pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: llaffey@gmail.com
dunlevygardenspch@gmail.com

MAILING DATE: July 21, 2020

Ms. Leah Laffey
Owner
TLC Healthcare, LLC
801 Elm Spring Road
Pittsburgh, Pennsylvania 15243

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432
License #: 447540

Dear Ms. Laffey:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on September 5, 2019 and September 10, 2019, found violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The enclosed Licensing Inspection Summary (LIS) specifies the violations.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you have any questions, please contact me at 412-874-6010.

Sincerely,

Jon B Kimberland

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Recieved BHSL
12/26/19

Facility Information

Name: *DUNLEVY MANOR* **License Number**: *44754*
Address: *2218 ROUTE 88,, DUNLEVY, PA 15432*
County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: *Leah Laffey* **Phone**: *7243265611* **Email**: *LLAFFEY@GMAIL.COM*

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection

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

Inspection Dates and Department Representative

09/05/2019 - On-Site: Vicki Siegert, Cindy Mulick, Desmond Grace

09/10/2019 - On-Site: Vicki Siegert, Cindy Mulick

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *16*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *15*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *4* **Have Physical Disability**: *0*

5a1 - DHS Access

Regulations

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 9/5/19 at approximately 1:45 p.m., agents of the Department requested the employee record for staff person A, the home's administrator. On 9/5/19, at 3:15 p.m., staff person B, the home's designee, was unable to print the information that was sent to her personal cell phone. On 9/10/19 at 12:00 p.m., staff person B was still unable to print the administrator's record for review nor have it accessed on the home's computer. Agent of the Department requested that the email be forwarded to the agent's Commonwealth email address. As of 9/10/19 at 6:30 p.m., the administrator's record including criminal history background check, qualifications, training and annual training still had not been provided to the Department.

On 9/10/19 at 10:10 a.m., agents of the Department requested a log of residents discharged since 7/1/19. As of 6:30 p.m., the requested log had not been provided.

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 Information on the administrator is now available in the home. The assistant administrator has created a File on the administrator. ALL staff is aware. Documents were provided 12/10/2019. The log of residents discharged since 7/1/2019 is included. Assistant Admin will continue the log for discharged. KK 12/26

Legal Entity Representative

Signature

Leah Lafferty Adm 12/26/2019

Printed Name and Title Date

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

The above plan of correction is approved as of 12/30/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Fully Implemented

☐ Not Implemented

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act – Enactment Act of June 23, 2016 indicates that . . .

"Section 3. Facility powers and duties.

(a) installation. - -

(1) An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance.

(2) If the approved carbon monoxide alarm cannot be heard by the staff on duty on a specific floor or wing of the facility, a single approved carbon monoxide alarm shall be installed where it can be heard by the staff on duty in addition to the alarm installed as directed under paragraph (1).

(3) If there are resident living units or bedrooms located between a fossil fuel burning appliance and any additional approved carbon monoxide alarm required under paragraph (2), a single additional approved carbon monoxide alarm shall be installed in a central location on the same level as the resident living units or bedrooms."

On 9/5/19, the home's carbon monoxide detector was located approximately 4 feet above the floor at the end of the hallway by the TV room in the back hallway. Two fossil fuel burning furnaces and two fossil fuel burning hot water heaters are located in the furnace room in the same hallway, however, multiple occupied resident rooms to include #4, #5, #11 and #12 are located between the detector and the fossil fuel burning devices.

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. New carbon monoxide alarm installed 9/6/2019 by maintenance. Alarm is audible in all areas.

2&3 - Alarm installed where surveyor & Desmond requested.

Maint. Man & designee will check weekly.

Legal Entity Representative

Signature | Leah Laffey, Administrator (Printed Name and Title) | Date

18 - Compliance With Laws *(continued)*

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Plan of correction implementation status as of 3/25/2020 (Date)

☒ Fully Implemented

☐ Not Implemented

25b - Contract Signatures

Regulations

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

On 9/5/19, the resident-home contract completed on 3/11/19 for resident #1, admitted 3/11/19, was not signed by the resident.

On 9/5/19, the resident-home contract completed on 7/24/19 for resident #2, admitted 7/27/19, was not signed by 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.)

Attached are updated Signed Contracts - corrected on 9/6/2019

Designee of Administrator will have meticulous oversight going forward with all contracts. This will be completed monthly with a review of all contracts by the Assistant Administrator.

Legal Entity Representative

Signature

Leah LaFfey Administrator 12-4-2019

Printed Name and Title Date

LL 12-26-2019

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☒ Not Implemented

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

The home was unable to demonstrate that a criminal history background check for staff person C was requested. Staff person C started working for the home on 4/20/19.

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.)

Criminal Background check obtained 12/6/2019. Administrater or designee will complete prior to hiring.

The Assistant Administrator will review all 11 employee files by 12/26/2019. Any new Hires will have the background check completed by the Assitant administrator. Files will be checked monthly by the assistant administrator for accuracy.

Legal Entity Representative

Staffy Leah Laffey — Administrator — 12-4-2019

Signature — Printed Name and Title — Date

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12-26-2019

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☐ Not Implemented

64f - Record of Training

Regulations

2600.

64.f. A record of training including the individual trained, date, source, content, length of each course and copies of certificates received shall be kept.

Description of Violation

As of 9/10/19 at 6:30 p.m., the home was unable to provide the Department with a record of 2018 annual training for the home's administrator, staff person A.

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 Administrator Jean Laffey now has a file at the Dunlevy Manor. All paperwork is in the File. The Assistant Administrator has knowledge of where the File is and all staff were inserviced on where to locate the File on 12/26/2019. This review will occur quarterly in 2020

Legal Entity Representative

Signature

Administrator 12/26/2019

Printed Name and Title Date

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☐ Not Implemented

82a - Poisonous Materials

Regulations

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

The following items located in a mop bucket in the home's laundry did not include the manufacturer's label:

* ¼ full 1000 ml spray bottle of blue liquid glass cleaner
* ½ full 1000 ml clear spray bottle of Odo-Ban odor eliminator
* full 1000 ml spray bottle of purple DBC-24 disinfectant cleaner

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.)

9/6 - All poisonous materials mentioned were disposed of.
As of 9/6 - all poisonous materials are being kept in their original containers and stored in a locked laundry room.
Maintenance man and Designee will check weekly. All staff oriented about correct process.

Legal Entity Representative

Signature | Printed Name and Title | Date

Signature: [signature] | Printed Name and Title: Leah Laffey Administrator | Date: 12/4/2019

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The above plan of correction was approved by [initials]

Plan of correction implementation status as of 3/25/2020 (Date)

☒ Fully Implemented

☐ Not Implemented

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 9/5/19 at 10:55 a.m., there was a mop bucket containing the following poisonous items in the home's unlocked, unattended, accessible laundry room:

* ¼ full quart spray bottle of bathroom cleaner with bleach
* ¼ filled 1,000ml unlabeled spray bottle of blue liquid glass cleaner
* ½ full 1000 ml clear liquid spray bottle of Odo-Ban odor eliminator
* full 1000 ml spray bottle of purple DBC-34 disinfectant cleaner with a warning label indicating contact poison control if swallowed.

Multiple residents in the home were assessed as being unsafe around poisons to include resident #1 as indicated on the resident's medical evaluation completed 3/13/19 and the resident assessment completed 3/22/19.

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.)

9/6 ALL POISON material is kept in a locked laundry room. Inservice given to all staff 9/6/2019. Designee + maint. man to check weekly. Staff - every shift.

Legal Entity Representative

Signature | Leah Laffey Administrator | 12/4/2019

Printed Name and Title | Date

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☐ Not Implemented

85c - Trash

Regulations

2600.
85.c. Trash shall be removed from the premises at least once a week.

Description of Violation

According to staff person B, trash is removed from the premises every other week.

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.)

Contract ~~st~~ has been changed to an every week contract. 12/26/2019 Assistant Administrator/Cook will notify the owner if there are any concerns or overflow with trash pickup. A large dumpster is present. Used furniture requires an additional pick up should this be needed.

Legal Entity Representative

Signature | Printed Name and Title | Date

Leah Laffey Adm 12/6/2019 12/26/2019

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☐ Not Implemented

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 9/5/19, the bedside lamp next to resident #2's bed in resident bedroom #2 did not have light bulbs.

On 9/5/19, the bedside lamp next to resident #3's bed in resident bedroom #12 was broken and does not turn 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.)

As of 9/6/2019, Maintenance Man replaced light bulbs and purchased new lamps. Staff & Designee Inserviced to Check on every shift.

Legal Entity Representative

Signature | Leah Laffey Adm (Printed Name and Title) | 12/6/2019 (Date)

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☐ Fully Implemented

☒ Not Implemented

101r - Bedroom - shades/drapes/window covering

Regulations

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 9/5/19 at approximately 11:30 a.m., resident bedrooms #1 and #5 had multiple broken blind slats which precluded the ability to provide privacy.

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.)

As of 9/6/2019, maintenance man replaced room 5 & room 1's blind slats.

Administrator & maintenance man will do weekly building rounds.

Legal Entity Representative

Signature: Khatty Leah Laffey: Admin — Printed Name and Title: 12/6/2019 — Date

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☐ Fully Implemented

☒ 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 9/5/19 at 11:15 a.m., refrigerator/freezer #2 did not have a thermometer in the freezer compartment.

On 9/5/19 at 11:20 a.m., refrigerator/freezer #3 did not have a thermometer in the refrigerator and the thermometer in the freezer was broken.

On 9/5/19 at 11:25 am., refrigerator/freezer #1 did not have a thermometer in the refrigerator or the freezer.

Repeat Violation: 10/4/18 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.)

On 9/6/19, New thermometers were purchased and replaced. Cooks on 2 shifts will check daily.

Legal Entity Representative

Signature | Printed Name and Title: Leah Laffey Adm | Date: 12/6/2019

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☐ Fully Implemented

☒ Not Implemented

121a - Unobstructed Egress

Regulations

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 9/5/19 at 11:25 a.m., the emergency exit passageway from emergency exit doors B and D, which exit the rear of the facility into a fenced in area in the rear of the home, leads to a gate located on the post office side of home which could not be opened without substantial force to lift the gate and unlock the latch.

On 9/5/19 at 11:35 a.m., the emergency exit door next to resident bedroom #1 required substantial force to be 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.)

on 9/6/2019 the maintenance man oiled an adjusted the hinge.

on 9/6/2019. the maintenance man also fixed this door. Swollen From weather.

Going Forward, the maintenance Man and Assistant Administrator will complete weekly checks for unobstructed Egress routes & sign the Form.

Legal Entity Representative

Signature: [signature] Leah Laffey Printed Name and Title: Adm Date: 12/6/2019

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

12/26/2019 [signature]

The above plan of correction is approved as of 12/30/19 (Date)

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

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Fully Implemented

☒ Not Implemented

130g - Smoke Detector Repair

Regulations

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 9/5/19 at approximately 1:30 p.m., it was observed that the home's fire alarm system display indicated:
Alarm: FIRE
Zone 1
02:48P 08142019

Staff person B, the home's designee, indicated to agents of the Department that he/she did not know why the display was indicating such but stated that the fire department conducted a fire drill on that date. Fire alarm company records indicate that the system was acknowledging "Test Trouble (System: 1)" twice a day from 9/1/19 through 9/5/19. The fire alarm company acknowledged that the alarm was set off by the fire department during a fire drill on 8/14/19. The alarm company also indicated that the system needed to be reset or the trouble alarm would continue. A letter from the Charleroi Fire Department dated 8/14/19 directed the home to contact the alarm company ASAP to get the system checked and advised the home to call 911 by phone for an emergency until the alarm system was fixed by the alarm company. With Zone 1 in alarm, the specific fire alarm device would not activate if it were placed in alarm again and the fire alarm system would not sound or notify the fire department of that specific alarm.

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.)

On 9/6/19, the designee and the Surveyor and the alarm company Spoke on the phone. All was Fixed immediately. All staff have been inserviced to call the alarm company @ 911 when necessary. Going Forward, the alarms will be checked on a daily basis by the Assistant Administrator @ COOK. The Alarm company was in @ inserviced the Staff on 12/10/2019

Legal Entity Representative

Signature | Leah Laffey - Admin (Printed Name and Title) | 12/6/2019 (Date)

130g - Smoke Detector Repair *(continued)*

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Plan of correction implementation status as of 3/25/2020 (Date)

☐ Fully Implemented

☒ Not Implemented

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

The home conducted a fire drill on 1/28/19 at 5:10 p.m. which took 4 minutes and 15 seconds for residents to evacuate. However, the home's safe evacuation time as determined by a fire safety expert on 10/12/18 was 4 minutes and 0 seconds.

Repeat violation 10/4/18, 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 Home Conducted a Fire drill on 10-1-19. Everyone out by 3minutes. 54 seconds. Copy of Log paper attached. A second Drill was held 12/23 at 05:55 during resident sleeping Hours. Results attached by Charleroi Fire department. 1 minute 54 seconds. Drills will be conducted monthly by the Charleroi Fire dept. With the document Completed. Drills on DIFFerent shifts.

Legal Entity Representative

Happy Leah Laffey — Signature

Adm — Printed Name and Title

12/6/2019 — Date

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

The above plan of correction is approved as of 12/30/19 (Date)

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

Plan of correction implementation status as of 3/25/2020 (Date)

[ ] Fully Implemented

[X] Not Implemented

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

The medical evaluation for resident #1, completed on 3/13/19, did not include the resident's height, weight, pulse, blood pressure and temperature. These sections were 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.)

The residents' vital signs were taken on 9/6/2019 and added to his record - Attached & placed in his file. Going Forward, the Assistant Administrator will review all current resident evaluation for completeness monthly. New admits will be reviewed after seen by the doctor.

Legal Entity Representative

Signature: Happy

Printed Name and Title: Leah Laffey - Admin

Date: 12/6/2019

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX! 12/26/2019

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Plan of correction implementation status as of 3/25/2020 (Date)

☐ Fully Implemented

☒ Not Implemented

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

The medical evaluation for resident #3, completed on 2/11/19, did not indicate if the resident's immunizations are current. This section was 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.)

Med Eval updated 9/6/2019
Immunizations are current.
Copy of Flu-Shot.

Going forward, the Assistant Administrator will review all medical Evals monthly to assure that at least annually, every resident will have a medical evaluation. This will also be input into tabula pro for monitoring.

Legal Entity Representative

Signature | Leah Laffey Admin | 12/6/2019
Printed Name and Title | Date

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☐ Fully Implemented

☒ Not Implemented

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 9/10/19 at 1:52 p.m., there was a red plastic case containing an injection syringe with manufacturer labeling "Glucagon Emergency Kit for Low Blood Sugar – Glucagon for injection (DNA origin) 1mg (1 unit)" in the clear plastic bin with other medications labeled for resident #1. The prescription label is partially torn off and does not include the name of the resident. The manufacturer label indicates that the medication expired 05 2019.

On 9/10/19 at 12:15 p.m., there was a bottle of Brimonidine Tartrate ophthalmic solution 0.2% in a box in the medication cart with resident #2's name written in marker. The prescription label was mostly torn off and illegible. The resident is not currently prescribed this medication.

On 9/10/19 at 11:40 a.m., there was a box containing a bottle of Refresh Optive sensitive eye drops with a prescription label for resident #3. The expiration date on the box is Apr 2018.

On 9/10/19 at 11:40 a.m., there was a box containing a tube of Miconazole 7.2% cream with prescription label for resident #3 – Apply externally to affected area three times a day for 1 week. The medication order was filled 7/11/19. This medication is no longer prescribed for the resident.

On 9/10/19 at 11:40 a.m., there was a box of Miconazole 3 Combo with prescription label for resident #3 indicating – Insert 1 suppository vaginally every day for 3 days as directed. Rx "orig 07/11/19". This medication is no longer prescribed for the resident.

On 9/10/19 at 2:40 p.m., there was a box of 5X3ml Humalog KwikPens 1—units per mL with 4 unopened pens in the box with prescription label for resident #4 that indicates "inject subcutaneous as directed to low dosage sliding scale before meals & at bedtime. Orig 08/07/19". This medication was discontinued on 8/30/19.

[redacted]

Violation Withdrawn 3/25/20

On 9/10/19 at 2:30 p.m., there was a bottle of liquid antacid/antigas with a prescription label for former resident #5. The bottle indicated an expiration date of 04/19.

183d - Prescription Current *(continued)*

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 Noted medications were disposed of on 9/10/2019 immediately during & after survey.

Assistant Administrator
The designee going Forward will check all medications at least weekly.

12/26/2019 Redstone Owner of Pharmacy will do a med cart check once a month in person. The Assistant Administrator will complete a daily check of medications. The pharmacist will review physician orders for medications in the Home monthly. All Staff have been educated on what meds can be kept in the Home. Need for prescription to match.

Legal Entity Representative

Signature: Leah Laffey — Printed Name and Title: Adm — Date: 12/6/2019

LL 12/26/2019

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The above plan of correction is approved as of 12/30/19 (Date)

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

Plan of correction implementation status as of 3/25/2020 (Date)

☐ Fully Implemented

☒ Not Implemented

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

On 9/10/19 at 1:52 p.m., there was an open bottle of Natures Bounty Acidophilus Probiotic 120 capsules for resident #1 in the medication cart. The manufacturer's label indicates "Refrigerate after opening." The medication is kept in the unrefrigerated medication cart. There were approximately 15 capsules remaining in the bottle.

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 designee inserviced all staff regarding refrigerating Medications. This medication was replaced and refrigerated.

12/20/2019 The assistant administrator will review all medications daily on 16 residents assuring refrigeration when needed. Medications will be organized and in the temperature under manufacturers instructions.

Legal Entity Representative

Signature | Printed Name and Title: Leah LaFfey - Adm | Date: 12/6/2019

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☒ Fully Implemented

☐ 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:

Description of Violation

Resident #1 is ordered Niacin 500 mg ER tab – take 4 tablets (1000 mg) at bedtime. The bottle of this medication did not have a prescription label. The manufacturer label indicates 1 capsule 1-2 times daily. There was no "directions changed" sticker on the bottle.

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.)

ON 9/11/2019, the designee spoke to the pharmacist and a correct label was obtained. The designee reviewed with current staff.

Going forward, The Redstone pharmacy Owner will do a monthly review in person. The Assistant Administrater will do a daily check of medications present to assure labels are in compliance with physician orders.

Legal Entity Representative

Shappy Lean Laffey Adm 12/6/2019
Signature Printed Name and Title Date

12/26/2019

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☐ Not Implemented

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 #1 is ordered blood glucose checks "every other day in the morning and every other evening." The blood glucose readings in the resident's glucometer were incorrectly entered onto the resident's September 2019 medication administration record (MAR)as follows:

* 9/8/19 6:03 glucometer reading of 102 was entered into MAR as 201

* 9/5/19 20:02 glucometer reading was entered into MAR as 105

Resident #3's glucometer was not calibrated to date/time. On 9/10/19 at 11:44 a.m., the resident's glucometer indicated that it was 9/9 11:53 a.m.

[redacted]

Violation Withdrawn 3/25/20

Resident #3 is prescribed Nystop powder as needed to affected areas. On 9/10/19 at 11:40 a.m., the medication was not available in the home for administration.

On 5/31/19, resident #6 was ordered Vitamin B-12 (1,000MCG/ML INJ SOLN) – 1,000 MCG intramuscularly weekly for B12 deficiency – cyanocobalamin. On 9/10/19 at 2:30 p.m., the medication was not available in the home for administration.

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 #1 - MAR readings corrected
Resident # 3 Calibration up to date.
[redacted]
Resident # 3 - Powder obtain
Resident # 6 - On Hospice. Hospice RN is giving. Reviewed with all staff.

See Page 25A of 30

Legal Entity Representative

[signature] Leah Laffey Adm 12/16/2019

Signature Printed Name and Title Date

Addendum

2600. 185 A.

Redstone Pharmacy will be coming monthly for med cart reviews and checks. This is beginning next week by Jan 3rd. The pharmacist / owner will also provide a medication inservice on medication errors, documentation of correct glucometer readings.

The Assistant administrator going Forward will observe med administration for 6 residents on different shifts. This will be completed for the month of JAN & then quarterly through 2020. This will ensure that all medications have safe storage, access, security and distribution.

Dawn Kappy
PCH Administrator
4/6/2020
previous submission

4/8/2020

185a - Implement Storage Procedures *(continued)*

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☐ Fully Implemented

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☒ Not Implemented

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 #2 is ordered Dorzolamine HCl-timolol 22.3/6.8mg – 1 drop bilaterally twice a day/ give 15 min after travatan for the PM dose. On 9/10/19, at 12:15 p.m., this medication was not present in the home. The resident's September 2019 medication administration record (MAR) has been signed off indicating that this medication has been administered at 9:00 a.m. and 9:00 p.m. from 9/1/19 through 9/10/19 at 9:00 a.m. Staff person B, a medication technician, indicated that he/she has been administering eye drops from a bottle of Brimonidine Tartrate ophthalmic solution 0.2% and signing off on the Dorzolamine MAR entry. The bottle of Brimonidine tartrate was in a box in the medication cart with no legible prescription label but had the resident's name written in black marker.

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 - Both eye drops have been obtained through the pharmacy and are correct.
Administrator / Designee to check medications daily
Staff has been re-inserviced on the importance of accurate medication administration.
New med training to take place in January 2020.
Pharmacist to complete staff inservice regarding Accurate documentation.

Legal Entity Representative

Signature: [signature] Printed Name and Title: Leah Laffey Admin Date: 12/6/2019

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Plan of correction implementation status as of 3/252020 (Date)

☐ Fully Implemented

☒ 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 ordered Dorzolamine HCl-timolol 22.3/6.8mg – 1 drop bilaterally twice a day/ give 15 min after travatan for the PM dose. On 9/10/19, at 12:15 p.m., this medication was not present in the home. The resident's September 2019 medication administration record (MAR) has been signed off indicating that this medication has been administered at 9:00 a.m. and 9:00 p.m. from 9/1/19 through 9/10/19 at 9:00 a.m. Staff person B, a medication technician, indicated that he/she has been administering eye drops from a bottle of Brimonidine Tartrate ophthalmic solution 0.2% and signing off on the Dorzolamine MAR entry. The bottle of Brimonidine tartrate was in a box in the medication cart with no legible prescription label but had the resident's name written in black marker.

Resident #3 is ordered "take blood sugars once daily for diabetes" according the resident's most recent medical evaluation. There is a blood glucose reading entry of 165 in the resident's September 2019 MAR on 9/8/19 at 9:00 a.m. However, there is not a coinciding reading in the resident's glucometer. Staff person D indicated that he/she did not take morning blood glucose readings on 9/8/19.

On 5/31/19, resident #6 was ordered Vitamin B-12 (1,000MCG/ML INJ SOLN) – 1,000 MCG intramuscularly weekly for B12 deficiency – cyanocobalamin. On 9/10/19 at 2:30 p.m., the medication was not available in the home and according to the resident's August 2019 and September 2019 MARs, the medication was only administered on 8/29/19 for the period 8/1/19 through 9/10/19.

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.)

Resident #2. Confusion was with family bringing meds vs. pharmacy. Eye drops are now current.

Resident #3 Designee reviewed blood sugar testing process with all staff members.

Resident #6 Licensed Hospice Nurse administers.

Legal Entity Representative 12/26 ALL meds will be reviewed daily by the assistant administrator designee when administrator is OFF.

Signature | Printed Name and Title | Date

Kathy Leah Laffey Adm 12/6/2019

09/05/2019 Designee will not allow meds brought in from home.

See Page 28A of 30

Addendum: 2600, 187. d.

Multiple Quality monitoring has been put in place for medication Administration.

1. Redstone pharmacist owner to provide training to all staff. 1st week of Jan.
2. Med training to take place in January
3. Daily oversight by Assistant administrator of medication admin process assuring that Dunlevy is following the directions of the prescriber.
4. Inservice regarding what defines a medication error and reporting this to the state.

Shaffy
12/26/2019

3/25/2020

187d - Follow Prescriber's Orders *(continued)*

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191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1 was not educated on the resident's right to question or refuse a medication if the resident believes there may be a medication error.

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 # 1 has been educated on this right & his contract has been updated. The Assistant Administrator will along with the ombudsman have an inservice with all staff to educate staff on resident rights. JAN 2020 This has been added to the residents' rights the Assistant Administrator will have these mtgs. quarterly going Forward. Focus on med errors.

Legal Entity Representative

Signature — Printed Name and Title: Leah LaFfey - Adm — Date: 12/6/2019

12/26/2019

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