pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: October 31, 2019

Ms. Patti Baker
Administrator
WRC Pennsylvania Memorial Home
985 Route 28
Brookville, Pennsylvania 15825

RE: Laurelbrooke Personal Care
133 Laurelbrooke Drive
Brookville, Pennsylvania 15825
License #: 424630

Dear Ms. Baker:

As a result of the Department's Bureau of Human Services Licensing inspection on July 11, 2019 and July 12, 2019, of the above facility, the citations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Janine Wenzig
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *LAURELBROOKE PERSONAL CARE* License Number: *42463*

Address: *133 LAURELBROOKE DRIVE, BROOKVILLE, PA 15825*

County: *JEFFERSON* Region: *WESTERN*

Administrator

Name: *Patti Baker* Phone: *8148493615* Email: *www.wrc.org*

Legal Entity

Name: *WRC PENNSYLVANIA MEMORIAL HOME*

Address: *985 ROUTE 28, BROOKVILLE, PA, 15825*

Certificate(s) of Occupancy

Type: *I-1* Date: *04/13/2011* Issued By: *Boro of Brookville*

Staffing Hours

Resident Support Staff: Total Daily Staff: *70* Waking Staff: *53*

Inspection

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

Reason: *Complaint*

Inspection Dates and Department Representative

07/11/2019 - On-Site: Debora McConnell, Trish Barlett

07/12/2019 - On-Site: Debora McConnell

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* Residents Served: *44*

Secured Dementia Care Unit

In Home: *Yes* Area: *Harmony Circle* Capacity: *20* Residents Served: *19*

Hospice

Current Residents: *na*

Number of Residents Who:

Receive Supplemental Security Income: *2*

Are 60 Years of Age or Older: *44*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *26*

Have Physical Disability: *1*

LAURELBROOKE PERSONAL CARE 42463

60a - Staff/Support Plan

Regulations

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home routinely schedules 3 staff persons on the 10:00 pm.-6:00 am. shift. In the event of an emergency, the home's night staffing is inadequate to meet the supervision needs of the residents. On 6/30/19 and 7/6/19, on the 10pm-6am shift, 42 residents were present in the home, including 26 residents with mobility needs, 19 of whom reside in the secured dementia unit (SDCU). Residents #1, #2 and #3 are physically immobile needing 2-person assistance to transfer and there are 7 physically immobile residents in personal care, 3 of whom needing 2-person assistance in transferring.

During an emergency evacuation, staffing is not sufficient to transfer all of the residents who are physically immobile and to supervise residents of the SDCU.

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 resident immobile total in house currently is six residents in personal care whom need 1-person assistance in transferring. The resident immobile total in house currently is 19 in the secured dementia unit (SDCU) whom 1-person requires 2-person assistance in transferring. Immobile total for the facility has decreased. The Personal Care Home Administrator/Resident Care Coordinator or designee will evaluate on regular basis to assure adequate staffing on 10 pm - 6 am shift. More than required non waking hour fire drills will be conducted to ensure the fire evacuation time frame is met.

Immediately - A designated staff person will review the staffing schedule daily and the administrator will review the staffing schedule at least weekly, to ensure staffing needs, including transferring and supervision needs, are sufficient at all times to meet residents' needs, based on the residents' assessments and support plans. --JRW 9/23/19

Legal Entity Representative

Patti Baker — Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 9/23/19 (Date)

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

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE SEP 0 1 2019 42463

65a - FS Orientation 1st Day

Regulations

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was 1/15/19, did not receive orientation training in any of the required topics in accordance with §2600.65a.

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 guide for orientation training has been developed and includes the attached documents: The guide will be used for training with the Administrator and Resident Care Coordinator. All new staff will be trained and the documents will be reviewed for the required signatures until audits show no omissions for three consecutive months. Random audits continue thereafter.

By 10/31/19 - Staff person A will receive orientation training under 2600.65a. Documentation will be kept. - JRW 9/23/19

Immediately - The administrator or designated staff person will review all training records to ensure that all staff persons have completed the required orientation training under 2600.65a. In the event any staff person has not received this training, the training will be provided. Documentation will be kept.- JRW 9/23/19

Legal Entity Representative

Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 9/23/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE 42463

SEP 0 1 2019

65b - Rights/Abuse 40 Hours

Regulations

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed her 40th scheduled work hour in 2019. However, staff person A did not receive orientation training in the Emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, or reporting of reportable incidents and conditions.

Staff persons B. C, D and E completed their 40th scheduled work hours in 2019. However, they did not receive orientation training in reporting of reportable incidents and conditions.

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 guide for orientation training has been developed and includes the attached documents: The guide will be used for the training with the Administrator and the Resident Care Coordinator. All new staff will be trained and the documents will be reviewed for required completion and signatures until audits show no omissions for three consecutive months. Random audits continue thereafter.

By 10/31/19 - Staff persons A, B and C will receive orientation in the identified topics.

Staff person D no longer works in the home. Staff person E has not worked in the home for several months. If staff person E returns to work in the home, this staff person will receive orientation training in reportable incidents and conditions on the first day he/she returns to work. - JRW 9/23/19

Immediately - The administrator or designated staff person will review all training records to ensure that all staff persons have completed the required orientation training under 2600.65a. In the event any staff person has not received this training, the training will be provided. Documentation will be kept. -JRW 9/23/19

Legal Entity Representative

Patti Baker — Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 9/23/19 (Date)

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

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE 42463

SEP 01 2019

65d - Initial Direct Care Training

Regulations

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person C, hired 3/3/19, provided unsupervised ADL services from March 2019 - July 2019; however, staff person C did not complete the Department-approved direct care training course and pass the competency test until 7/11/19.

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.)

A checklist for new staff has been developed. Instructions have been reviewed with new Administrator and Resident Care Coordinator on completing the required documents prior to providing unsupervised ADL services. The Personal Care Home Administrator/Resident Care Coordinator or designee will audit staff documents for three consecutive months. All current staff documents will be updated and reviewed for accuracy.

Legal Entity Representative

Patti Baker — Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 9/23/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE 42463

SEP 0 1 2019

141a - Medical Evaluation

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.

Description of Violation

The initial medical evaluation for resident #4, signed by the physician on 4/23/19, does not indicate the date the resident was evaluated. This area is blank.

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.)

Instructions were reviewed with the newly hired Resident Care Coordinator on completion of the initial medical evaluation including when to revise. A guide list has been developed to audit admissions for completed documents and signatures and will be audited until audits show no omissions for three consecutive months. Random audits continue thereafter.

Legal Entity Representative

Patti Baker
Signature

Patti Baker PCHA
Printed Name and Title

08/31/19
Date

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

The above plan of correction is approved as of 9/23/19 (Date)

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

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE 42463

SEP 0 3 2019

227a - Support Plan 30 Days

Regulations

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

The support plan,for resident #5, dated 7/3/19, does not indicate the resident receives hospice services, or the type and frequency of the services provided by hospice.

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.)

Instructions were reviewed with the newly hired Resident Care Coordinator on completion of the support plan including when to revise. Leadership team meets every AM to discuss residents with changes in condition, admission, discharge etc. The support plan will be revised/updated to indicate the type and frequency of services provided by hospice. The Personal Care Home Administrator/Resident Care Coordinator or designee will audit monthly for three months. All current residents support plans will be updated and reviewed for accuracy by the end of the month.

Resident #5 is no longer in the home. - JRW 9/23/19

Legal Entity Representative

Patti Baker — Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 9/23/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE SEP 0 1 2019 42463

227d - Support Plan Medical/Dental

Regulations

2600:
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The support plan,for resident #6, dated 5/30/19, does not address the type and frequency of services provided by hospice.

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.)

Instructions were reviewed with the newly hired Resident Care Coordinator on completion of the support plan including when to revise. Leadership team meets every AM to discuss residents with changes in condition, admission, discharge etc. The supoort plan will be revised/updated to indicate the type and frequency of services provided by hospice. The Personal Care Home Administrator/ Resident Care Coordinator or designee will audit monthly for three months. All current residents support plans will be updated and reviewed for accuracy by the end of the month.

Resident #6 is no longer in the home. - JRW 9/23/19

Legal Entity Representative

Patti Baker

Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 9/23/19 (Date)

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

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE SEP 0 1 2019 42463

231b - Medical Evaluation

Regulations

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 4/17/19; however, the resident's medical evaluation does not indicate a diagnosis of dementia or the need for a SDCU.

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.)

Administrator and Resident Care Coordinator will review all new admissions using the guide list for admissions (see attached document). The guide will be used for training with the Administrator and Resident. All required documents and signatures will be audited until audits show no omissions for three consecutive months. Random audits continue thereafter.

The physician for resident #4 updated the resident's medical evaluation on 10/22/19 to include a diagnosis of dementia and the need for a SDCU. - JRW 10/24/19

Legal Entity Representative

Patti Baker

Signature

Patti Baker PCHA — Printed Name and Title

08/31/19 — Date

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

The above plan of correction is approved as of 10/24/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 10/24/19 (Date)

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

LAURELBROOKE PERSONAL CARE SEP 0 1 2019 42463

231c - Preadmission Screening

Regulations

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure SDCU on 4/17/19. However, the resident's written cognitive preadmission screening was not completed until 4/25/19.

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.)

A guide list for admissions has been developed and includes:
DME, RASP, Prescreen, Cognative Screen, MA-51, Picture, Facesheet, POA, Living Will, admissions contract with appropriate dates and signatures.
The guide will be used for training with the Administrator and Resident Care Coordinator.
All new admissions will be reviewed for required documents and signatures until audits show no omissions for three consecutive months. Random audits continue thereafter.

All written cognitive preadmission screenings for new residents of the SDCU will be completed within 72 hours prior to admission. - JRW 9/23/19

Legal Entity Representative

Signature | Patti Baker PCHA (Printed Name and Title) | 08/31/19 (Date)

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

The above plan of correction is approved as of 9/23/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/23/19 (Date)

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

LAURELBROOKE PERSONAL CARE 42463

SEP 01 2019

233d - Electronic/Magnetic System

Regulations

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The door from the SDCU's main entrance to the parking lot does not consistently shut and lock with the electronic or magnetic locking system. The door remains open approximately 1", posing an elopement hazard for residents of the SDCU. On 4/21/19, during the 2:00 pm.-10:00 pm. shift, resident #4 went outside through this door into the parking lot and was brought inside by staff.

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 upon discovery maintenance was notified and the door keypad timer was adjusted. The alarm sounds in two seconds. An automatic closure was installed secondary to the automatic closure built into the door hinges already in place. Attached picture.

A staff person will monitor the door at least once daily to ensure it is closing properly. - JRW 9/23/19

Legal Entity Representative

Patti Baker

Signature

Patti Baker PCHA

Printed Name and Title

08/31/19

Date

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

The above plan of correction is approved as of 9/23/19 (Date)

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

Plan of correction implementation status as of 9/23/19 (Date)

- ☑ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented