



October 29, 2019

Ms. Laura R. Roy  
Executive Director  
Passavant Retirement and Healthcare  
105 Burgess Drive  
Zelienople, Pennsylvania 16063

RE: Lutheran Senior Life Passavant Community  
103 Burgess Drive  
Zelienople, Pennsylvania 16063  
Certificate #: 446120

Dear Ms. Roy:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 23, 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 light blue horizontal line.

Kevin Hancock  
Deputy Secretary  
Office of Long Term Living

Enclosure  
Violation Report

## Violation Report

## Facility Information

Name: LUTHERAN SENIOR LIFE PASSAVANT COMMUNITY  
Address: 103 BURGESS DRIVE, ZELIENOPLE, PA 16063  
County: BUTLER Region: WESTERN

License Number: 44612

## Administrator

Name: Christine Macedonia Phone: 7244525400 Email: LAURA.ROY@LUTHERANSENIORLIFE.ORG

## Legal Entity

Name: PASSAVANT RETIREMENT AND HEALTH CENTER  
Address: 105 BURGESS DRIVE, ZELIENOPLE, PA, 16063

## Certificate(s) of Occupancy

Type: I-2 Date: 10/02/2014 Issued By: Zelienople

## Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 52 Waking Staff: 39

## Inspection

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

## Inspection Dates and Department Representative

07/23/2019 - On-Site: Laurie Garrigan, Joseph Eveses

## Resident Demographic Data as of Inspection Dates

## General Information

License Capacity: 68 Residents Served: 33

## Secured Dementia Care Unit

In Home: Yes Area: Shenandoah Capacity: 32 Residents Served: 16

## Hospice

Current Residents: 0

## Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 33  
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
Have Mobility Need: 19 Have Physical Disability: 0

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

At approximately 11:20 a.m., the fire doors outside the Shenandoah kitchen area did not close properly. The right side door remained open approximately 1-inch and did not latch when it was closed.

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 fire doors outside Shenandoah kitchen area were reported to maintenance on day of inspection as not functioning properly. A work order was issued to repair the fire doors. (Attachment A) *Repairs were completed and doors checked for operation on 7/23/19.* 9/17/19 Maintenance Supervisor developed a tool to monitor the fire doors monthly for six months and annually thereafter to ensure that the fire doors outside Shenandoah kitchen are functioning properly. (Attachment B) If doors do not meet compliance, service will be performed to ensure doors function properly.

*Within 30 days of receipt of this plan of correction, all staff will be educated on their responsibilities in ensuring that floors, walls, ceilings, windows, doors and other surface areas are clean, in good repair and free of hazards as specified in §2600.88(a). This education will include, reporting and/or correcting any areas that are not in good repair or hazardous.* 9/17/19

Legal Entity Representative

*Christine Macedonia*  
Signature

*Christine Macedonia, Administrator 9-9-19*  
Printed Name and Title Date

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

The above plan of correction is approved as of 9/17/19  
(Date)

Plan of correction implementation status as of 9/17/19  
(Date)

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

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

103f - Refrigerator/Freezer Temps

Regulations

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:26 a.m., the silver Whirlpool refrigerator in the Blue Ridge kitchen was 46 degrees Fahrenheit, and the freezer compartment was 10 degrees Fahrenheit.

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.)

Household Coordinator began immediately on day of inspection monitoring the temperatures of the Whirlpool refrigerator in the Blue Ridge dining room beyond the three times daily they are always monitored and recorded. A large stock shipment was delivered to Blue Ridge that morning and filling the refrigerator for a period of time may have contributed to the rise in temperature.

Household Coordinator and/or Household Assistants will continue to monitor refrigerator temperature three times daily to ensure proper temperatures are maintained. (Attachment C)

If refrigerator temperature is not in compliance the Household Coordinator will be notified and maintenance called to repair or call for service.

The administrator or designated staff person will monitor temperature logs at least weekly to ensure that staff are monitoring and documenting temperatures three times a day and that any necessary follow up and maintenance is completed. *[Signature]* 9/17/19

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Signature

*Christine Macedonia, Administrator 9.9.19*  
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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, dated 1/9/19, did not include his height. This section of the form was blank.

Plan of Correction (POC)

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The nurse called physician's office after the inspection to obtain Resident #1's height and the DME was updated to reflect this. (Attachment D)

The Healthcare Manager audited all personal care resident DME's to ensure all areas of the form were completed - this was completed on 8/6/19.

The Healthcare Manager ordered a Stadiometer so that going forward nurses can check heights of residents if needed. (Attachment E)

Personal Care Nurses were inserviced on the DME and the importance of ensuring all information is filled in. (Attachment F)

Personal Care Nurses are to check the DME immediately when received from the physician's office to ensure all items are completed. If any item is not completed, Nurse will call physician's office to obtain the information and fill in the blank on the DME. Nurse will document date, time and person spoken with next to the correction.

Once the DME is complete it will be scanned into the EMR and the original will be given to the Healthcare Manager to double check completeness.

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Signature

*Christine Macedonia, Administrator 9.9.19*  
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*JL*  
(Initials)

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144c1 - Smoking Area Guidelines

Regulations

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At 12:15 p.m., there was a broken down cardboard box on the ground next to the smoke stack in the home's smoking area.

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 cardboard was removed and properly disposed of on the day of inspection 7.23.19.

Signage was posted at the smoking area to instruct those using the area that all combustable materials must be disposed of properly and cannot be located in the smoking area. (Attachment G)

Household Coordinator for Personal Care developed a monitor to inspect smoking area daily for 6 months to ensure continued compliance. (Attachment H)

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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 was prescribed Aricept 10 mg tablet- give 1 tablet orally every day for dementia. However, this medication was not available 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.)

Resident #2's medication was ordered on date of inspection from pharmacy and arrived that evening 7.23.19.

Personal Care staff were in-serviced on the importance of having all medications available that are prescribed. (Attachment I)

New guidelines for ordering medications were implemented as well as a tracking sheet for all medications ordered from pharmacy or if family supplies OTC medications. (Attachment J)

Personal Care Nurses will check this tracking sheet and follow up on any medications that have not arrived by the next day.

Healthcare Manager will do random checks weekly for the next six months to ensure that medications on the EMAR are available for the residents.

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Signature

*Christine Macedonia, Administrator 9-9-19*  
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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 was prescribed Immuplex 4940 capsules-give 2 tablets orally every day for Immune Support. However, the medication was not administered to the resident 7/17/19 through 7/23/19 due to not being available 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.)

Immediately after inspection the family of Resident #1 was notified of the need for the Immuplex 4940 capsules to be ordered. Medication arrived on 8/1/19.

Staff were in-serviced on how to reorder medications. (Attachment I)

The procedure for notifying families of the need for medications they provide was changed to have the initial call to family placed when the medication bottle is half full, instead of when a weeks' worth of the medication is left. Families will be given a period of 10 days from the time of initial notification to bring in the supply of medication. If they do not bring the supply within the 10 days, a follow up phone call will take place. This change in procedure was reviewed with staff at daily huddles. (Attachment K)

If the family fails to bring in the medication prior to the supply running out, they will be notified by the Administrator or designee that they are in violation of the home rules which requires all medications, including those provided by the family to be available in house for administration to the resident. This violation may lead to a 30 day notice. *only after documented, repeat violations of the home rules in accordance with §2600.228(h)(7).*

*[Signature]* 9/17/19

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Signature

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