December 2, 2019

Ms. Donna Strittmatter
President, NHA
Smith Health Care LTD
453 South Main Road
Mountain Top, Pennsylvanian 18707

RE: Smith Health Care LTD
License #229230

Dear Ms. Strittmatter:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 22, 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: *SMITH HEALTH CARELTD*

License Nu mber: *22923*

Address: *453 SOUTH MAIN RO AD., MOUNTAIN TOP, PA 18707*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

Name: *Tammy Preston* *Phone:5708683664* **Email:** *SHCAP@FRONTIER.COM*

Legal Entity

Name: *SMITH HEALTH CARELTD*

Address: *453 SOUTH MAIN ROAD,, MOUNTAIN TOP, PA, 18707*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: ~~XX/XX/~~*2008* 11/01/2008 Issued By: *PA L&I*

Staffing Hours

Resident Support Sta ff: *0* **Total Daily Sta ff:** *62* **Waking Staff:** *47*

Inspection

Type: *Full* **BHA Docket #:** **Not ice:** *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

08/22/2019 - On-Site: Ann O' Haire, Ryan Yankoy

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *93* **Residents Served:** *62*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: ~~XX~~ 10

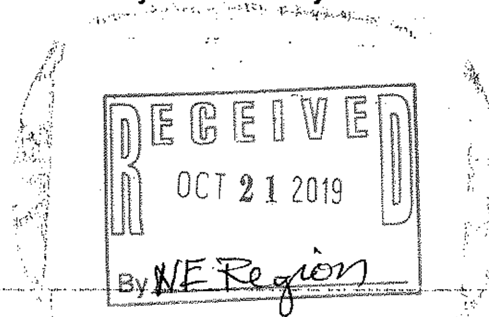
Diagnosed with Mental Illness: ~~XX~~ 10

Have Mobility Need: *0*

Are 60 Years of Age or Older: *60*

Diagnosed with Intellectual Disability: *2*

Have Physical Disability: *2*



51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101-10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff person #1, hired 6/1/19, did not have a Pennsylvania State Police Criminal Background Check completed.

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.)

Prior to the start date employee #1 had a FBI Criminal Background check completed, as employee did not reside in PA the last 2 years. The new HR employee misunderstood the regulation and did not run a PA Background check also. On 8\22\2019, a PA State Police Criminal Background check was immediately completed. HR was educated on reg. 2600.51. All employee files were reviewed for compliance with regulation 2600.51 by HR. All in compliance. All new hire employee files will be reviewed by HR for compliance with 2600.51 and submitted to QA committee\Administrator for quarterly review.

Legal Entity Representative

Signature [signature] PCHA   Printed Name and Title Tammy P[illegible] PCHA   Date 10/8/19

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

The above plan of correction is approved as of 10.22.19 (Date)   Plan of correction implementation status as of 10.22.19 (Date)

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

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

63a - First Aid/CPR Training

Regulations

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 8/10, 8/11 & 8/12/19 the home served 62 residents. On 8/10/19 no one was certified in First Aid and CPR from 7p-7a, one person was certified in First Aid and CPR from 3p-7p. On 8/11/19 no one was certified in First Aid and CPR from 3a-7a, one person was certified in First Aid and CPR from 7p-3a. On 8/12/19 one person was certified in First Aid and CPR from 11p-7a.

Plan of Correction (POC)

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2600.63.a
Administration did not ensure up to date CPR certification of all staff. A CPR class was held on 8\27\2019 to bring new staff up to date with CPR and First Aid. The facility was in compliance with regulation 2600.63.a on 8\27\2019. The administrator will maintain CPR\First Aid certifications and submit to QA quarterly for review to ensure ongoing compliance with regulation 2600.63a.

Legal Entity Representative

Signature Printed Name and Title Tammy Preston [illegible] Date 10/18/19

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64c - Annual Training

Regulations

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

The homes Administrator Staff person "A" completed 12 hours of online training of the required 24 hours of annual training for 2018.

Plan of Correction (POC)

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2600.64c
The personal care home administrator did have 24 hours of required training completed for calendar year 2018. At the time of inspection, the administrator was unable to provide complete proof of such required training. The training is submitted with this POC. The administrator had 24 hours of live seminars along with 19 hours of online credits totally 43 credits for 2018. The administrator will submit completed training on an ongoing basis to QA quarterly.

Compliant 2018.
10.22.19
MM

Legal Entity Representative

Signature [signature] Printed Name and Title Tammy Preston PCHA Date 10/8/19

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88a - Surfaces

Regulations

2600.

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

Description of Violation

The lower level shared shower room had a hole in the wall by the spa tub that ran from the floor and up the wall that was approximately 2 feet wide and 2 feet high. This area also had debris on the floor which may be hazard to residents

Plan of Correction (POC)

(Attach pages as ne cessary. 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.)

2600.88.a
The wall in the LL tub\shower room was under repair at the time of inspection. A plastic covering was taped over the area that had started to come off and some dry wall was on the floor. This was immediately cleaned. A new covering was placed over the wall and materials were ordered for repair. Maintenance repaired the wall on September 5th. An inservice was held with maintenance regarding safety and repairs of facility. The maintenance safety committee member will do a random walk through of the facility and ensure compliance with reg. 2600.88.a. This will be submitted to QA committee\Administrator for quarterly review.

Legal Entity Representative

Signature

Tammy Preston Pcha — Printed Name and Title

10/18/19 — Date

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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

The lower level shower room did not have a tub that had functioning facets. There was no running hot or cold water.

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.)

2600.95
The whirlpool tub in the Ground floor tub room was the tub under repair at the time of inspection. The tub was having problems and it was determined the tub needs to be replaced. There is a sign on the tub "Out of Order". Administration has been looking into replacing the whirlpool tub. In the meantime, the tub has not been used. The residents have 2 other tubs and 3 showers for use. The facility has always maintained compliance with tub\shower to resident ratio. Administration has decided on a replacement tub and is moving forward with purchasing. The new tub will be installed and operable by 12\31\19.

Legal Entity Representative

Signature Printed Name and Title Date

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105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At approximately 9:30 AM when the initial walk through was being conducted, the laundry room's dryers had lint in the lint baskets. 4 out of the 5 dryers had an accumulation of lint.

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.)

2600.105.g
Lint was immediately removed from all dryers in the laundry room. Laundry staff were inserviced on the importance of maintaining lint free baskets at all times. The safety committee Laundry designee will perform random weekly checks of the laundry room to ensure compliance with reg. 2600.105g. This will then be submitted to QA\Administrator quarterly for review and to ensure compliance.

Legal Entity Representative

Signature

Tammy Plcstn PcHA 10/18/19

Printed Name and Title / Date

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124 - Notice to Fire Department

Regulations

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The notice to the fire department dated 11/12/18 does not indicate the capacity of the home.

Plan of Correction (POC)

(Att ach pages as nece ssa ry. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to preve nt a similar viol at io n from occurring again. If steps cannot be completed i mmed iate ly. include dates by whic h the steps will be completed.)

2600.124
A new letter was sent to WTFD that included the capacity of the home. It was reviewed with the Fire Chief and the Fire Safety Expert. The Fire Chief signed the updated a letter 8\26\2019. A copy was retained for their records.

Legal Entity Representative

Signature Tammy Preston Pc HA Printed Name and Title 10/8/19 Date

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132d - Evacuation

Regulations

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Through interviewing the home's administrator, it was determined that the home was not calculating the home's evacuation time during fire drills accurately. The home evacuates its residents to the exterior of the building during fire drills and the home was timing the time for residents to get out of the identified affected area and calling the drill over. Residents on other floors and wings of the facility were still in the process of evacuating. The fire drills conducted from 10-29-18 thru 07-18-19 were not timed accurately .

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.)

2600.132.d
A fire drill was conducted on 8\29\2019. It was timed for all 60 residents to evacuate or get to a fire safe area. It was with in the FSE specified time. A meeting was held with the FSE and Administrator. The administrator was only recording the time it took for the fire floor to evacuate. When FSE conducts the monthly fire drill he records the time for the fire floor and the time for the entire building to evacuate. All fire drills will be submitted to QA\Administrator quarterly for review.

Legal Entity Representative

Signature

Tammy Plestin NHA 10/8/19

Printed Name and Title Date

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132h - Designated Meeting Place

Regulations

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

It has been determined through interviews that not all the residents are evacuating to a designated fire safe area or to the outside of the building during fire drills. During the fire drill, if the residents do not go to a designated fire safe area, the residents will congregate near the exit door - but do not exit to the outside of the building.

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.)

2600.132.h
On 10\14\2019 a mandatory inservice was held by the FSE and administrator with all staff regarding Reg. 2600.132. All Fire regulations were reviewed. Emphasis was placed on evacuation and fire safe area locations. A drill was also conducted and the alarm was pulled in the fire safe area. All residents on that floor were evacuated outside of the building. All other residents were moved to safe designated Fire Safe Areas. The evacuation was completed with in the FSE specified time period. All fire drills will be submitted to QA\Administration for quarterly review.

Legal Entity Representative

Signature: [signature] Printed Name and Title: Tammy Preston PCHA Date: 10/18/19

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183e - Storing Medications

Regulations

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident# l's Victoza was not dated when the insulin was opened. The manufacturer's instructions note to date the pen when opened. The manufactures directions are to discarded the medication after 30 days when opened.

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.)

2600.183.e
On 8\22\19 an investigation was conducted on when this resident's victozia was opened. The date and time was able to be verified so it was labeled as such. On 8\22 all insulin in the facility was checked to ensure proper labeling when opened. All were found to be in compliance. All staff will be inserviced by 11\5\19. A random check of all insulin will be conducted by Adm\designee to ensure compliance with Reg. 2600.183.e This will be submitted to QA\Administrator quarterly for review.

Legal Entity Representative

Signature — Tammy Preston Pctha 10/8/19
Printed Name and Title — Date

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224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 daysfrior to admission and documented on the Department's preadmission screening form that the needs o the resident can be met by the services provided by the home.

Description of Violation

Resident #2's (corrected by hand to 3) DOA 01/26/19, did not have a preadmission screening form completed. Resident #3 's preadmission screening form dated 11/01/18 didn't indicate if the home was able to meet the resident's needs.

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.)

2600.244.a
It was resident #3 that had missing information on the preadmission screen. Resident #3 was reviewed by administrator on 8\22\19 and reaffirmed that the resident's needs are in fact able to be met by facility. Employee responsible for admissions was inserviced on Reg 2600.224.a on 8\22\19. All current resident charts were reviewed for completeness of PreAdmission screen. All were found in compliance. All pre admission screens will be reviewed for completeness and submitted to QA\Administator quarterly for review.
All staff will be inserviced on all admission paperwork (pre adm. Screen, Assessement, DME, RASP, Nursing Assessment) by 11/5/19.

Legal Entity Representative

Signature

Tammy Plestow PCHA 10/8/19

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 on 05 /11/19 and his RASP had an assessment date of 05 /24/19. The resident's support plan was not completed until 08/06/19. Resident's RASP was not completed within 30 days.

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.)

2600.227.a
This chart was reviewed. This was administrators' error. It was actually a typo that was not caught. The completed date of the support Plan was 6/6/19. The administrator reviewed all current resident RASPs for completeness and timeliness and noted to be compliant. All new admissions will be reviewed by Adm\designee. The new admission QA check list will be submitted by the admission designee to QA\Administrator quarterly for review.

Legal Entity Representative

Signature

Tammy Preston 10/8/19

Printed Name and Title Date

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252 - Record Content

Regulations

2600.

252. Content of Resident Records - Each resident's record must include the following information:

2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

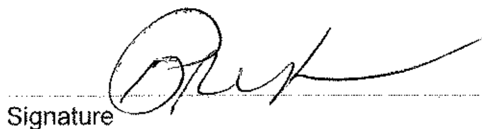
Resident #S's resident record did not state the resident's hair color or if the resident had any identifiable marks .

Plan of Correction (POC)

(Attach pages as necessa ry. 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 comp lete d.)

2600.252
Resident #5 record was reviewed and identifiable marks and hair color were completed immediately on 8/22/19 after the exit interview. Designee reviewed all current resident charts for completeness of nursing assessment and all in compliance with reg. 2600.252. On admission all nursing assessments will be reviewed by Designee and submitted to QA\Administrator for quarterly review.

Legal Entity Representative



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Tammy Preston 10/18/19

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