pennsylvania
DEPARTMENT OF HUMAN SERVICES

November 5, 2019

Ms. Laura L. Thompson, LPN
Administrator
Concordia Lutheran Ministries of Pittsburgh
1300 Bower Hill Road
Pittsburgh, Pennsylvania 15243

RE: Concordia at the Cedars
4363 Northern Pike
Monroeville, Pennsylvania 15146
Certificate #: 446240

Dear Ms. Thompson:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 7, 2019 and August 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.

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: *CONCORDIA AT THE CEDARS*
License Number: *44624*
Address: *4363 NORTHERN PIKE,, MONROEVILLE, PA 15146*
County: *ALLEGHENY*
Region: *WESTERN*

Administrator

Name: *Kimberly Ley*
Phone: *4123733900*
Email: *MSULLIVAN@CONCORDIALM.ORG*

Legal Entity

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*
Address: *1300 BOWER HILL ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-1*
Date: *08/19/1998*
Issued By: *Department of Health*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *89*
Waking Staff: *67*

Inspection

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

Inspection Dates and Department Representative

08/07/2019 - On-Site: Michael Marini, Karen Georgoulis

08/08/2019 - On-Site: Michael Marini, Karen Georgoulis, Joshua Hoover

RECEIVED
9/30/2019
Western Region Field Office
Bureau of Human Services Licensing

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *87*
Residents Served: *65*

Secured Dementia Care Unit

In Home: *No*
Area:
Capacity:
Residents Served:

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *65*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *24*
Have Physical Disability: *6*

65e - 12 Hours Annual Training

Regulations

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A, hired on 3-12-15, received only 8.5 hours of annual training during the 2018 training year.

Direct care staff person B, hired on 8-21-05, received only 5.75 hours of annual training during the 2018 training year.

Repeat Violation: 8-24-18, et. al.

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.)

Disagree with violation due to our 2017 violations being received in 2018 and POC not being approved until May 8, 2018.
Sign in sheets for all required in-services were validated for both employee A&B and while length of in-service was not designated on several sign-in sheets this was already addressed on last years plan of correction which went into effect after these in-service dates.
Employee "A" received all in-services, but can only confirm 10 hours due to missing time on sign in sheets and employee "B" received all in-services as seen on attached sign in sheets. Will continue with POC from last year and write time more clearly on sign sheet.

See Page 3A of 24

Legal Entity Representative

KA Ley
Signature

Kimberly Ley PCHA
Printed Name and Title

9-30-19
Date

65e - 12 Hours Annual Training *(continued)*

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

The above plan of correction is approved as of 10/4/19 (Date)

Plan of correction implementation status as of 10/4/19 (Date)

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

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

65e - 12 Hours Annual Training

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2600.
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Description of Violation

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Direct care staff person B, hired on 8-21-05, received only 5.75 hours of annual training during the 2018 training year.

Repeat Violation: 8-24-18, et. al.

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.)

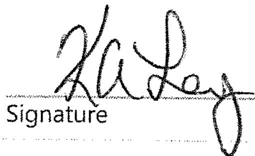
By 12/31/19: Staff person A shall receive a total of 15.5 hours of training related to their job duties. Documentation of the training shall be kept in accordance with 2600.65i.

By 12/31/19: Staff person B shall receive a total of 18.25 hours of training related to their job duties. Documentation of the training shall be kept in accordance with 2600.65i.

Immediately: A designated staff person shall review all direct care staff training records to ensure each direct care staff person receives at least 12 hours of annual training related to their job duties by the end of the training year.

Immediately: A designated staff person shall develop and implement a system to ensure each direct care staff person receives at least 12 hours of annual training related to their job duties each training year. The system shall be reviewed at least quarterly.

Legal Entity Representative



Signature

Kimberly Ley PCHA — Printed Name and Title

10-4-19 — Date

65f - Training Topics

Regulations

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
6. Safe management techniques.

Description of Violation

Direct care staff person A, hired on 3-12-15, did not receive annual training on the following topics during the 2018 training year:

* Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan

* Safe management techniques

Direct care staff person B, hired on 8-21-05, did not receive annual training on safe management techniques during the 2018 training year.

Repeat Violation: 8-24-18, et. al.

Plan of Correction (POC)

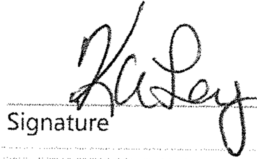
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Disagree with violation.
Both Employees attend an in-service on 3-18-18 that covered support plans/safe management techniques. Please see Attachment.

See Page 5A of 24

65f - Training Topics *(continued)*

Legal Entity Representative



Signature

Kimberly Ley
Printed Name and Title

9-30-19
Date

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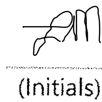
The above plan of correction was approved by  (Initials)

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65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
6. Safe management techniques.

Description of Violation

Direct care staff person A, hired on 3-12-15, did not receive annual training on the following topics during the 2018 training year:

* Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan

* Safe management techniques

Direct care staff person B, hired on 8-21-05, did not receive annual training on safe management techniques during the 2018 training year.

Repeat Violation: 8-24-18, et. al.

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: Staff persons A and B shall receive training on safe management techniques. Documentation of the training shall be kept in accordance with 2600.65i.

Immediately: A designated staff person shall review all direct care staff training records to ensure each direct care staff person receives training on all topics specified in 2600.65f by the end of the training year.

Immediately: A designated staff person shall develop and implement a system to ensure each direct care staff person receives training on all topics specified in 2600.65f during each training year. The system shall be reviewed at least quarterly.

KaLey Kimberly Ley PCHA 10-4-19

65i - Training Record

Regulations

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff person A's 2018 record of training did not include the length of the course for the following courses:

* Safe Lifting and transfers
* Medication self-administration
* Alzheimer's/Dementia

Staff person B's 2018 record of training did not include the length of the course for the following courses:

* Bloodborne pathogens/infection control
* Assessments and support plans
* Safe lifting and transfers
* Falls and accident prevention
* Nutrition and dental care
* Emergency and disaster preparedness
* Medication self-administration

Repeat Violation: 8-24-18, et. al.

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.)

Disagree with violation due to our 2017 violations being received in 2018 and POC not being approved until May 8, 2018. We were actively working on working on our POC and will continue working on our POC from 2018 to rectify this issue.

See Page 7A of 24

Plan of Correction (POC) *(continued)*

Legal Entity Representative

Signature: K a Ley

Printed Name and Title: Kimberly Ley PCHA

Date: 9-30-19

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

The above plan of correction is approved as of 10/4/19 (Date)

Plan of correction implementation status as of 10/4/19 (Date)

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

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

65i - Training Record

Regulations

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff person A's 2018 record of training did not include the length of the course for the following courses:

* Safe Lifting and transfers

* Medication self-administration

* Alzheimer's/Dementia

Staff person B's 2018 record of training did not include the length of the course for the following courses:

* Bloodborne pathogens/infection control

* Assessments and support plans

* Safe lifting and transfers

* Falls and accident prevention

* Nutrition and dental care

* Emergency and disaster preparedness

* Medication self-administration

Repeat Violation: 8-24-18, et. al.

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: A designated staff person will review all current 2018 training records to ensure all items specified in 2600.65i are present.

Within 15 days of receipt of the plan of correction: All staff persons responsible for conducting staff training shall be educated that staff training documents shall contain all items specified in 2600.65i.

Immediately: All staff training records shall be reviewed at least quarterly to ensure they are completed in their entirety and contain all items specified in 2600.65i.

K.A. Ley   Kimberly Ley PCHA 10-4-19

82c - Locking Poisonous Materials

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 8-7-19 at approximately 11:45 AM, a can Airwick Air Freshener, with a manufacture's label indicating, "Contact a doctor or poison control center if swallowed", was unlocked and accessible to residents in the men's common bathroom. Residents of the home, including residents #1, #2 and #3, have not been assessed capable of recognizing and using poisons safely.

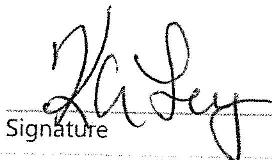
Repeat Violation: 8-24-18, et. al.

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 Airwick Air Freshener was removed immediately.
We will establish a rounding paper that will audit all of the public bathrooms with on a ~~weekly~~ daily basis. JM 10/2/19
This will be done for 3 months by housekeeping supervisor and then included in our weekly room rounds.
Round Sheets will be given to the administrator and be reported on during our quarterly QA&A meetings and monthly safety meetings.

Legal Entity Representative



Signature

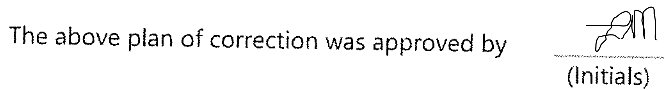
Kimberly Ley

Printed Name and Title

9-30-19

Date

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



The above plan of correction is approved as of 10/4/19 (Date)

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

Plan of correction implementation status as of 10/4/19 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8-7-19 and 8-8-19, there was a strong odor of urine throughout the halls of the facility.

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.)

Wheelchairs and seat cushions were cleaned immediately. Staff to be educated on changing the linen carts every shift and as needed. Staff to be educated on checking residents to change more frequently if needed. Staff training shall be completed within 30 days of receipt of the plan of correction. 10/2/19 JM
This will also be added on our newly established rounding sheet and be done by Housekeeping Supervisor for 3 months and then included in our weekly room rounds.
Round Sheets will be given to the administrator and be reported on during our quarterly QA&A meetings.

Legal Entity Representative

Signature

Kimberly Ley PCHA — Printed Name and Title

9-30-19 — Date

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Plan of correction implementation status as of 10/4/19 (Date)

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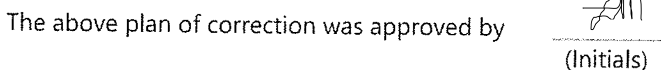

93a - Handrails

Regulations

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 8-7-19, the handrail to the right of the elevator was not securely attached to the wall.

On 8-7-19, the handrail on the steps to the right of the building was not securely attached. The support bar was rusted and broken.

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.)

Both handrails were fixed by maintenance before exit. (Please see pictures attached).
This was added on our newly established rounding sheet and be done by maintenance supervisor for 3 months and then included in our weekly room rounds.
Round Sheets will be given to the administrator and be reported on during our Quarterly QA&A meetings and Monthly Safety Meetings.

Legal Entity Representative

KaLey
Signature

Kimberly Ley PCHA
Printed Name and Title

9-30-19
Date

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

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

Plan of correction implementation status as of 10/4/19 (Date)

- [ ] Fully Implemented
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- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

95 - Furniture and Equipment

Regulations

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

A loud buzzing sound is present when the light fixture on the left wall in resident #6's bedroom is turned on.

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 lightbulb was replaced before exit.
This will also be added on our newly established rounding sheet and be done by maintenance supervisor for 3 months and then included in our weekly room rounds.
Round Sheets will be given to the administrator and be reported on during our Quarterly QA&A meetings and Monthly Safety Meetings.

Legal Entity Representative

K. Ley — Signature

Kimberly Ley PCHA — Printed Name and Title

9-30-19 — Date

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

The above plan of correction is approved as of 10/4/19 (Date)

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

Plan of correction implementation status as of 10/4/19 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

100a - Exterior - Free of Hazards

Regulations

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

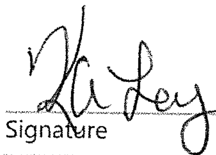
The home's dryer exhausts vent into a cement pit outside the building. However, on 8-7-19, there was an approximate 2" accumulation of dryer lint and over 20 cigarette butts in the cement pit.

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 dryer pit area was cleaned out by the maintenance department. (Please see pictures attached). The facility became non-smoking to staff on Sept. 1, 2019. This was added on our newly established rounding sheet and be done weekly by maintenance supervisor for 3 months and then included in our weekly room rounds.
Round Sheets will be given to the administrator and be reported on during our Quarterly QA&A meetings and Monthly Safety Meetings.

Legal Entity Representative



Signature — Kimberly Ley PCHA — 9-30-19
Printed Name and Title — Date

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

Plan of correction implementation status as of 10/4/19 (Date)

- ☐ 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

On 8-7-19, there was no thermometer in the 1st floor kitchenette refrigerator.

On 8-7-19 at 11:40 AM, the small refrigerator by the kitchen stove measured 46 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.)

Thermometer put in fridge before exit.
This was added on our newly established rounding sheet and be done by dietary supervisor for 3 months and then included in our weekly room rounds.
Round Sheets will be given to the administrator and be reported on during our Quarterly QA&A meetings and Monthly Safety Meetings.
Fridge temperature was noted to be within parameters by surveyor on the second day. The 46 degrees temperature was noted during meal service after repeated opening and closing of fridge. Will continue with our monitoring of fridge temperatures daily.

Immediately: A designated staff person shall inspect each refrigerator and freezer daily to ensure an operable thermometer is present and that safe temperatures are maintained in accordance with 2600.103f. [initials] 10/2/19

Legal Entity Representative

[signature] Signature — Kimberly Ley PCHA (Printed Name and Title) — 9-30-19 (Date)

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

The above plan of correction is approved as of 10/4/19 (Date)

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

Plan of correction implementation status as of 10/4/19 (Date)

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

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

Resident #4's medical evaluation, dated 5-7-19, does not include the following information, as these sections of the form are blank:

* Ability to self-administer medications
* Special health or dietary needs
* Mobility needs assessment
* Health Status
* Cognitive functioning

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 4 was corrected immediately.

A new spreadsheet will be developed and completed by October 30, 2019. This will include tracking of medical evaluation due dates. This will be audited by designee and followed up by the administrator on a weekly basis to ensure timeliness of documentation.

Legal Entity Representative

Signature

Kimberly Ley RCHA 9-30-19

Printed Name and Title — Date

141a - Medical Evaluation *(continued)*

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

The above plan of correction is approved as of 10/4/19 (Date)

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

Plan of correction implementation status as of 10/4/19 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

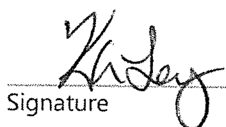
Resident #2's most recent medical evaluation was completed on 1-7-19; however, the resident's previous medical evaluation was completed on 11-27-17.

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.)

This will be included on the same spreadsheet as the violations for 2600.141.a and audited by designee and followed up by the administrator on a weekly basis to ensure timeliness of documentation.

Legal Entity Representative



Signature

Kimberly Ley PCHA
Printed Name and Title

9-3-19
Date

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The above plan of correction is approved as of 10/4/19 (Date)

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

Plan of correction implementation status as of 10/4/19 (Date)

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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 #5 is prescribed Novolog Flexpen 100u/ml-Inject subcutaneously 2 times daily in accordance with sliding scale; however, the pharmacy label indicates Novolog 100u/ml-Inject subcutaneously 3 times daily in accordance with sliding scale.

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 #5 Novolog #5 100u/ml inject order is accurately labeled on the pharmacy label. Order and pharmacy label match
Current patents with orders for insulin for a sliding scale have the potential to be affected. The facility will complete an audit on current residents with this type of order and validate order matches pharmacy label.
The designee will educate the med tech on the regulation 2600.184.a.within 30 days of receipt of the plan of correction. [initials] 10/3/19
The facility will audit insulin orders 2x a month for 3 months and then monthly thereafter. Results will be shared at the quarterly QA&A meeting.

Legal Entity Representative

[signature] Signature — Kimberly Ley PCHA Printed Name and Title — 9-30-19 Date

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Plan of correction implementation status as of 10/4/19 (Date)

The above plan of correction was approved by [initials] (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 #2 is prescribed Amlodipine 5mg-Take 1 tablet by mouth daily. However, the medication was not administered on 8/3/19, because it was not available in the home for administration.

Resident #5 is prescribed Novolog Flexpen 100u/ml-Inject subcutaneously 2 times daily in accordance with the following sliding scale: <150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units. The current physician order does not include insulin administration for blood sugars over 300; however, on the following dates/times, 6 units of insulin was administered when the resident's blood sugar was over 300.

Date & Time	Blood Sugar Reading
* 8/1/19 8:00 PM	371
* 8/2/19 8:00 PM	361
* 8/3/19 8:00 PM	377
* 8/4/19 8:00 PM	347
* 8/5/19 8:00 AM	505
* 8/5/19 8:00 PM	414
* 8/6/19 8:00 AM	303
* 8/6/19 8:00 PM	391
* 8/7/19 8:00 AM	351
* 8/7/19 8:00 PM	467
* 8/8/19 8:00 AM	310

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 is now receiving Amlodipine per physician order.
Resident #5 is no longer in our facility.
Current patients with orders for sliding scales have the potential to be affected. The facility will complete audit on current residents with orders for sliding scale coverage to determine any other

Plan of Correction (POC) *(continued)*

affected residents. Identified residents will have corrective action taken. The facility will complete an audit on to determine any patient in that 24-hour period who did not have medications administered due to being unavailable. Identified patients will have corrective action taken.
The facility will have designee educate the Med Tech on the regulation 2600.187.d within 30 days of receipt of the plan of correction. [initials] 10/3/19
The facility will audit med administration records weekly for 3 months for compliance with regulation 2600.187.d. Results of this audit will be shared at QA&A quarterly.

Legal Entity Representative

[signature] Kimberly Ley PCHA 9-30-19

Signature | Printed Name and Title | Date

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190a - Completion Medication Course

Regulations

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A has not completed an annual practicum since 2017; however, staff person A administered numerous medications to resident #5 on 8-6-19.

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.)

Staff person A was re-certified 8-14-19. Med Tech files will be Audited on a monthly basis by the designated person and given to the Administrator. Results of this audit will be shared at QA&A quarterly.

Legal Entity Representative

K Ley — Signature

Kimberly Ley PCHA — Printed Name and Title

9-30-19 — Date

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

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225a - Assessment 15 Days

Regulations

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3 was admitted to the home on 2-7-19; however, an assessment was not completed for the resident until 3-1-19.

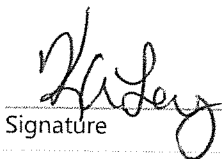
Resident #4 was admitted to the home on 6-20-19; however, no assessment was completed for the resident.

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.)

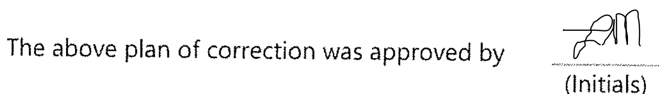
Resident 4 assessment was completed. on 8/12/19. AM 10/4/19
266.225.a will be monitored on the same spreadsheet with 260.141a and 2600.141.b.1 and audited on a weekly basis first by the designated person and then by the Administrator.

Legal Entity Representative



Signature

Kimberly Ley ACHA 9-30-19
Printed Name and Title Date



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225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #6 has a catheter which must be changed every 4 weeks and as needed, and needs flushed 3 times a week and as needed. However, this is not indicated in resident #6's most recent assessment, dated 10-12-18.

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 ~~#4~~ 6 RASP update now reflects current catheter orders
Audit on current Residents with catheters to validate RASPS reflect current care.
Will educate Med Techs on Reg. 2600.225.C within 30 days of receipt of the plan of correction. 10/3/19
Will Audit Foley Catheter on a monthly basis to see if the RASPS reflect correctly.
Education to be done by Oct. 30 on RASP updates.

Legal Entity Representative

Signature

Kimberly Ley PCHA 9-30-19
Printed Name and Title — Date

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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

Resident #4 was admitted to the home on 6-20-19; however, no support plan was completed for 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.)

Support Plan completed on 7-29-19.
A new spreadsheet will be developed and completed by October 30, 2019. This will include tracking of Support Plan due dates. This will be audited by designee and followed up by the administrator on a weekly basis to ensure timeliness of documentation.
Any discrepancies or issues will be addressed to staff immediately.

Resident #4's support plan was completed on 8/12/19. JM 10/4/19

Legal Entity Representative

KLey
Signature

Kimberly Ley PCHA
Printed Name and Title

9-30-19
Date

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227g -Support Plan Signatures

Regulations

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's most recent support plan, dated 3-1-19, is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

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 corrected. and signed by the resident on 8/12/19. AM 10/4/19

A new spreadsheet will be developed and completed by October 30, 2019. This will include tracking of Resident signature dates. This will be audited by designee and followed up by the administrator on a weekly basis to ensure timeliness of documentation.
Any discrepancies or issues will be addressed to staff immediately.

Legal Entity Representative

Signature

Kimberly Ley PCHA 9-30-19

Printed Name and Title | Date

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