representative

Jackie Hainer — Signature

Jackie Hainer, Executive Dir — Printed Name and Title

5/22/2019 — Date

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The above plan of correction is approved as of 5/30/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

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

Community Name: The Pines of Mount Lebanon

License Number: 433610

Date of Visit: May 3, 2019

Date of Submission: May 22, 2019

1. Violation Review:
   REGULATION 2600.185a 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.

2. Violation Interpretative Statement:
   The home's current policy regarding the delivery of medications to a resident's room who is a self-administrator of medications was not enough to prevent an event.

3. Review the benefit of the Regulation, per RCG:
   The primary benefit of this regulation is to ensure the risk is reduced for medications and medical equipment being misplaced, lost or misused.

4. Description of the Repair of the Immediate Problem:
   The Medication Assistant involved in this incident has been terminated from employment.

5. Determine / document the Root Cause of the Violation:
   The Medication Assistant involved in this incident failed to secure delivered medications in the locked medication storage box within the resident's room.

6. Detail Action Steps / System Developed to prevent future occurrence:

   a. Changing practice?
      Upon medication delivery, pharmacy manifests will be reconciled and signed by the receiving nurse. Medications delivered to residents room will be done so with the resident present and the team member will witness the medications being placed in locked storage. A manifest of medications will be signed by the delivering team member and the resident who self-administers medications

   b. Teaching or Training?

See Page 3B of 3

5/30/19

Authorized Signature [signature] Date: 5-22-2019

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All team members who are approved medication administrators have been educated to the change in policy regarding the handling and storage of medications.

c. On-going Monitoring?
The Director of Wellness or Designee will receive all pharmacy manifests and review by initials and date that the manifests have been reconciled. Any errors will be first reported, then investigated accordingly.

7. Designated position responsible and specify target date for correction.
The Director of Wellness and/or designee will be responsible to review pharmacy manifests and then report any follow up action accordingly. Reportable events will continue to be reviewed in monthly Safety and Quality committees on an ongoing basis.
Date of Completion: May 24, 2019

All residents who self-administer medications will be reeduated on the home's policies and procedures for accounting for medications and instructed to report any discrepancies. Documentation will be kept. --JRW 5/30/19

5/30/19

Authorized Signature [signature] Date: 5-22-2019

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