MAILING DATE: August 30, 2019

Ms. Diana Ponterio
Sr. Vice President of Operations
Regulatory Compliance
Country Meadows Associates
830 Cherry Drive
Hershey, Pennsylvania 17033

RE: Country Meadows of South Hills I
3560 Washington Pike
Bridgeville, Pennsylvania 15017
Certificate #: 430660

Dear Ms. Ponterio:

As a result of the Department's Bureau of Human Services Licensing inspection on 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

RECEIVED
AUG 8 2019
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report

Facility Information

Name: *COUNTRY MEADOWS OF SOUTH HILLS I*
License Number: *43066*
Address: *3560 WASHINGTON PIKE, BRIDGEVILLE, PA 15017*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: *Jessica Ciancio* **Phone:** *4122572855* **Email:**

Legal Entity

Name: *COUNTRY MEADOWS ASSOCIATES*
Address: *830 CHERRY DRIVE, HERSHEY, PA, 17033*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *03/24/1987* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *108* **Waking Staff:** *81*

Inspection

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

Inspection Dates and Department Representative

07/12/2019 - On-Site: Josh Hoover

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *66*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Shadyside* **Capacity:** *50* **Residents Served:** *23*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *66*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *42*
Have Physical Disability: *1*

15a - Resident Abuse Report

Regulations

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 6/25/2019, resident #1, age 96, a resident of the Secure Dementia Care Unit (SDCU), entered the exterior courtyard of the SDCU between the hours of 7:00p.m. and 8:00p.m. Resident #1 was not accounted for until approximately 1:30a.m. on 6/26/2019, when she was found lying on the ground of the courtyard by staff person D, LPN. Staff persons A, B, and C, neglected to perform safety checks during their shifts. The resident was locked out of the home for approximately 6 ½ hours, fell, was taken to the hospital and diagnosed with fractures of the left hip and humeral head. The resident underwent surgery and was then placed in a skilled nursing facility for rehabilitation.

This incident was not reported to the local Area Agency on Aging until 7/15/2019.

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.)

1.) Report sent to Department of Human Services on 6/25/2019, date of the incident. Reported to Area Agency on Aging on 7/15/2019, this was the date that we became aware that the incident needed to be reported to AAA. We called in the verbal report and completed the Act 13 on 7/15/19. South Fayette Police notified of incident on 7/15/19, again after being made aware that the incident required reporting.

All staff were trained on the requirement of reporting expected abuse immediately to Area on Aging according to regulation 2600.15.a within the time frame defined by AAA.

To prevent further violations, staff will continue to be trained upon hire and annually on Abuse Prevention and Reporting.

Ongoing compliance will continue to be monitored by Campus Director of Nursing and Executive Director.

Legal Entity Representative

Signature

Diana Pontero Sr Vice President

Printed Name and Title

8/6/19

Date

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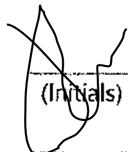
The above plan of correction is approved as of 8/9/19 (Date)

Plan of correction implementation status as of 8/9/19 (Date)

The above plan of correction was approved by  (Initials)

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

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 6/25/2019, resident #1, age 96, was a resident of the Secure Dementia Care Unit (SDCU) entered the courtyard of the SDCU between the hours of 7:00p.m. and 8:00p.m. Resident #1 was not accounted for until approximately 1:30a.m. on 6/26/2019, when she was found lying on the ground of the exterior courtyard by staff person D, LPN. The resident complained of pain, was taken to the hospital and diagnosed with fractures of the left hip and of the left humeral head. The resident underwent surgery and was then placed in a skilled nursing facility for rehabilitation. The home failed to supervise the resident and ensure her safety for approximately 6 1/2 hours, resulting in serious bodily injury. According to the resident's assessment, dated 5/13/2019, she has moderate supervision needs.

On 6/25/2019, at approximately 8:00p.m., staff person A, Medication Assistant, locked the doors leading to the SDCU courtyard, but neglected to adhere to the home's policy, which indicates that "upon locking the first door, the [staff person] will step outside and walk along the area to the next door to ensure that no residents are left outside in that area. They will then lock the next door and proceed around the entire courtyard area until all doors have been secured. After locking the last door, they will take one additional walk along the entire perimeter of the outside area to ensure that no residents have been left outside."

At 10:03p.m., staff person A documented that resident #1 was present in the home, despite having failed to check on the resident. Additionally, staff person A neglected to administer the resident's prescribed Systane eye drops at 8:30p.m., yet signed the medication administration record as having administered the medication.

During the 3:00p.m. to 11:00p.m. shift, staff person B, LPN, neglected to perform any safety checks on resident #1. The home's policy indicates that nursing staff are to complete at least two safety checks per shift; one check during the first half of the shift and one check during the second half of the shift.

Also during the 3:00p.m. to 11:00p.m. shift , staff person C, the Personal Care Aide (PCA) assigned to resident #1, neglected to perform safety checks on the resident. Interviews with staff of the home, including the home's administrator, indicate that PCAs are to perform a minimum of 2-hour checks on all residents.

On 6/26/2019, at approximately 1:00a.m., during the first round of safety checks on the following shift, staff person D, LPN, discovered that resident #1 was missing. Staff persons D and E began a search of the SDCU. At approximately 1:30a.m., resident #1 was found on the ground in the SDCU courtyard.

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)*

As soon as managers were made aware of the incident the investigation of the incident began immediately.

1.) Staff member A, B, and C were immediately suspended by the Campus Executive Director on 6/26/2019, pending investigation. On 6/26/2019 Staff member C voluntarily resigned during interview process of the investigation. Staff members A and B were terminated on 6/27/2019 following completion of investigation by the Campus Executive Director.

2.) On 6/26/2019, immediately re-trained all Personal Care Associates, Nurses, and Medication Associates on the importance of completing house rounds, accounting for all residents whereabouts at scheduled times, reporting any resident not located to the nurse, elopement procedures and abuse and neglect.

3.) On 6/26/2019, immediately re-trained all Nurses and Medication Associates on the proper policy and procedure for unlocking and locking the courtyard doors.

4.) Added additional shift to shift communication procedure among Personal Care Associates, Nurses, and Medication Associates to ensure resident safety and care needs.

5.) All staff members responsible for locking and unlocking the courtyard doors will be trained upon hire and re-trained annually. Ongoing compliance and training will be monitored by Campus Director of Nursing and Assistant Director of Nursing.

6.) All staff members responsible for safety checks and house rounds will be trained upon hire and re-trained annually. Ongoing compliance and training will be monitored by Campus Director of Nursing and Assistant Director of Nursing.

Immediately and once daily thereafter - The administrator or designee will conduct a walk-through of the SDCU to ensure staff are adhering to policies and procedures related to accounting for resident whereabouts. Walk-throughs will be conducted at random times and on varying shifts. -- JRW 8/13/19

Within 60 days of receipt of this plan of correction - The administrator will ensure that Elopement Risk Assessments are completed, including a facility-specific elopement risk assessment, and a resident elopement risk assessment for each resident. Resident support plans will incorporate elopement risk into the plan of care with individualized interventions. - JRW 8/9/19

A mock elopement drill will be conducted at least once within 90 days of receipt of this POC and at least every 6 months thereafter. Mock elopement drills will be documented to include date, time, name of the person conducting the drill. Documentation will be kept. - JRW 8/9/19

Legal Entity Representative

Diana Pontorio Sr Vice President 8/6/19

Signature | Printed Name and Title | Date

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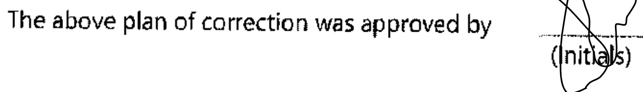
- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

The above plan of correction was approved by (Initials)



187b - Date/Time of Medication Admin.

Regulations

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is ordered Systane Solution Eye Drops, instill 1 drop in each eye four times daily. This medication was not administered on 6/25/2019 at 8:30p.m. However, staff person A initialed resident #1's June 2019 medication administration record as having administered 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.)

1.) On 6/26/2019, medication error was reported to DHS and PCP by Campus Director of Nursing. Staff member A had been suspended on 6/26/2019, terminated on 6/27/2019 so did not work following the incident.

2.) All staff members that administer medications were retrained on the 6 rights of medication administration. All staff members that administer medications are trained annually on the 6 rights of medication administration. Ongoing compliance and training will be monitored by the Campus Director of Nursing.

Legal Entity Representative

Signature

Diana Pontero Sr Vice President
Printed Name and Title

8/6/19
Date

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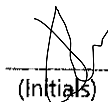
The above plan of correction was approved by  (Initials)

- ☐ 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 #1 is ordered Systane Solution Eye Drops, instill 1 drop in each eye four times daily; however, this medication was not administered on 6/26/2019 at 8:30p.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.)

1.) On 6/26/2019, medication error was reported to DHS and PCP by Campus Director of Nursing. Staff member A had been suspended on 6/26/2019, terminated on 6/27/2019 so did not work following the incident.

2.) All staff members that administer medications were educated on the importance of following prescriber's orders. If unable to complete order in 2 hour time frame, staff will notified the nurse immediately so the nurse can follow up with the prescriber. Ongoing compliance and training will be monitored by the Campus Director of Nursing.

Legal Entity Representative

D Porterio — Diana Porterio Sr Vice President — 8/6/19

Signature — Printed Name and Title — Date

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