pennsylvania
DEPARTMENT OF HUMAN SERVICES

September 26, 2019

Ms. Melissa L. Margotta
Administrator
Ecumenical Enterprises, Inc.
200 Lake Street
Dallas, Pennsylvania 18612

RE: The Meadows Manor
License #243650

Dear Ms. Margotta:

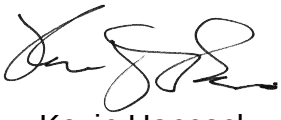
As a result of the Department's Bureau of Human Services Licensing annual inspection on July 1, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

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,



Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *THE MEADOWS MANOR* **License Number:** *24365*
Address: *200 LAKE STREET, DALLAS, PA 18612*
County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

Name: *Melissa Margotta* **Phone:** *5706759336* **Email:** *LKANARR@EEIDALLAS COM*

Legal Entity

Name: *ECUMENICAL ENTERPRISES INC*
Address: *200 LAKE STREET, DALLAS, PA, 18612*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *12/04/1996* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *51* Waking Staff: *38*

Inspection

Type: *Full* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

07/01/2019 - On-Site: Amy Deluca, Jason Harvey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *44*

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:** *44*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *7* Have Physical Disability: *0*

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.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff persons A and B did not have training in the following required annual training topic for 2018: Care for residents with dementia and cognitive impairment.

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.)

Effective immediately, the administrator and administrative assistant established a tracking chart with the required annual training topics as it pertains to regulation 65.f & 65.g that includes the person's name; date of hire; training topic and date(s) held.
During qualilty managment meetings held quarterly, a review will be completed of all training records and attendance to ensure that all staff members (direct care or other), substitute personnel and regularly scheduled volunteers received their required annual training. Documentation of this review will be maintained in the quality management meeting minutes.
In order to ensure current compliance, the administrator and administrative assistant completed a thorough audit of current training records.

Legal Entity Representative

Melissa L Margotta PCHA — Signature

Melissa L. Margotta, PCHA — Printed Name and Title

8-1-19 — Date

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

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

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

Plan of correction implementation status as of 8-8-19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ 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.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not have training in the following required annual training topic for 2018: Falls and accident prevention.

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: POC will be implemented in conjunction with POC for prior violation for regulation 65.f

The administrator will develop a staff training plan that includes the following information:

(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly-scheduled volunteer

(2) The required training courses for each person identified in (1).

(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g.

Legal Entity Representative

8-8-19
MM

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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

The following objects were found behind the home's row of four dryers located in the laundry room: 2 socks, several dryer sheets, a collection of lint, and a small washcloth.

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 discovery of items while performing the walk though with DHS licensing representatives, the administrator immediately notified maintenance staff to address area. Items were immediately removed & area was thoroughly cleaned.
Effective 7-2-19, a weekly inspection is now completed by maintenance department. Dryers are moved away from the wall and a thorough cleaning is also performed at time of inspection.
Nursing, dietary, housekeeping & maintenance department were in-serviced on regulation 125.a and what was found at time of inspection. Those staff members addressed are asked to also check areas when utilizing them.
To ensure continued compliance, weekly inspection sheets will be reviewed at quality management meeting & the administrator will perform random inspections of the area.

Legal Entity Representative

Signature Melissa L Margotta

Melissa L. Margotta, PCHA
Printed Name and Title

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132h - Designated Meeting Place

Regulations

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

On 10/10/2018 the local fire department conducted a fire drill in the home. According to the administrator, during the drill not all residents were evacuated to the interior of the fire safe stair towers of the home as per instruction by the fire department officials conducting the 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.)

The administrator will be present for the 2019 fire drill and inspection with the local fire department.
The administrator will inform all fire personal present that they must not block the hallways or stair towers impeding egress for the residents during the drill.
The administrator or maintenance staff present for all drills will ensure residents are evacuated in compliance with regulation 132.h.

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162c - Menus Posted

Regulations

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home had only the current week's menu posted in the home during the inspection.

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 discovery of only one week's menu being posted at time of walk through with DHS licensing representatives, the administrator immediately informed the dietary manager of the issue and it was immediately corrected.
Following the annual inspection, the dietary manager began in-servicing on regulation 162.c. Now, all dietary staff members are responsible to check on posted area daily and replace any menus not present.
The administrator and administrative assistant will also perform random audits of area to ensure ongoing compliance.

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THE MEADOWS MANOR 24365

182b - Prescription Medication

Regulations

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

The annual practicum for staff person D was overdue. The last practicum that was completed for staff person D is dated 5/11/2018. Staff person D currently passes medications.

The most current annual practicum documented for staff person A is incomplete because it was not dated and signed by the certified medication administration trainer.

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.)

Effective immediately, the administrative office will maintain records pertaining to the medication administration training.
The administator and administrative assistant developed a calendar tracking for all med techs to inform nursing staff of any upcoming annual practicums due.
A review was held of all records to ensure proper signatures were obtained and accounted for.
Current records of annual practicums will be maintained in the administrative office & will be reviewed during quality managment meetings to ensure all documentation is current & signed.
Record of the same will be maintained in the quality management meeting minutes.

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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 has an order for Toprol XL ½ tablet to be taken daily. The label on the blister pack stated the medication should be held for SBP<100 or HR<60. The pharmacy label does not match the current order for 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.)

A review was held & update completed to The Manor's Receiving Medications Policy to address errors that may occur from pharmacy labeling right at time of arrival.
The administrator requested a pharmacy review med cart audit to be completed to ensure all current medications are labeled in conjuction with the EMAR and physician orders.
All med tech/nursing staff will be in-serviced on the updates to the policy & also the use of "change of directions" stickers.

Legal Entity Representative

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185a - Implement Storage Procedures

Regulations

2600.

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

Description of Violation

Resident #2 receives regular blood glucose checks. On 6/28/19 the reading in the resident's meter was 214 but was recorded as 217 on the glucose monitoring 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.)

The administrator met with the Resident Care Manager & LPN Supervisor to develop a clear and concise Glucometer Policy to be implemented immediately.
Diabetic trained staff members will immediately be in-serviced on the policy.
In an effort to maintain accurate records, in addition to the EMAR recording of glucose testing results, we will be initiating a back up system of paper documentation.
The Resident Care Manager will complete weekly audits of glucometer readings, EMAR and paper doumentation of results. These results will be reviewd at quarterly quality manangement meetings and record of the same will be maintained in the quality management minutes.

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187c - Refusal of Medication

Regulations

2600.

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

Description of Violation

Resident #3 refused medications on 6/19/19 at 9:20am and on 6/24/2019 at 9:04am. The refusals were not reported to the resident's physician within 24 hours of these dates.

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 administrator, administrative assistant, resident care manager & LPN supervisor completed a review of our refusal of medications & treatments policy and updates were completed. The development of a Medication Refusal Report was also created and will be implemented immedately upon staff in-servicing of both.
The Medication Refusal Report contains information as it pertains to regulation 187.c and instruction to alert the PCP within 24 hours. RCC or LPN supervisor will be responsbile to review reports to ensure ongoing compliance and report forms will be maintained in resident charts.

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187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #1 receives regular blood glucose checks with insulin administered on a sliding scale. On the following dates and times these errors were noted on the glucose monitoring sheets:
Readings documented on 6/26/19 at 7:39am, 12:04pm, and 5:38pm were not found in the resident's glucometer.
6/30/2019 the 5:25pm reading was 265 requiring 6 units of insulin; 0 units were administered.
Resident #4 has orders for Lisinopril and Metoprolol, both to be held for SBP< 100 and DBP< 60.
On these dates both medications should have been held but were not:
6/1/19-6/5/19 at 9:00am and 6/4/19 at 5:00pm; 6/10/19-6/12/19 at 7:00am
Also, on 6/21/2019 staff did not administer any of his evening medications.

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 first violation listed above in relation to resident #2 will be addressed with the steps taken for POC in relation to regulation 185.a.
In regards to the second violation, Resident #2 is often non-compliant with insulin orders. With this on-going issue, the Resident Care Manager has contacted Resident #2's primary care physician to address the issue. The PCP referred resident to his endocrinologist to be seen. That appointment is scheduled for Friday, August 2nd. Any new orders received will be followed.
Violation #3 was reported to the DHS on Tuesday, July 2nd after discovered during the annual inspection that occured on Monday July 1st. (Please see attached reportable & corrective action)
Updates are as follows:
*Nursing in-services have already been completed.
*Annual Practicums are in process.
*Resident #4's PCP verified instances via a phone call with Resident Care Manager. No new orders were implemented. Current order was verified by PCP verbally during call.

Legal Entity Representative

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