



pennsylvania
DEPARTMENT OF HUMAN SERVICES

October 4, 2019

Mr. James E. Stambaugh II
Administrator / Owner
Hillside Manor Personal Care Home, Inc.
177 Oliver Road
Uniontown, Pennsylvania 15401

RE: Hillside Manor Personal Care Home
License #: 467990

Dear Mr. Stambaugh:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 12, 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, appearing to read "Kevin Hancock".

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The current license was not posted in the home. The license posted in the home was expired on 4/9/19.

The most recent renewal inspection licensing inspection summary (LIS) completed on 6/6/18 and 6/17/18 was not posted in the home. Only a LIS from 11/7/18 complaint investigation was posted.

There was no copy of Pa 55 Code Chapter 2600 posted in the home.

Repeat Violation 6/6/18, 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.)

See Page 2A of 17

Legal Entity Representative

Signature *James E. Stambough II*

Printed Name and Title *James E. Stambough*
Administrator Date *8/14/19*

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

The above plan of correction is approved as of 8/21/19 (Date)

Plan of correction implementation status as of 8/21/19 (Date)

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

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

3C. 2600

The current license was immediately posted to the Facility Information Board (see attached photo). Designated staff person will check weekly to verify current license is posted on the Facility Information Board.

Effective Immediately

We were not aware that the most recent annual inspection results were required to be posted. The most recent complaint inspection was posted because it was the most current inspection report. Immediately the last annual inspection report was inserted into the binder on the Facility Information Board (see attached photo). Designated staff person will check weekly to verify the most current annual inspection report is posted on the Facility Information Board.

Effective Immediately

The PA 55 Code Chapter 2600 was inserted into a sleeve of the binder attached to the Facility Information Board (see attached photo). Designated staff person will check weekly to verify the PA 55 Code Chapter 2600 is posted.

Effective Immediately

James E. Handley

8/21/19



65e - 12 Hours Annual Training

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

The home's documentation of training demonstrates that direct care staff person A only completed 6 hours of training during the 2018 staff training year (1/1/18-12/31/18).

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.)

See Page 3A of 17

Legal Entity Representative


Signature 

Printed Name and Title *James E. Stambaugh* *Adminis*
Date *8/14/19*

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

The above plan of correction is approved as of *8/21/19*
(Date)

Plan of correction implementation status as of *8/21/19*
(Date)


The above plan of correction was approved by 
(Initials)


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

65e.2600

It was not brought to our attention during inspection that the inspectors were unable to locate all of the annual 2018 required training for staff person A. Staff person A 2018 training was mixed in with staff person A 2019 training (see attached certificates, tests, and attendance sheets). A designated staff person will coordinate and verify that at least 12 hours of required annual training related to job duties is completed annually.

Effective Immediately

Immediately: The administrator shall develop and implement a policy and procedures to ensure all required documentation is available to the Department upon request. 8/21/19 

8/21/19 

James E. Spadek

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self-administration training.

Description of Violation

Direct care staff person A, hired 2/16/17, did not receive annual training in medication self-administration during the 2018 staff training year (1/1/18- 12/31/18).

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.)

See Page 4A of 17

Legal Entity Representative

James E. Stambaugh II
Signature

James E. Stambaugh
Printed Name and Title
Administrator

8/14/19
Date

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

The above plan of correction is approved as of 8/21/19
(Date)

Plan of correction implementation status as of 8/21/19
(Date)



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

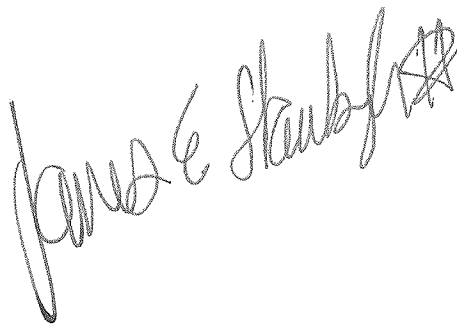
- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

65f.2600

It was not brought to our attention during inspection that the inspectors were unable to locate all of the annual 2018 required training for staff person A. Staff person A 2018 training was mixed in with staff person A 2019 training (see attached certificates, tests, and attendance sheets). A designated staff person will coordinate and verify that all staff receives annual education on medication self-administration training.

Immediately: The administrator shall develop and implement a policy and procedures to ensure all required documentation is available to the Department upon request. 8/21/19

 8/21/19 



65i - Training Record

Regulations

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Neither the Attendance Sheets nor certificates of training for the following topics for the 1/1/18-12/31/18 staff training year included the length of the course: depression; falls; emergency preparedness; universal precautions; instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan; geriatric skin integrity; and stress management.

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 Page 5A of 17

Legal Entity Representative

Signature *James E. Stambaugh*

Printed Name and Title *James E. Stambaugh*
Administrator

Date *8/14/19*

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

The above plan of correction is approved as of *8/21/19*
(Date)


Plan of correction implementation status as of *8/21/19*
(Date)

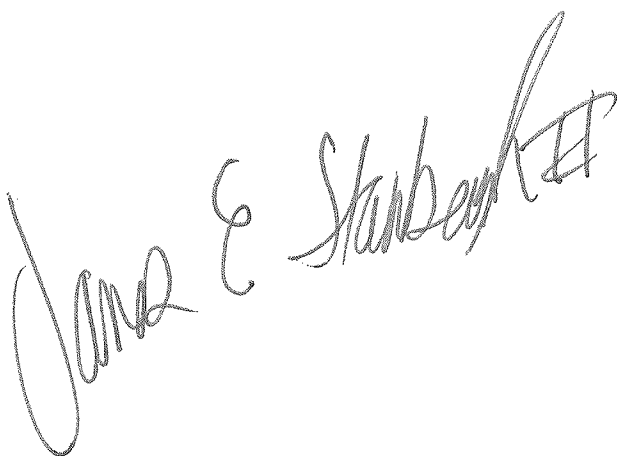
The above plan of correction was approved by *[Signature]*
(Initials)


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

65i.2600

A individual staff training completion sheet is kept in addition to the attendance sheet. The individual staff training sheet was implemented from a 2014 inspection when we were told that we needed to have a approximate date of completion for each training topic. The length of the course is also included on the individual staff training completion sheet (see attached). In addition to each staff member signing off on the individual staff training sheet, all of the 2018 certificates included a length of training except depression (see attached certificates). A new attendance sheet was made which includes the length of training and a certificate is attached to show that the length of training has been added (see attached).

Immediately: The administrator shall develop and implement a policy and procedures to ensue all required documentation is available to the Department upon request. 8/21/19 



8/21/19 

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 10:29 a.m., one half of the two-sided split lid of the dumpster located to the right of the building was open. The dumpster was 1/4 full of black bags of trash and a yellow mop bucket.

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 Page 6A of 17

Legal Entity Representative

James E. Stanbaugh
Signature

James E. Stanbaugh
Printed Name and Title *Administrator*

8/14/19
Date

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

The above plan of correction is approved as of 8/21/19 (Date)


Plan of correction implementation status as of 8/21/19 (Date)

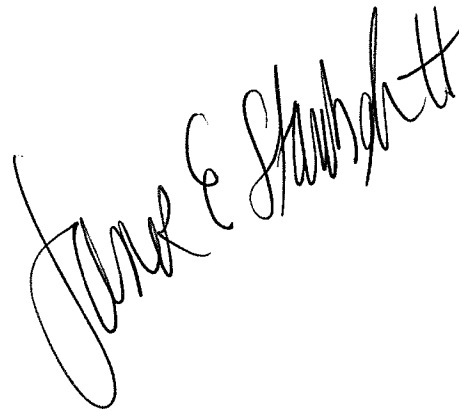
- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented


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

85e.2600

A designated staff person will check the dumpster daily to ensure that both sides of the split lid dumpster are closed.

Violation corrected at the time of inspection. 8/23/19 



8/21/19 

Effective immediately

92 - Windows

Regulations

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At 11:50 a.m. there was a hole measuring approximately 6" X 5" in the screen of the window in Bedroom #408.

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 Page 7A of 17

Legal Entity Representative

James E. Stambaugh #
Signature

James E. Stambaugh # *8/14/19*
Printed Name and Title *Administrator* Date

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

The above plan of correction is approved as of *8/21/19*
(Date)

Plan of correction implementation status as of *8/21/19*
(Date)

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


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

92.2600

Bedroom # 408 was unoccupied. A screen was ordered prior to inspection. The screen has been delivered and replaced (see attached photo). A designated staff member will check the screens/windows monthly.

Effective immediately

James E. Stanley/ets

8/21/19 

96a - First Aid Kit

Regulations

2600. 96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

At 3:30 p.m., the home's first aid kit located in the kitchen did not include gauze or bandages.

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 Page 8A of 17

Legal Entity Representative

James E. Stanbury II
Signature

James E. Stanbury II
Printed Name and Title Administrator

8/14/19
Date

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

The above plan of correction is approved as of 8/21/19 (Date)

Plan of correction implementation status as of 8/21/19 (Date)

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


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

96.a.2600

Effective
8/21/19
Lump & denton

Gauze and bandaids were added to the first aid kit. A designated staff person will check the kit weekly to ensure that all required items are in the kit.

James E. Lump & Denton

8/21/19 

103i - Outdated Food

Regulations

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 10:25 a.m., there were 6 frozen sausage patties in an unlabeled, undated plastic bag in the home's walk-in freezer.

At 10:28 a.m., there was a dented 6.56lb can of Arrezzo Marinara Sauce in the dry foods area off the kitchen.

Repeat violation 6/6/18, 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.)

See Page 9A of 17

Legal Entity Representative

James E. Stambaugh II
Signature

James E. Stambaugh II
Printed Name and Title
Admin. Director

8/14/19
Date

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

The above plan of correction is approved as of

8/21/19
(Date)

Plan of correction implementation status as of

8/21/19
(Date)

The above plan of correction was approved by

JS
(Initials)

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

103.i.2600

The sausage patties were immediately thrown away. The kitchen staff was re-educated that EVERYTHING must be labeled and dated. Effective immediately designated staff person will check weekly to ensure that all food is labeled and dated.

The can of marinara sauce was returned to the food company (Sysco) on 6/7/19(Friday is food delivery day). Effective immediately, all kitchen staff instructed to put a note on any dented cans that will be returned for credit to food company.

James E. Spaulding

8/21/19



123b - Emergency Procedures Posted

Regulations

2600. 123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The emergency preparedness plan for the local municipality were not posted in 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 Page 10A of 17

Legal Entity Representative

Signature: *James E. Stankovich*

Printed Name and Title: James E. Stankovich administrator Date: 8/14/19

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

The above plan of correction is approved as of 8/21/19 (Date)


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

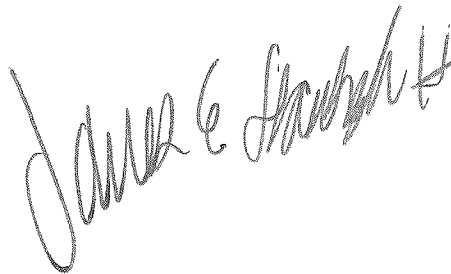
Plan of correction implementation status as of 8/21/19 (Date)


- Plan of correction implementation status as of 8/21/19 (Date)
[] Fully Implemented
[X] Partially Implemented - Adequate Progress
[] Partially Implemented - Inadequate Progress
[] Not Implemented

123.b.2600

The emergency plan was immediately placed in the binder on the Facility Information Board (see attached photo). The plan was not posted because we were in the process of working with the township to review and update the plan. The plan will remain posted until a revised plan is obtained.

Immediately: The administrator or designated staff person shall check weekly to ensure the emergency preparedness plan for the local municipality is posted in a public and conspicuous place. 8/21/19 



8/21/19 

132c - Fire Drill Records

Regulations

2600. 132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record for the fire drill conducted on 5/21/19 at 2:33 p.m. does not indicate which exit routes were used during the fire drill.

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 Page 11A of 17

Legal Entity Representative

Signature [Handwritten Signature]

Printed Name and Title: James E. Stambaugh # Administrator Date: 8/14/19

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

The above plan of correction is approved as of 8/21/19 (Date)

Plan of correction implementation status as of 8/21/19 (Date)


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

- Plan of correction implementation status as of 8/21/19 (Date): [] Fully Implemented, [X] Partially Implemented - Adequate Progress, [] Partially Implemented - Inadequate Progress, [] Not Implemented

132.c.2600

The fire drill record was immediately updated during inspection by the staff person responsible for fire drills. Effective immediately, designated staff person will check monthly to ensure that fire drill record is complete.

James E. StaubyRott

8/21/19 

183b - Meds and Syringes Locked

Regulations

- 2600.
- 183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 11:14 a.m., the following medications were setting on the tray table next to the bed in the unlocked, unattended resident bedroom #109 with prescription labels for resident #1:
 *120 Nystatin 100,000u/gm topical powder with pharmacy label indicating "use as directed."
 *56.7 Zinc oxide ointment – apply topically to buttocks 3 times daily for skin breakdown.

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 Page 12A of 17

Legal Entity Representative

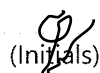

 Signature

James E. Stambaugh
 Printed Name and Title *Administrative*
 Date *8/14/19*

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

The above plan of correction is approved as of *8/21/19*
 (Date)

Plan of correction implementation status as of *8/21/19*
 (Date)

The above plan of correction was approved by 
 (Initials)

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

183.b.2600

Medications were immediately returned to the nurses station. All staff responsible for administering medications were re-educated on not leaving any medications in resident's rooms. Effective immediately, designated staff member will inspect rooms weekly to ensure no medications are in resident rooms.

James E. Skubgahst

8/21/19



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:

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is prescribed polyethylene glycol – Mix 8.5 grams (on-half capful) into 8 oz of beverage of choice and take by mouth daily as needed. However, the prescription label indicates Polyethylene glycol 255gm – Dissolve 1/2 capful (8.5gm) in 4 oz of water and take by mouth daily as needed for constipation.

Resident #2 is prescribed lactulose 10 gram/15mL oral solution – Take 15 milliliters by oral route 1 time per day as needed for constipation only. However, the prescription label for this medication indicates Lactulose 10gm/15ml solute – take 2 tablespoonfuls (30ml) by mouth daily as needed for constipation.

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 Page 13A of 17

Legal Entity Representative

James E. Stambaugh
Signature

James E. Stambaugh
Printed Name and Title

8/14/19
Date

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

The above plan of correction is approved as of 8/21/19 (Date)

Plan of correction implementation status as of 8/21/19 (Date)

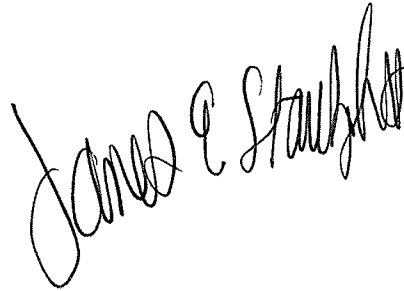
- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented


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

184.a.2600

A direction change sticker was placed on Polyethylene Glycol and Lactulose. New signed orders were obtained from CRNP so prescriber orders match MAR (see attached). Effective immediately designated staff persons will ensure that all prescriber orders match MAR and pharmacy labels.

Immediately: The administrator or designated staff person qualified to administer medications will conduct an initial and monthly review of all medications to ensure the original container for prescription medications shall be labeled with a pharmacy label in accordance with regulation 2600.184a. 8/21/19



8/21/19 

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

Resident #1 receives blood glucose monitoring 3X daily. The blood glucose reading in the resident's glucometer for 6/9/19 at 12:24 p.m. was 98. However, the 6/9/19 12:00 p.m. blood glucose entry in the resident's June 2019 medication administration record (MAR) was 84.

Resident #3 receives blood glucose monitoring 3X daily before meals. The blood glucose reading in the resident's glucometer for 6/5/19 at 6:45 a.m. was 176. However, the 6/5/19 7:30 a.m. blood glucose entry in the resident's June 2019 MAR was 161. There is a second entry for 6/5/19 at 8:00 a.m. which is 141.

The June 2019 MAR for resident #3 includes the following entries for blood glucose readings which are not indicated in the resident's glucometer to include:

6/9/19 at 7:30 a.m. BG 100
6/9/19 at 8:00 a.m. BG 108
6/10/19 at 7:30 a.m. BG 110
6/10/19 at 8:00 a.m. BG 108.

The June 2019 MAR for resident #4 includes the following entries for blood glucose readings which are not indicated in the resident's glucometer to include:

6/5/19 at 6:00 a.m. BG 113
6/6/19 at 6:00 a.m. BG 95
6/7/19 at 6:00 a.m. BG 114
6/11/19 at 6:00 a.m. BG 125
6/12/19 at 6:00 a.m. BG 104.

The June 2019 MAR for resident #5 includes the following entries for blood glucose readings which are not indicated in the resident's glucometer to include:

6/1/19 at 8:00 a.m. BG 100
6/4/19 at 8:00 a.m. BG 112
6/5/19 at 8:00 a.m. BG 100
6/7/19 at 8:00 a.m. BG 140
6/10/19 at 8:00 a.m. BG 103

On 6/12/19 at 4:47 p.m., the glucometer for resident #6 was not calibrated to the correct date and time. The glucometer indicated it was 5/1 at 11:08 a.m.

Description of Violation *(continued)*

The June 2019 MAR for resident #6 includes the following entries for blood glucose readings which are not indicated in the resident's glucometer to include:

- 6/5/19 at 6:00 a.m. BG 123
- 6/6/19 at 6:00 a.m. BG 114
- 6/7/19 at 6:00 a.m. BG 130
- 6/10/19 at 6:00 a.m. BG 108
- 6/12/19 at 6:00 a.m. BG 124


Repeat violation 6/6/18, 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.)

See Page 15A of 17

Legal Entity Representative



 Signature

 8/24/17
 Printed Name and Title *Administrator* Date

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

The above plan of correction is approved as of 8/21/19
(Date)

Plan of correction implementation status as of 8/21/19
(Date)

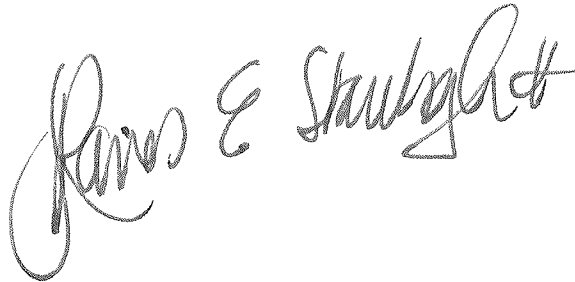
The above plan of correction was approved by 
(Initials)

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

185.a.2600

All staff that administer medications were re-educated on entering routine and as needed blood glucose results into Quickmar. New glucometers were obtained for all resident's that have a physician's order for blood glucose checks (see attached pharmacy labels and delivery sheets). Effective immediately designated staff person will check all glucometers weekly for calibration and to ensure that all readings in glucometer match MAR.

Immediately: The administrator or designated staff person shall review resident glucometers and blood glucose records daily to ensure glucometer readings coincide with the blood glucose records. 8/21/19



8/21/19



190a - Completion Medication Course

Regulations

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Resident #1 is prescribed Liquacel Liq protein - Flush PEG tube w/ 15ml water; then give 2 tablespoonfuls (30ml) of liquid protein via tube at 12 noon; flush again with 15cc after (do not give on Monday; Wednesday; and Friday). The medication was administered on 6/1, 6/2, 6/4, 6/8, and 6/9/19 at 12:00 p.m. by staff person B who is not licensed to administer medication via a PEG tube. The medication was administered on 6/11/19 at 12:00 p.m. by staff person C who is not licensed to administer medication via a PEG tube.

Resident #1 is prescribed Phospha 250 neutral tablet - Crush one tablet into a fine powder, mix with 30ml of lukewarm water and give via PEG tube [flush tube with 30ml of water before and after giving medication]. The medication was administered on 6/1-6/4/19 and 6/7-6/10/19 at 12:00 p.m. by staff person B who is not licensed to administer medication via a PEG tube. The medication was administered on 6/5/19 and 6/11/19 at 12:00 p.m. by staff person C who is not licensed to administer medications via a PEG tube.

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.)

Immediately: The administrator shall develop and implement a policy and procedure to ensure documentation of staff training and qualifications is available to the Department upon request. All staff persons shall be educated on the policy and procedures. Documentation of education shall be kept. 8/21/19

[Handwritten signature]

Legal Entity Representative

[Handwritten signature]
Signature

James E. Stambaugh #
Printed Name and Title
8/14/19
Date

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

The above plan of correction is approved as of 8/21/19 (Date) Plan of correction implementation status as of 8/21/19 (Date)

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

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

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 #7's initial assessment, completed 10/6/18, was not updated to include the diagnoses of depression that was indicated on the resident's medical evaluation completed 3/21/19.

Repeat violation 11/7/18

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.)

See Page 17A of 17

Legal Entity Representative

James E. Stanbaugh
Signature

James E. Stanbaugh 8/14/19
Administrator Date

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

The above plan of correction is approved as of 8/21/19 (Date)

Plan of correction implementation status as of 8/21/19 (Date)

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

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

225.a.2600

A new DME was obtained (see attached) and RASP was updated for a significant change (see attached). Effective immediately designated staff person will compare DME diagnosis list to diagnosis list on RASP to ensure that all diagnoses have been addressed.

Within 30 days of receipt of the plan of correction: The administrator or designee will review all resident assessments for accuracy and completion. Any incomplete or inaccurate assessments will be corrected immediately. 8/21/19

