



July 2, 2019

Ms. Brenda Campbell
Administrator
Chicora Medical Center, LP
160 Medical Center Road
Chicora, Pennsylvania 16025

RE: Quality Life Services - Chicora
Certificate #:405530

Dear Ms. Campbell:

As a result of the Department's Bureau of Human Services Licensing annual inspection on April 23, 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,

A handwritten signature in black ink that reads "J. Rowe".

Jacqueline L. Rowe
Director

Enclosure
Violation Report

Violation Report

Facility Information

Name: *QUALITY LIFE SERVICES CHICORA*

License Number: *405530*

Address: *160 MEDICAL CENTER ROAD, CHICORA, PA 16025*

County: *BUTLER*

Region: *WESTERN*

Administrator

Name: *Brenda Campbell*

Phone: *7244452000*

Email: *BCAMPBELL@QUALITYLIFESERVICES.COM*

Legal Entity

Name: *CHICORA MEDICAL CENTER LIMITED PARTNERSHIP*

Address: *ATTN BRENDA CAMPBELL 160 MEDICAL CENTER ROAD, PA, 16025*

Certificate(s) of Occupancy

Type: *C-1*

Date: *02/05/1992*

Issued By: *Dept Health*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *12*

Waking Staff: *9*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

04/23/2019 - On-Site: Desmond Grace, Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26*

Residents Served: *11*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *10*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *1*

Have Physical Disability: *0*

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.

At approximately 10:15 a.m., the hard-wired carbon monoxide detector located on the ceiling of the boiler room was approximately 6 feet from the fossil fuel burning furnace.

Plan of Correction (POC)

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

The Carbon Monoxide Alarm was installed by Select Security who also monitor our fire alarm system attached is a floor plan of the boiler room which is not big enough for the alarm to be placed 15 feet away from the boiler.

A new carbon monoxide alarm has been placed outside the boiler room on the wall next to the door going into the boiler room

At least monthly, the administrator or a designated staff person will inspect the home and ensure that an operable carbon monoxide detector is present outside the boiler room door. *fy* 6/7/19

Legal Entity Representative

Brenda Campbell
Signature

Brenda Campbell PC Administrator 5-31-19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 6/7/19
(Date)

Plan of correction implementation status as of 6/7/19
(Date)

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

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

51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff person A, hired on 1/10/19, did not have a criminal background check completed until 3/28/19.

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.)

Upon doing a peer review of staff records before our inspection this staff's file was found not having a criminal background check, one was done immediately.

The Human Resource will audit current direct care staff records, that all have criminal background checks done.

Human Resource will do criminal backgrounds checks on all potential new hires before being hired.

Within 30 days of receipt of the plan of correction, all staff involved in the hiring process will be educated on §2600.51 and the Older Adult Protective Services Act. *JY* 6/7/19

Legal Entity Representative

Brenda Campbell

Signature

Brenda Campbell PCA Administrator 5-31-19

Printed Name and Title

Date

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(Initials)

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- Not Implemented

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff person B, hired 11/25/13, did not receive fire safety training completed by a fire safety expert or by a staff person trained by a fire safety expert during the 1/1/18 to 12/31/18 annual training year.

Repeat violation: 4/19/18 et al

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.)

Administrator has contacted the local fire department to set up a training during the day to include ancillary staff, direct care staff had their yearly training May 1, 2019. The Administrator will monitor the staff training plan monthly to ensure that all direct care staff and ancillary staff are trained annually on the requirements of Chapter 2600.65 (g) 1-6. waiting to hear back from fire Department - letter sent Administrator will contact fire Chief the beginning of each year to set up trainings

Legal Entity Representative

On 6/7/19, the home submitted a training record indicating staff person B recieved fire safety training on 6/7/19. *JS* 6/7/19

Brenda Campbell
Signature

Brenda Campbell PC Administrator 5-31-19
Printed Name and Title Date

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- Not Implemented

85e - Trash Outside Home

Regulations

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:00 a.m. there was a partially uncovered, 1/2 full dumpster located in the rear parking lot of the home next to the entrance to the main kitchen. The dumpster contained multiple garbage bags and the right side of the lid was left open.

Plan of Correction (POC)

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

The dumpsters are used by both the skilled unit and personal care unit along with dietary and housekeeping. Administrator spoke to all department heads at the department head meeting if they could all inservice their staff on shutting the dumpster lids and if one side of a dumpster is full go to the backside of dumpster or check a different one do not put trash in a side that the lid will not close.

Signs are posted where all staff can see

Maintenance Department will do rounds when doing building checks through out the day to ensure lids are closed they will make department head aware if dumpsters are open so they can remind staff to close lids when taking out trash.

Within 30 days of receipt of the plan of correction, all staff shall be educated on the need to keep trash covered at all times to prevent the penetration of insects and rodents. *JY* 6/7/19

Legal Entity Representative

Brenda Campbell
Signature

Brenda Campbell PC Administrator 5-31-19
Printed Name and Title Date

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141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on 3/19/19. However, the resident's previous medical evaluation was completed on 2/22/18.

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.)

when resident had his previous evaluation the doctor filled it out later and when next appointment was set up went off wrong date.
Administrator will have residents yearly medical Evaluation done within one year of the past evaluation being done and have the doctor fill out the form the same day as evaluation is done so there is no mistakes on dates.

Administrator will review charts and do a audit of when residents medical Evaluations are due.

Administrator reviews and edits will occur at least monthly. *JY* 6/7/19

Resident #2's next medical evaluation will be completed no later than 3/19/20. *JY* 6/7/19

Legal Entity Representative

Brenda Campbell
Signature

Brenda Campbell PC Administrator 5-31-19
Printed Name and Title Date

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171b5 - First Aid Kit

Regulations

2600.

171.b.5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

At 9:30 a.m., the first aid kit in the Ford van used by the home to transport residents did not include disposable gloves, antiseptic, a thermometer, eye coverings, a breathing shield, or tweezers.

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.)

A First Aid Kit has been put together and placed in the Van 5-28-19
 A check list has been placed on the kit of what is contained in the kit along with a sign out sheet to be signed by who opened the box and what was removed and instruction to let the Administrator know of anything that has been removed so it can be replaced.
 The kit will be checked monthly by the administrator and sign that the kit has been checked and all supplies are there if anything is missing it will be replaced.

Legal Entity Representative

Brenda Campbell

Signature

Brenda Campbell PC Administrator 5-31-19

Printed Name and Title

Date

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(Date)

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6/7/19

(Date)

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BC
(Initials)

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

184a - Labeling OTC/CAM

Regulations

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.

Description of Violation

Resident #3 was prescribed Acetaminophen 500 mg-give 2 tablets by mouth 3 times per day as needed for pain or elevated temperature. However, the pharmacy label on the medication does not indicate that the medication is administered as needed.

Resident #3 was prescribed Meloxicam 7.5 mg- give 2 tablets by mouth 1 time per day as needed for pain. However, the pharmacy label on the medication indicates give as needed in the morning.

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 orders had been changed, change of directions sticker has been placed on Pill card and bottle.
 Administrator and Designee will audit orders, Mar's, pharmacy labels to make sure they all match audits and any correction will be done by 7-19
 Administrator and Designee will review all new order to see that pharmacy labels match and they are put in Mar to match order and change of orders where we still have medication will put a change of direction sticker on till new meds come in.

Legal Entity Representative

The administrator or a designated staff person qualified to administer medications will review prescription labels monthly for accuracy. 6/7/19

Brenda Campbell
 Signature

Brenda Campbell PC Administrator 5-31-19
 Printed Name and Title Date

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 (Date)

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 (Initials)

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- Not Implemented

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 4/6/19 and 4/10/19 at 8:00 a.m., Staff person C administered Tamsulosin 0.4 mg to resident #4 as prescribed. However, staff person C did not initial the resident's April 2019 medication administration record (MAR) when administering the medication.

On 4/6/19 and 4/10/19, Staff person C administered Ecotrin 81 mg to resident #4 as prescribed. However, Staff person C did not initial the resident's April 2019 MAR when administering the medication.

Plan of Correction (POC)

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

All Staff educated on making sure to be signing the Mars when giving medication.

Administrator will audit mars for 2 weeks for any missed signings and will report results to QA meeting in June.

Administrator will re educate and review with staff if any holes are found in the mars

At least monthly, the administrator or a designated staff person qualified to administer medications will audit the medication carts and records for proper documentation of medication administration. *[Signature]* 6/7/19

Legal Entity Representative

Brenda Campbell

Signature

Brenda Campbell PC Administrator 5-31-19

Printed Name and Title

Date

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(Initials)

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- Not Implemented

224a - Preadmission Screen Form

Regulations

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.

Description of Violation

6/7/19

WITHDRAWN

[Redacted text]

Resident #3's preadmission screening, completed on 2/18/19, does not include an indication that needs of the resident can be met by the home. This section of the form was left blank.

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.)

When a resident is to be admitted to the home a preadmission screening will be done before admission this will be done by the Administrator or designee If a resident goes to the skilled and returns to personal care a new pre screen will be done a check list has been created for all new admission's and readmission from skilled that will be use to check off as admission forms are being done This will be reviewed during the first month of admission to make sure all forms are completed. Resident #3 preadmission screening has been corrected Administrator or Designee will have a second person review the form to make sure no boxes or parts of the form has been missed

Legal Entity Representative

At every new admission, the administrator or designated staff person will ensure that all residents have a preadmission screening form completed within 30 days prior to admission, indicating the needs of the resident can be met by the services provided by the home.

Brenda Campbell

Signature

Brenda Campbell PC Administrator 5-31-19

Printed Name and Title

Date

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- Fully Implemented
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- Not Implemented

225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3 was admitted to the home on 2/19/19; however, the resident's initial assessment was not completed until 3/6/19.

Repeat violation: 4/19/18 et al

Plan of Correction (POC)

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

All residents Assessments will be Audited by the Administrator and designee for accuracy and any correction if needed by 6-7-19
Each resident will have assessment done annually or upon a significant change.

Administrator will report results at the QA meeting in June

Resident #3 was one day over due to day of admission not being counted as one of the 15 day to have assessment done

The day of admission will be included as one of the 15 days to have assessment done

Within 30 days of the plan of correction and monthly thereafter, the administrator will audit resident assessments for compliance with §2600.225 (a) 6/7/19

Legal Entity Representative

Brenda Campbell

Signature

Brenda Campbell PC Administrator 5-31-19

Printed Name and Title

Date

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The above plan of correction was approved by [initials] (Initials)

- Fully Implemented
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- Not Implemented

225c - Additional Assessment

Regulations

2600.

225.c. The resident shall have additional assessments as follows:

- 1. Annually.
- 2. If the condition of the resident significantly changes prior to the annual assessment.
- 3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #2's initial assessment was completed on 5/5/17; however, the next assessment was not completed until 11/5/18.

Repeat violation: 4/19/18 et al

Plan of Correction (POC)

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

All new admission will have assessment done within 15 days of being admitted then yearly within one year prior to previous assessment unless there is a significant change in the resident then a assessment would be done sooner
 Administrator and designee will audited assessment to ensure they are being done within the year or sooner for a significant change

Within 30 days of receipt of the plan of correction, all staff persons involved in completing resident assessments will be educated in §2600.225c (1)-(3). *fy* 6/7/19

Legal Entity Representative

Brenda Campbell

Signature

Brenda Campbell PC Administrator 5-31-19

Printed Name and Title

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