



MAILING DATE: September 18, 2019

Ms. Margie McCarty
Executive Director
Manor Care Linden Village of Lebanon PA, LLC
333 North Summit Street, 16th Floor
Toledo, Ohio 43604

RE: Linden Village Manor Care Health Services
100 Tuck Court
Lebanon, Pennsylvania 17042
Certificate #: 324270

Dear Ms. McCarty:

As a result of the Department's Bureau of Human Services Licensing inspection on June 3, 2019 of the above facility, the citations 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.

Sincerely,

Gloria Emick

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: LINDEN VILLAGE MANOR CARE HEALTH SERVICES
Address: 100 TUCK STREET, LEBANON, PA 17042
County: LEBANON **Region:** CENTRAL

License Number: 324270

Administrator

Name: Margie McCarty **Phone:** 7172747400 **Email:** margie.mccarty@hcr-manorcare.com

Legal Entity

Name: MANOR CARE LINDEN VILLAGE OF LEBANON PA LLC
Address: 333 NORTH SUMMIT ST, 16TH FLOOR, TOLEDO, OH, 43604

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 10/01/1998 **Issued By:** L & I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 86 **Waking Staff:** 65

Inspection

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

Inspection Dates and Department Representative

06/03/2019 - On-Site: Kellie Cargile

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 64 **Residents Served:** 53

Secured Dementia Care Unit

In Home: Yes **Area:** Mt. Hope and Tabor **Capacity:** 32 **Residents Served:** 31

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 52
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 33 **Have Physical Disability:** 0

Rec'd
8/2/19
GE

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation dated 2/11/19, did not include health status or cognitive functioning.

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.)

1. Resident Services Coordinator and Marketing Director were inserviced on 7/29/2019 by Executive Director on Regulation 141.a to ensure compliance. (Attachment: Copy of Regulation & In-Service)
2. An audit of all Medical Evaluations was done by Executive Director on 8/1/2019 and going forward.
3. A new DME was completed on 7/29/2019 to include Health Status and Cognitive Functioning. The DME was noted as a Status Change at DHS request (there is no change in status). (Attachment: DME)

Legal Entity Representative

Margie McCarty
Signature

Margie McCarty Executive Director
Printed Name and Title

8-2-19
Date

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The above plan of correction is approved as of 9/18/19
(Date)

Plan of correction implementation status as of 9/18/19
(Date)

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

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

#141a1

133a3

2600.133(a)(3) - If the home serves nine or more residents, exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

Discussion: Self-explanatory.

Inspection Procedures: Inspectors will check each exit door during the physical site inspection and verify that the posted exit sign meets the height and width requirements.

Primary Benefit: Signage may be obscured by smoke during fires. Large lettering helps people locate exit doors.

RESIDENT HEALTH

Resident Medical Evaluation and Health Care

141a1

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

Discussion: This seemingly straightforward regulation is a source of much confusion for many personal care homes.

It is important to remember that the primary focus of this requirement is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner - NOT that a form be properly completed. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation (see § 2600.141(a)(2)).

Compliance with this regulation is achieved by following three basic steps:

1. A resident is evaluated *in person* by a physician, physician's assistant, or certified registered nurse practitioner within the specified timeframe. The evaluation includes checking everything required by § 2600.141(a)(2).
2. The evaluation results are documented on the Department's Documentation of Medical Evaluation (DME) form.
3. The physician, physician's assistant, or certified registered nurse practitioner who completed the evaluation signs and dates the DME form, certifying that the information is true and that it was established via an in-person examination.

Homes are PERMITTED to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

Margie McCarty
Margie McCarty, Executive Director
8-2-19

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 4/9/19. The resident's previous medical evaluation was completed on 4/7/17.

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.)

1. An audit was completed by Resident Services Cordinator and Executive Director to ensure all Medical Evaluations were completed annually.
2. LPN's were inserviced by Executive Director on 7/29/19 and 7/30/2019 on Regulation 141.b.1 (Attachment: Copy of Regulation and In-service Sheet)
3. System was implemented by Resident Services Cordinator or designee to ensure all Medical Evaluations are completed annually. Date-8-1-2019 and ongoing.
4. Executive Director and Resident Services Cordinator will audit charts monthly for compliance. 8/1/2019 and ongoing.

Legal Entity Representative

Margie McCarty
Signature

Margie McCarty, Executive Director
Printed Name and Title

8/2/19
Date

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M Argie McCarty
 Marge McCarty Executive Director

8/2/19

141.21

141a2

2600.141(a)(2) - The medical evaluation must include the following:

- (1) A general physical examination by a physician, physician's assistant or nurse practitioner.
- (2) Medical diagnosis including physical or mental disabilities of the resident, if any.
- (3) Medical information pertinent to diagnosis and treatment in case of an emergency.
- (4) Special health or dietary needs of the resident.
- (5) Allergies.
- (6) Immunization history.
- (7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
- (8) Body positioning and movement stimulation for residents, if appropriate.
- (9) Health status.
- (10) Mobility assessment, updated annually or at the Department's request.

Discussion: Self-explanatory.

Inspection Procedures: Inspectors will review DMEs to verify that the medical evaluation included all of the required elements. If an element is not recorded on the DME, but the home is able to obtain evidence that the in-person evaluation did include the element by the exit conference on the last day of the inspection, there is no regulatory violation. If necessary, inspectors may verify with the physician, physician's assistant or certified registered nurse practitioner that corrected information is valid.

Primary Benefit: Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

141b1

2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

Discussion: See § 2600.141(a)(1). In this case, "annually" means "within 12 months of the most recent medical evaluation that included all of the elements at § 2600.141(a)(2)." Additionally, the Department allows a 15-day grace period for completion of the annual evaluation, so annually actually means "within 12 months and 15 days of the most recent medical evaluation that included all of the elements at § 2600.141(a)(2)."

Inspection Procedures: See § 2600.141(a)(1) and (2). Remember that homes have a 15-day grace period to ensure completion of the evaluation.

Primary Benefit: Accurate, updated medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

- 1. Resident's name.
- 3. Name of medication.
- 4. Strength.
- 5. Dosage form.
- 6. Dose.
- 7. Route of administration.
- 8. Frequency of administration.
- 9. Administration times.
- 13. Date and time of medication administration.
- 14. Name and initials of the staff person administering the medication.

Description of Violation

-Resident #1 is prescribed Levothyroxine, 100 mcg. This medication was administered on 4/28/19 and 4/30/19 at 7 am; however, it is not included on the resident's medication administration record (MAR).

-On 4/29/19, Resident #1 was out of the facility. The resident's MAR does not notate that the resident was out of the facility for the following medications: Anacin Tablet at 8 am, Calcium 600 + Vitamin D 400 at 9 am, Lamotrigine ER, 25 mg at 9 am, Metoprolol Tartrate, 50 mg at 9 am, Levothyroxine, 100 mcg 7 am, and Lorazepam, .5 mg at 9 am and 2 pm.

-On 4/26/19, Resident #2's MAR indicated that 9 am medications were administered. Resident #2 did not receive prescribed medications at that time due to ingesting another resident's medication and being sent to the emergency room.

Plan of Correction (POC)

* See attached page. * Page 4A of 5

(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

Legal Entity Representative

Margie McCarty
Signature

Margie McCarty Executive Director
Printed Name and Title

8/2/19
Date

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Plan of Correction (POC)

187a

1. Employees Identified as responsible for administering medications to Residents #1 and #2 were counseled by Resident Services Coordinator on appropriate medication record procedures. (Attachments: counseling forms)
 2. The Medication Carts are audited weekly by the Resident Services Supervisors to ensure compliance with regulation 187.a. The audits will be reviewed by the Resident Services Coordinator or designee weekly. (Attachment: Medication Cart Audit form).
 3. All nurses and certified medication administration employees were in-serviced on regulation 187.a by the Resident Services Coordinator on 7/31/2019. (Attachment: In-Service Sheet)
-

Margie McCarty _____
 Signature

Margie McCarty Executive Director 8/2/19
 Printed Name and Title

Margie McCarty
 Margie McCarty Executive Director
 8/2/19

187a

Medication Records

187a

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

- (1) Resident's name.
- (2) Drug allergies.
- (3) Name of medication.
- (4) Strength.
- (5) Dosage form.
- (6) Dose.
- (7) Route of administration.
- (8) Frequency of administration.
- (9) Administration times.
- ~~(10) Duration of therapy, if applicable.~~
- (11) Special precautions, if applicable.
- (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
- (13) Date and time of medication administration.
- (14) Name and initials of the staff person administering the medication.

Discussion: The medication administration record is commonly referred to as the MAR. Proper MAR use is critical, as it:

- Creates a record of proper medication administration
- Allows physicians and emergency personnel to know when a medication was last administered
- Creates a system to account for medications, especially controlled substances.

What medications must be recorded on the MAR?

- Prescription medications
- OTC medications
- Vitamins
- CAM

What medications are not required to be recorded on the MAR?

- Nutritional supplements
- Special diets

Nutritional supplements and special diets do not need to be recorded on the MAR, but the home must be aware of and provide nutritional supplements and special diets if ordered by a physician.

Remember, homes are responsible for ensuring that residents may take OTC medications without causing allergic reactions or impacting prescription medications prescribed to the resident.

What administration information must be recorded on the MAR? If several pills are packaged together in one blister pack and administered together at the same time, information for each pill in the blister must be listed individually on the MAR; the reason for this relates to residents' right to refuse medications. If a person refuses to take a pill or if one or more of the pills in the blister is not administered, the home must have a means of documenting the refusal.

The administration of a medication by a source outside of the home (such as a monthly scheduled injection in a physician's office or medication administered while visiting family) **should not** be documented on the MAR for the home. Only medication given by staff members of the home are to be documented on the MAR. However, any documentation given to the resident as a result of receiving administration of a medication by a source outside of the home (such as invoices, doctor's notes; etc) should be kept in the resident's record for reference purposes.

Diagnosis must be included because the same medications may be used to treat different conditions.

If there is a specific time of administration listed on the medications record, such as 8:00 AM and 8:00 PM, the actual clock time of each administration is not required to be recorded. The record can simply include staff initials. This means the medication was given within 60 minutes plus or minus the specified time. If the medication record does not list a clock time (such as am, pm, at breakfast, after lunch) the exact time of administration must be recorded.

252 - Record Content

Regulations

2600.

252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #1's record does not include eye color or hair color.

~~Resident #3's record does not include eye color.~~

Plan of Correction (POC)

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Resident #1 face sheet was updated to include eye and hair color. (Attachment: Updated face sheet)
Resident #3 face sheet was updated to include eye color. (Attachment: Updated face sheet)

Chart audit was completed by Executive Director and Resident Services Coordinator on 7/29/2019 and will be completed ongoing to ensure all required information is included on face sheets upon move-in.

Legal Entity Representative

Margie McCarty
Signature

Margie McCarty Executive Director
Printed Name and Title

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