



January 22, 2020

Ms. Lori Lasosky
Owner/Administrator
Lasosky's Personal Care Home, Inc.
200 Nobles Road
Brownsville, Pennsylvania 15417

RE: Lasosky's Personal Care Home
23 Main Street
Clarksville, Pennsylvania 15322
Certificate #: 418580

Dear Ms. Lasosky:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 19, 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", is written over a faint, larger version of the signature.

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

10/16/19

Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: LASOSKY'S PERSONAL CARE HOME, INC.

License Number: 41858

Address: 23 MAIN STREET,, CLARKSVILLE, PA 15322

County: WASHINGTON

Region: WESTERN

Administrator

Name: Lori Lasosky

Phone: 7243772680

Email: LASOSKY56@GMAIL.COM

Legal Entity

Name: LASOSKYS PERSONAL CARE HOME INC

Address: 200 NOBLES ROAD, BROWNSVILLE, PA, 15417

Certificate(s) of Occupancy

Type: C-2 LP

Date: 07/02/1998

Issued By: L & I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 23

Waking Staff: 17

Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal

Inspection Dates and Department Representative

06/19/2019 - On-Site: Lynn Winters, Joe Eveges

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 25

Residents Served: 21

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 4

Are 60 Years of Age or Older: 18

Diagnosed with Mental Illness: 5

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 2

Have Physical Disability: 0

17 - Record Confidentiality

Regulations

2600.

- 17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The resident privacy coding document, to include the names of residents #2 and #4, was posted on the home's bulletin board along with the violation report dated 7/6/18.

Repeat Violation: 7/6/18

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.)

The coding sheet was removed immediately. Managers were educated regarding privacy. Administrator will post violation reports from now on.

Immediately, then at least twice weekly, the administrator or designated staff person shall inspect all areas of the home to ensure resident records and documentation are kept confidential and inaccessible. Documentation of inspections shall be kept.

SE 12/24/19

Legal Entity Representative

Lori Lasosky
Signature

Lori Lasosky Admin 10/10/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/24/19
(Date)

Plan of correction implementation status as of 12/24/19
(Date)

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

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

20b3 - Written Receipts

Regulations

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

- 3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

No signature was obtained from resident #7 for cash withdrawals on 6/3/19, 6/5/19, 6/7/19, 6/10/19, 6/12/19, 6/14/19, 6/17/19 and 6/19/19. The home provides financial management for resident #6.


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.)

Signatures have been obtained. All staff educated regarding the importance of obtaining signatures. Administrator will check lock box weekly for signatures. Documentation of checks shall be kept.

 12/24/19

Legal Entity Representative



Signature

Lori Lasosky, Admin 10/10/19
Printed Name and Title Date

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(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

No criminal history check was completed for staff person A, hired 1/29/19.

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.)

Criminal Record check was completed immediately. All files were audited for accuracy. Managers educated regarding contents of employee records. New hire checklist completed for files.

Within 30 days of receipt of the plan of correction and then at least monthly: The administrator or designated staff person shall audit all current staff records to ensure a completed criminal history check is on file. Any missing criminal history checks shall immediately be obtained. Documentation of the audits shall be kept.

SE 12/24/19

Legal Entity Representative

Lai Lasosky
Signature

Lori Lasosky Admin. 10/10/19
Printed Name and Title Date

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- Partially Implemented - Inadequate Progress
- Not Implemented

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

A portable urinal containing a small amount of yellow liquid was sitting on the sink in the 1st floor common bathroom/shower.

A brown smear of what appeared to be feces was on the wall next to the light switch in bedroom #4.

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.)

urine was immediately emptied and wall cleaned. All staff educated regarding cleanliness of facility. Manager to make weekly rounds of facilities for cleanliness. Documentation of rounds shall be kept. SE 12/24/19

Reviewed with all staff during staff meeting on 10/14/19

Legal Entity Representative

Signature: [Handwritten Signature]

Printed Name and Title: Lori Lasosky

Date: 10/10/19

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- Partially Implemented - Inadequate Progress
- 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 approximately 11:00 AM, the dumpster was full of white garbage bags and the lids were 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.)

Dumpster lids closed immediately. All staff educated regarding keeping dumpster covered. Staff entering the Building upon start of shift will check to ensure it is covered. Manager to monitor weekly.

Documentation of checks shall be kept.

Reviewed with all staff at staff meeting 10/14/19

SE 12/24/19

Legal Entity Representative

Signature: Lore Lasosky

Printed Name and Title: Lore Lasosky Admin Date: 10/10/19

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Partially Implemented - Inadequate Progress
Not Implemented

101j3 - Bed/Linens/Pillows/Blankets

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

Resident #3's fitted bed sheet contained multiple holes and a large, bright red stain approximately 1" X 5". The bed did not have a flat sheet.

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.)

Fitted sheet was removed & discarded. Staff educated regarding disposing of worn linens & the need to have proper linens on beds at all times. Managers to make weekly rounds assessing linens. Documentation of rounds shall be kept. *SE* 12/24/19

Reviewed with all staff during staff meeting on 10/14/19

Legal Entity Representative

Jaci Lasosky
Signature

Lori Lasosky Admin 10/10/19
Printed Name and Title Date

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- Not Implemented

102i - Soap Dispenser

Regulations

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

No hand soap was present in the 1st floor common bathroom across from bedroom #6.

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.)

Hand soap was immediately Replaced.
(a Resident had Removed it.) Staff educated
to check soaps each shift in all Bathrooms
Manager to spot check weekly. Documentation of checks shall be kept.
SE 12/24/19

Reviewed with all staff during staff meeting on
10/14/19

Legal Entity Representative

L. Lasosky
Signature

Lori Lasosky Admin 10/10/19
Printed Name and Title Date

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- Partially Implemented - Inadequate Progress
- Not Implemented

107c - Food/Water 3 Day Supply

Regulations

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 6/19/19, the home was serving 21 residents, requiring 63 gallons on emergency water. However, the home only had 10 gallons of emergency water onsite. In addition, the contractual agreement with a vendor, dated 3/14/19, does not indicate the water will be delivered immediately upon request, 24-hours-per-day and it does not indicate the water will be delivered as a priority even in the event of a regional general emergency.

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 65 gallon water Buffalo was purchased & filled & will be kept in the home. Manager to check it monthly to be sure it is full. Documentation of checks shall be kept. *SE* 12/24/19

Picture enclosed

The home shall maintain the water storage tank in accordance with the manufacturer's instructions. Documentation shall be kept.

SE 12/24/19

Legal Entity Representative

Lori Las
Signature

Lori Lasosky Admin
Printed Name and Title Date

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- Partially Implemented - Inadequate Progress
- Not Implemented

109a - Pets

Regulations

2600.

109.a. The home rules shall specify whether the home permits pets on the premises.

Description of Violation

The home rules indicate pets are not permitted to live at the residence; however, on 6/19/19 there were 2 cats and 1 dog residing 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.)

The home rules were updated. Rules regarding pets are at administrator discretion & with proper vaccinations

Home Rules will be reviewed annually at Quality management meeting

Immediately, a copy of the updated home rules shall be given to all residents. Documentation shall be kept.

SE 12/24/19

Legal Entity Representative

Lori Lasosky
Signature

Lori Lasosky Admin.
Printed Name and Title

Date

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- Partially Implemented - Inadequate Progress
- Not Implemented

125a - Combustible Storage

Regulations

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A plastic mattress pad was wedged between a wheel chair and the furnace and a basket of paper/plastic poinsettias was sitting on the hot water heater in the new wing furnace room.

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.)

Mattress pad & paper / plastic poinsettias
 were removed immediately. Staff educated
 regarding Reg 125a. during staff meeting on
 Monday, Oct 14. Manager to check facility
 weekly for combustible materials near heat source.
 Reviewed with all staff during staff meeting
 on 10/14/19

Documentation of checks shall be kept.

SE 12/24/19

Legal Entity Representative

Lori Lososky
Signature

Lori Lososky
Printed Name and Title

10/14/19
Date

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(Date)

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- Partially Implemented - Inadequate Progress
- Not Implemented

131f - Fire Extinguisher Inspection

Regulations

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguishers in the following locations have not been inspected by a fire safety expert since May, 2018.

- * Front entrance
- * Dining/kitchen area
- * Front stairwell landing

The tag on fire extinguisher in the basement did not indicate in which month of 2018 it was inspected by a fire safety expert.

Plan of Correction (POC)

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

Fire Safety Company called & extinguishers were checked. During weekly Rounds Manager to check Fire extinguishers. We are on the companies annual automatic inspection. It was an error on the companies part.

Documentation of checks shall be kept. *SE* 12/24/19

Immediately, the fire extinguishers at the front entrance, dining/kitchen area, front stairwell landing and basement, shall be inspected and approved by a fire safety expert. Documentation shall be sent to the regional office.

SE 12/24/19

Legal Entity Representative

Jan Lasosky
Signature

Lois Lasosky Admin 10/14/19
Printed Name and Title Date

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(Date)

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(Initials)

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

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 fire drill record for the drill conducted on 7/9/18 does not indicate the exit routes used, the number of residents in the home at the time the alarm sounds, or the number of residents evacuated.

Repeat Violation: 7/6/18

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.)

All managers educated on completion of fire drill log. Tom Bonua (fire safety expert) to complete + review on 10/29. Administrator to check log

monthly for accuracy.

Monthly, the administrator or designated staff person shall audit the home's fire drill records immediately after each fire drill to ensure the following information is documented: 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.

SE 12/24/19

Legal Entity Representative

18 staff were present for fire safety training, conducted by a fire safety expert, on 10/29/19.

SE 12/24/19

Signature [Handwritten Signature]

Lori Lasosky Admin. 10/14/19
Printed Name and Title Date

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Plan of correction implementation status as of 12/24/19 (Date)

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

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

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Within the past year, the home did not have a fire safety expert designate in writing the location of fire safe areas (if any).

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.)

[Redacted] (Fire Safety Expert) to conduct Training and Fire Drill on 10/29. We had previously used our local Fire Dept. He will assess for fire safe areas. I will send that for verification once completed. Administrator to Review Fire Safety letter for Accuracy

A fire safety inspection was conducted by a fire safety expert on 10/29/19. The fire safety expert determined the home does not have a fire-safe area. SE 12/24/19

Within 15 days of receipt of the plan of correction: The administrator shall develop and implement a tracking system to ensure that at least once every 12 months, a fire safety expert designates in writing any fire-safe areas in the home. Within 30 days of receipt of the plan of correction, any staff involved in scheduling the annual fire safety inspection shall be trained on the new tracking system. Documentation shall be kept.

Legal Entity Representative

[Signature]
Signature

Lori Lasosky Admin
Printed Name and Title

10/14/19
Date

SE 12/24/19

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Plan of correction implementation status as of 12/24/19 (Date)

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

- Fully Implemented
Partially Implemented - Adequate Progress (checked)
Partially Implemented - Inadequate Progress
Not Implemented

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 initial medical evaluation does not indicate the date the resident was evaluated, the date the form was completed, blood pressure, height, weight, pulse rate, temperature, special health or dietary needs, immunization history, assessments of body positioning/moment, health status, cognitive functioning and mobility needs and the medical professional's name.

There is no medical evaluation for resident #3, admitted 5/15/19.

Repeat Violation: 7/6/18

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.)

Resident #1 DME was re sent to MD for completion -
 Resident #3 was evaluated & DME completed.
 All files audited to ensure accuracy
 all staff educated regarding time lines
 for Documentation. Spreadsheet completed
 with dates Documentation is due.

Within 30 days of receipt of the plan of correction and at least monthly thereafter: The administrator or designated staff person shall audit all resident records to ensure an initial medical evaluation is completed within 60 days prior or within 30 days after admission. The audit shall also include ensuring all required information is accurate and complete. Missing or incomplete medical evaluations shall immediately be returned to the physician for completion or new medical evaluations shall be scheduled. Documentation of the audits shall be kept.



12/24/19

Plan of Correction (POC) (continued)

Legal Entity Representative

Lori Lasosky
Signature

Lori Lasosky Adm. 10/14/19
Printed Name and Title Date

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The above plan of correction is approved as of 12/24/19
(Date)

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(Date)

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

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

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 annual medical evaluation, dated 8/10/18, does not indicate the resident's weight, special health or dietary needs, assessments of body positioning/movement, health status, cognitive functioning, medical professional name, medical professional license number, or date signed. Page 2 indicates the resident was examined on 11/27/17 and the form was completed 11/27/17.

Resident #4's annual medical evaluation, dated 3/5/18, does not indicate the resident's height or weight.

Repeat Violation: 7/6/18

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.)

New DME was completed - evaluation 7/1/19 for resident #2

Resident #4 ht & wt added & recent to MAs

Staff educated regarding completing proper completion of forms. All DMEs shall be checked by manager after MA signs. If not completed will be resent.

All files audited.

New checklist completed

SE 12/24/19

Legal Entity Representative

Within 30 days of receipt of the plan of correction and at least monthly thereafter: The administrator or designated staff person shall audit all resident records to ensure an in-person medical evaluation has been completed within the past year, in its entirety, for all residents in accordance with 2600.141b1. Documentation of the audits shall be kept.

Signature: [Handwritten Signature]

Printed Name and Title: Lorichasosy Admin

Date: 10/14/19

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

- Options: Fully Implemented, Partially Implemented - Adequate Progress (checked), Partially Implemented - Inadequate Progress, Not Implemented

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 4/2/19, resident #8 was prescribed and dispensed Albuterol 2.5 mg/3ml (0.083%) - inhale every 6 hours, take for 14 days. On 6/19/19, the medication was present 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.)

The Albuterol was discarded on 6/19/19.
Staff educated during staff meetings on 10/14/19 that once medication is dried that it must be discarded or returned to pharmacy.
Manager to check for outdated medication weekly

Documentation of checks shall be kept.

SE 12/24/19

Legal Entity Representative

Lori Lasosky
Signature

Lori Lasosky Admin
Printed Name and Title

10/24/19
Date

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- Partially Implemented - Inadequate Progress
- Not Implemented

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

2 oxygen canisters were sitting in the corner of resident#2 and resident#5's bedroom. The canisters were not stored in a rack or cart.

Resident #5's glucometer was not calibrated to the current date and time.

The home has a glucometer labelled "Spare Kit". Staff interviews indicate this glucometer is used if a resident's glucometer does not work. The glucometer contained multiple readings from 1/30/19 - 6/12/19.

Resident #6 is prescribed Novolog Inj Flexpen 100 unit/ml - inject sub-q as per sliding scale before meals: 70-130=0U, 131-180=2U, 181-240=4U, 241-300=6U, 301-350=8U, 351-400=10U, greater than 400=12U

Resident #6's June 2019 Medication Administration Record (MAR) indicates multiple blood glucose readings that do not correspond with the blood glucose readings in his glucometer, to include the following:

Date/Time	Glucometer	MAR
6/8/19, 8:49 AM	177	185
6/14/19, 7:33 AM	174	180
6/17/19, 12:07 PM	157	164
6/19/19, 11:24 AM	213	208

Resident #9 is prescribed Novolog Inj Flexpen 100 unit/ml - inject sub-q as per sliding scale 4 times a day: 70-130=0U, 131-180=2U, 181-240=4U, 241-300=6U, 301-350=8U, 351-400=10U, greater than 400=12U and call MD

Resident #9's June 2019 MAR indicates his blood glucose reading on 6/12/19 at 9:00 AM was 103, and 6/16/19 at 9:00 AM was 85; however, these readings were not on his glucometer.

Resident #9's June 2019 MAR indicates his blood glucose reading on 6/18/19 at 9:00 AM was 102; however, the blood glucose reading on his glucometer was 106.

Repeat Violation: 7/6/18

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.)

Plan of Correction (POC) (continued)

oxygen canisters were removed on 6/19/19 & medical equipment company called to pick up.

Resident #5 is not diabetic & Does not have a glucometer

Spare kit was discarded on 6/19/19

All glucometers were checked with Mar for errors. Resident #6 glucometer was malfunctioning. A new one was purchased.

All staff educated on proper documentation during staff meetings on 10/14/19.

2 staff will be required to document BS Readings & insulin given.

Manager to check for errors daily until 0 errors for 1 month

Within 30 days of receipt of the plan of correction: All staff persons performing blood glucose testing and/or administration of insulin injections shall successfully complete a Department-approved diabetes patient education program. This training shall be conducted an individual not working in the home, who is a certified diabetes instructor, trained by the National Certification Board for Diabetic Educators or a nurse practitioner with an advanced diabetes management certification. Documentation shall be sent to the regional office.

Legal Entity Representative

 12/24/19



Signature

Lori Lasosky Admin 10/14/19
Printed Name and Title Date

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The above plan of correction is approved as of 12/24/19 (Date)

Plan of correction implementation status as of 12/24/19 (Date)

The above plan of correction was approved by  (Initials)

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

187d - Follow Prescriber's Orders

Regulations

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 is prescribed Novolog Inj Flexpen 100 unit/ml - inject sub-q as per sliding scale before meals: 70-130=0U, 131-180=2U, 181-240=4U, 241-300=6U, 301-350=8U, 351-400=10U, greater than 400=12U

On 6/8/19 at 8:49 AM his blood glucose reading was 177 and 4 units of Novolog were administered. However, according to the prescriber's orders, 2 units of Novolog should have been administered.

Repeat Violation: 7/6/18

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.)

All staff educated regarding the importance of proper administration during staff meeting on 10/14/19
2 staff must observe glucometer & insulin dose
manager will check daily for errors.

Immediately, then once per week for 3 months, the administrator shall observe each staff person responsible for diabetic care perform blood glucose checks/insulin administration to ensure blood glucose readings are accurately documented on the resident MAR and insulin is administered in accordance with the directions of the prescriber. Documentation of the observations shall be kept.

 12/24/19

Legal Entity Representative

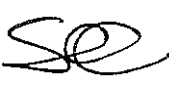

Signature

Lon Lasosky Admin 10/14/19
Printed Name and Title Date

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224c - Preadmission Screening

Regulations

2600.

224.c. The preadmission screening shall be completed by the administrator or designee. If the resident is referred by a State-operated facility, a county mental health and intellectual disability program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

Description of Violation

There is no printed name or signature of the person who completed the preadmission screening form for resident #3 on 5/15/19.

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.)

*Name was added to the pre screen.
managers educated regarding completion of forms
All files audited for appropriateness
Admission Checklist added for managers.*

Within 30 days of receipt of the plan of correction and then at least monthly, the administrator or designated staff person shall audit all resident records to ensure all residents have a preadmission screening form completed and present in each resident file. Documentation of the audit shall be kept.

 12/24/19

Legal Entity Representative



Signature

hori lasosky Admin 10/14/19
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of 12/24/19
(Date)

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(Initials)

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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

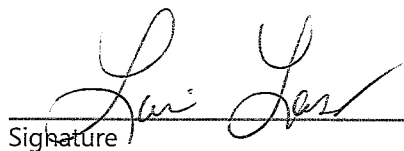
Resident #3's initial assessment, dated 5/17/19, does not include a description of service needs, a description of supervision needs, a description of mobility needs, social and recreational needs and medical and psychological diagnoses.

Plan of Correction (POC)

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

Resident # 3 assessment completed. All Records Audited for Appropriateness. Spreadsheet developed to track timeliness of completion. Administrator will check one Record per month to ensure completion. training completed for manager who was new at this time

Legal Entity Representative



Signature

Lori Lasosky Admin 10/14/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/24/19
(Date)

Plan of correction implementation status as of 12/24/19
(Date)

The above plan of correction was approved by 
(Initials)

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- Not Implemented

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's support plan, dated 5/17/19, is not signed by the resident nor does it indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

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.)

Support plan updated. Resident Refused to sign.
Manager educated Regarding the need for residents to sign or mark Refused or unable if appropriate

Within 30 days of receipt of the plan of correction: The administrator or designated staff person shall audit all current and newly completed support plans to ensure completion, including signatures of those involved in the development of the plan. Documentation of the audit shall be kept.

SE 12/24/19

Legal Entity Representative

Lori Lasosky
Signature

Lori Lasosky Admin 10/14/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/24/19
(Date)

Plan of correction implementation status as of 12/24/19
(Date)

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

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