



September 24, 2019

Ms. Carin Constantakis  
Chief Executive Officer  
Orion Personal Care Corporation  
2191 Ferguson Road  
Allison Park, Pennsylvania 15101

RE: Orion Personal Care  
License #: 431260

Dear Ms. Constantakis:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 8, 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](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", written over a white background.

Kevin Hancock  
Deputy Secretary  
Office of Long Term Living

Enclosure  
Violation Report

### Facility Information

Name: ORION PERSONAL CARE

License Number: 43126

Address: 2191 FERGUSON ROAD, ALLISON PARK, PA 15101

County: ALLEGHENY

Region: WESTERN

### Administrator

Name: Brandi Bankston

Phone: 4124929789

Email: brandi.bankston@oriongenerations.com

### Legal Entity

Name: ORION PERSONAL CARE CORPORATION

Address: 2191 FERGUSON ROAD, ALLISON PARK, PA, 15101

### Certificate(s) of Occupancy

Type: C-2 LP

Date: 12/12/1996

Issued By: Dept of L&I

### Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 42

Waking Staff: 32

### Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal

### Inspection Dates and Department Representative

07/08/2019 - On-Site: Scott Klein, Lauren Spagna

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: 25

Residents Served: 21

#### Secured Dementia Care Unit

In Home: Yes

Area: Entire Home

Capacity: 25

Residents Served: 21

#### Hospice

Current Residents: 10

#### Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 21

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 21

Have Physical Disability: 0

25b - Contract Signatures

Regulations

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1 had a resident-home contract dated 7/11/2018; however, the contract was not signed by the resident.

Resident #2 had a resident-home contract dated 4/18/2017; however, the contract was not signed by the resident.

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: Resident's legal POA signed agreement on Resident behalf. Due to dementia status, Resident was not cognitively able to sign the contract upon admission.

Resident #2: Resident's legal POA signed agreement on Resident behalf. Due to dementia status, Resident was not cognitively able to sign the contract upon admission.

Immediately: The administrator or designated staff person shall review and current and new contracts to ensure required signatures are present. If a resident is unable to sign the contract, the reason shall be documented on the contract. 7/29/19

*[Signature]*

Legal Entity Representative

*Brandi Banks-ton*

Signature

*Brandi Banks-ton, Administrator*

Printed Name and Title

*7/29/19*

Date

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

The above plan of correction is approved as of 7/29/19  
(Date)

Plan of correction implementation status as of 7/29/19  
(Date)

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

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

25b - Contract Signatures

Regulations

2600. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from  
25.b. the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1 had a resident-home contract dated 7/11/2018; however, the contract was not signed by the resident.

Resident #2 had a resident-home contract dated 4/18/2017; however, the contract was not signed by the resident.

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:** Resident's legal POA signed agreement on Resident behalf.  
Due to dementia status, Resident was not cognitively able to sign the contract upon admission.

**Resident #2:** Resident's legal POA signed agreement on Resident behalf.  
Due to dementia status, Resident was not cognitively able to sign the contract upon admission.

Immediately: All residents who participate in the development of their support plan shall be provided the opportunity to sign the support plan. If the resident is unable to sign the support plan, the reason shall be indicated on the support plan. 7/29/19

Legal Entity Representative

*Brandi Bankston*  
Signature

Brandi Bankston  
Printed Name and Title

7-27-19  
Date

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54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A. does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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.)

**Direct care staff person A's GED:** Despite repeated attempts and warnings, we were unsuccessful in obtaining a copy of A's GED as promised. As a result, she is no longer employed at OPCH. Moving forward, we will obtain proper documentation prior to employee start date.

Immediately: The administrator or designated staff person shall review all current direct care staff records to ensure all direct care staff persons meet the qualifications in accordance with regulation 2600.54(a). 7/29/29



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88a - Surfaces

Regulations

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The vinyl flooring in the bathroom next to resident bedroom #11 is in disrepair as follows:

- \* The vinyl flooring in front of the toilet has a tear measuring approximately 2 inches by 3 inches.
- \* The vinyl flooring in front of the sink has a tear measuring approximately 4 inches by 5 inches which is detached from the sub-floor.

Plan of Correction (POC)

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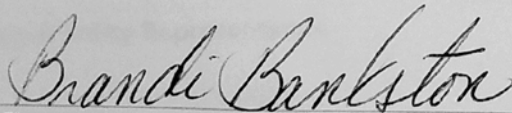
Vinyl flooring in Pod 3 bathroom: Arrangements are being made to replace the bathroom flooring. Date of correction by August 23, 2019. We will submit photo upon completion.

Immediately: A designated staff person shall check the home weekly to ensure compliance with regulation 2600.88(a).

7/29/19



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101j6 - Mirror

Regulations

2600.

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

6. A mirror.

Description of Violation

There is no mirror in resident bedroom #1. Resident #2 resides in bedroom #1.

Plan of Correction (POC)

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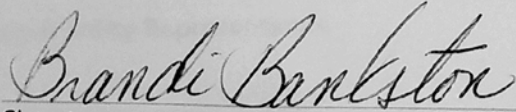
**Resident #2 (Rm #1) bedroom mirror:** Resident does have a wall mirror in her bedroom. However, prior to room inspection, Resident removed and packed the mirror in her suitcase in preparation for a trip. Day of inspection, the mirror was located and replaced on Resident's wall. DOC: July 8, 2019.

Immediately: A designated staff person shall check all resident rooms to ensure compliance with regulation 2600.101(j)(6).

7/29/19



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132e - Fire Drill Sleeping Hours

Regulations

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.


Description of Violation


On 6/10/18 at approximately 5:15 a.m. the home conducted a sleeping hours fire drill. However, the next sleeping hours fire drill was not conducted until 2/13/19 at approximately 5:30 a.m.

Plan of Correction (POC)

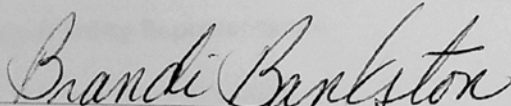
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

**Fire drill during sleeping hours every 6 months:** Moving forward, fire drill during sleeping hours will be scheduled, conducted, and documented every 6 months.

Immediately: The home shall conduct a sleeping hour fire drill. Documentation of the fire drill shall be kept. 7/29/19 

Immediately: The administrator shall monitor the home's fire drill record monthly to ensure a fire drill is conducted and a sleeping hour fire drill is conducted every six months. 7/29/19 

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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:

Description of Violation

Resident #1 is prescribed Lantus Solostar Pen 5X3ML, inject 25 units sub-Q in the PM as directed. However, the bag containing the pen is labeled with instructions to inject 36 units sub-Q in the evening as directed.

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.)

**Medication direction/label change:** Revised label reflecting direction change to Resident's medication was provided and subsequently applied to original medication container on July 8, 2019. In addition, the MAR was updated to reflect the direction change. Moving forward, In the event there is a direction change to a Residents medication, the Pharmacy will provide and OPCH will apply a new label to the original container and the change will be documented in Resident MAR.

Immediately: A designated staff person qualified to administer medications shall audit all prescription orders and prescription labels monthly to ensure compliance with regulation 2600.184(a) 7/29/19



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233c - Key-Locking Devices

Regulations

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

At approximately 10:05 a.m. the door to the courtyard is locked using a keypad-locking device,. However, the directions to unlock the device are not posted conspicuously near the device.

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.)

**Magnetic Keypad directions to lock/unlock secured exit doors:** Per OPCH & DHS policy we post, maintain & periodically update instructions for mag-lock door use, conspicuously near keypad for all mag-lock door exits. Updated directions were posted securely and conspicuously by courtyard door keypad July 8, 2019.

Immediately: A designated staff person shall check all keypad doors weekly to ensure compliance with regulation 2600.233(c).

7/29/19 

Legal Entity Representative section with signature of Brandi Bankston, printed name, and date 7-27-19.

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX! Section containing approval dates (7/29/19) and implementation status checkboxes (Fully, Partially Adequate, Partially Inadequate, Not Implemented).

234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #3 was admitted to the home on 1/10/19. However, a support plan was not developed for the resident until 1/25/19.

Plan of Correction (POC)

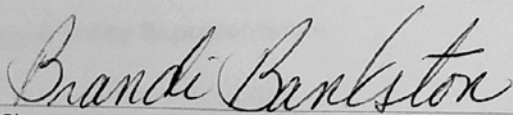
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

**Resident #3 support plan was not developed within 72 hours of admission:** This was the result of a miscommunication between administrator and assistant administrator. We immediately reviewed and discussed our in-house Resident checklist process and have implemented a double check system to avoid this in the future.

Immediately: The administrator or designated staff person shall audit all new resident admissions to ensure a support plan has been developed within 72 hours. 7/29/19



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