MAILING DATE: November 8, 2019

Mr. Daniel Guill
President / COO
Barnes Aid OPCO LLC
2021 James Street
Latrobe, Pennsylvania 15650

RE: Barnes Place
Certificate #: 444880

Dear Mr. Guill:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 16, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Larry Mazza
Human Services Licensing Supervisor

Enclosure
<Licensing Inspection Summary>

RECEIVED

10/31/2019

Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *BARNES PLACE*

License Number: *44488*

Address: *2021 JAMES STREET,, LATROBE, PA 15650*

County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: *Melissa Hice* Phone: *7245378005* Email: *MHICE@ENLIVANT.COM*

Legal Entity

Name: *BARNES AID OPCO LLC*

Address: *2021 JAMES STREET,, LATROBE, PA, 15650*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/26/1997* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *73* Waking Staff: *55*

Inspection

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

Reason: *Renewal*

Inspection Dates and Department Representative

10/16/2019 - On-Site: Ashley Roser, Barb Barone, Amy Duncan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *68* Residents Served: *54*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *54*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *19*

Have Physical Disability: *0*

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

There were no influenza poster posted in a public and conspicuous place in the home in accordance with the Influenza Awareness Act, enacted in July, 2016.

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.)

See Page 2A of 15

Legal Entity Representative

Signature: Melissa Hice

Printed Name and Title: Melissa Hice, Executive Director

Date: 10/30/19

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

2600.18

- Influenza poster was posted in public and conspicuous place on 10/17/2019.
- Poster was previously posted in hallway, but was taken down to have the community hallways painted.
- Executive Director received training on regulation 2600.18 by the Regional Director of Care Services on 10/17/2019
- The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit that the poster remains posted in a public place weekly for 3 months. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion date: 10/31/2019

Melissa Hace ED

41c - Rights Poster

Regulations

2600.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

The Department's resident's rights poster was not posted in a public and conspicuous place in the home.

Plan of Correction (POC)

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

See attached

See Page 3A of 15

Legal Entity Representative

Signature: Melissa Hice | Printed Name and Title: Melissa Hice, ED | Date: 10/30/19

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ]
- [ ]
- [ ] Not Implemented

2600.41c

- Department's poster of the list of resident's rights was posted on 10/18/2019.
- Poster was previously posted in hallway, but was taken down to have the community hallways painted.
- Executive Director received training on regulation 2600.41c by the Regional Director of Care Services on 10/17/2019

- The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit that the poster remains posted in a public place weekly for 3 months. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date: 10/31/2019

44g - Telephone Number

Regulations

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP), the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline were not posted in a public and conspicuous place in the home.

Plan of Correction (POC)

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

See attached

See Page 4A of 15

Legal Entity Representative

Melissa Hice ED — Signature

Melissa Hice ED — Printed Name and Title

10/30/19 — Date

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.44g

- The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy Inc, The local Law Enforcement Agency, The Commonwealth Information Center and the Personal Care Complaint Hotline were posted in a public place on 10/17/2019.
- Poster was previously posted in hallway, but was taken down to have the community hallways painted.
- Executive Director received training on regulation 2600.44g by the Regional Director of Care Services on 10/17/2019
- The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit that the poster remains posted in a public place weekly for 3 months. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date: 10/31/2019

Melissa Hess ED

103d - Storing Food Off Floor

Regulations

2600.
103.d. Food shall be stored off the floor.

Description of Violation

There were 81 gallons of emergency water stored on the floor in the home's Riser room.

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.)

See attached

See Page 6A of 15

Legal Entity Representative

Melissa Hice ED — Signature
Melissa Hice ED — Printed Name and Title
10/30/19 — Date

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.103d

- Maintenance Tech built a pallet and placed the emergency water in the Riser Room on it on 10/17/2019.
- Maintenance Tech was educated on Regulation 2600.103d by Executive Director on 10/17/2019.
- The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit that the Emergency water is stored off the floor weekly for 3 months. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date: 10/31/2019

103f - Refrigerator/Freezer Temps

Regulations

2600.

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

Description of Violation

At 10:14 a.m., the temperature in dairy cooler #6 was 44 degrees Fahrenheit, and at 1:46 p.m., it was 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.)

See attached

See Page 7A of 15

Legal Entity Representative

Signature: [signature] | Printed Name and Title: Melissa Hice ED | Date: 10/30/19

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.103f

- Items in cooler were temped; all were below 40 degrees, so they were moved into other coolers. #6 Dairy Cooler was previously temped at 8am on 10/16/2019 by Maintenance Tech and was 36 degrees Fahrenheit.
- Culler refrigeration called and on-site at 4pm. Stated thermostat was sticking and new one will need ordered. Cooler not in use.
- Culler refrigeration called on 10/28/2019 that part is in and will replace on 10/30/2019
- Maintenance Tech educated on regulation 2600.103f by Executive Director on 10/17/2019.
- Maintenance Tech to audit temperatures of coolers and will report to Executive Director any variance in temp above 40 degrees. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date: 10/30/2019

103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 10:26 a.m. there were 4 waffles unsealed in the activities kitchenette freezer.

REPEAT VIOLATION: 12/18/2018

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.)

See Page 8A of 15

Legal Entity Representative

Signature: [signature] Melissa Hice ED

Printed Name and Title: Melissa Hice ED

Date: 10/30/19

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

☑ Implemented
☐ [redacted]
☐ [redacted]
☐ Not Implemented

2600.103g

- Waffles were discarded on 10/16/2019.
- Life Enrichment Coordinator was educated on regulation 2600.103g by Executive Director on 10/17/2019.
- Residents will be educated on regulation 2600.103g at the Resident Council Meeting that is scheduled for 10/30/2019.
- Posting placed on refrigerator to remind residents/staff to seal food items prior to placing in freezer
- Clips placed in pouch on freezer to be used to close items prior to being placed in freezer
- The Life Enrichment Coordinator is responsible for sustained compliance. The Life Enrichment Coordinator and/or designee will audit that all items in freezer are sealed 5 x week for 4 weeks, 3 x week for 4 weeks then weekly for 4 weeks. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date: 10/30/2019

Melissa Hice ED

103i - Outdated Food

Regulations

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 10:26 a.m., there were 4 waffles unlabeled and undated in the activities kitchenette freezer.

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.)

See attached

See Page 9A of 15

Legal Entity Representative

Melissa Hice ED — Signature
Melissa Hice ED — Printed Name and Title
10/30/19 — Date

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.103i

- Waffles were discarded on 10/16/2019.
- Life Enrichment Coordinator was educated on regulation 2600.103i by Executive Director on 10/17/2019.
- Residents will be educated on regulation 2600.103i at the Resident Council Meeting that is scheduled for 10/30/2019.
- Posting placed on refrigerator to remind residents/staff to label/date food items prior to placing in freezer
- Labels and sharpie marker placed in pouch on freezer to be used to date/label items prior to being placed in freezer
- The Life Enrichment Coordinator is responsible for sustained compliance. The Life Enrichment Coordinator and/or designee will audit that all items in freezer are dated/labeled 5 x week for 4 weeks, 3 x week for 4 weeks, then weekly for 4 weeks. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date: 10/30/2019

123b - Emergency Procedures Posted

Regulations

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's and municipality's emergency procedures are not posted in a public and conspicuous place in the home.

Plan of Correction (POC)

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

See attached

See Page 10A of 15

Legal Entity Representative

Melissa Hice EO — Signature

Melissa Hice EO — Printed Name and Title

10/30/19 — Date

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

The above plan of correction is approved as of 11/4/19 (Date)

Plan of correction implementation status as of 11/4/19 (Date)

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

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.123b

- Copies of Emergency Procedures were posted behind the concierge desk the date of the survey
- Copies of the Communities and Municipalities emergency procedures were placed in a binder mounted on the wall inside the front door on 10/17/2019.
- Executive Director was educated on regulation 2600.123b by the Regional Director of Care Services on 10/17/2019.
- The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit that the Emergency procedures are posted inside the main door to the community weekly for 3 months. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completion Date : 10/30/2019

Melissa Hee ED

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's maximum safe evacuation time specified in writing within the past year by a fire safety expert is 7 minutes; however, during the fire drill conducted on 6/24/19 at 11:28 p.m. the evacuation time was 7 minutes and 23 seconds, which exceeds the maximum safe evacuation time.

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.)

See Page 11A of 15

Legal Entity Representative

Signature: Melissa Hice ED — Printed Name and Title: Melissa Hice ED — Date: 10/30/19

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ]
- [ ]
- [ ] Not Implemented

2600.132d

- Fire Drill log audited by Executive Director to address any areas of concern or patterns on 10/17/2019. No other areas of concern identified.
- Night shift drill completed on 09/29/2019 was within safe evacuation time @ 5minutes 20 seconds.
- Maintenance Tech was educated on regulation 2600.132d by the Executive Director on 10/17/2019.
- A Fire drill will be completed on each shift by 11/8/2019 to assure that all residents can be evacuated within the time designated by the fire safety expert.
- The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit the Fire Drill log within 24 hours of a fire drill being completed to address and areas of concern for 3 months. If an area of concern is noted, another drill will be completed within 24 hours. The audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.
- Completed 10/30/2019

Melissa Hice ED

183b - Meds and Syringes Locked

Regulations

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 12:53 p.m., there was a bottle of Zinc Oxide-20% cream unlocked, unattended and accessible in a blue bin next to resident #1's bed.

At 9:40 a.m., there was a bottle of Tums, a bottle of Biofreeze, and a bottle of Aspercream unlocked, unattended and accessible in resident #2's bedroom.

At 10:00 a.m., there was a bottle of Phytoplex 4oz Z-Guard Paste unlocked, unattended and accessible in the shared bedroom of residents #4 and #5.

REPEAT VIOLATION: 12/18/2018

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.)

See attached

See Page 13A of 15

Legal Entity Representative

Melissa Hice ED — Signature

Melissa Hice ED — Printed Name and Title

Date

183b - Meds and Syringes Locked *(continued)*

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] [redacted] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.183b

- Medications were placed in the locked medication room/ or locked cabinet at the time of the survey.
- Audit of current resident rooms for medications, prescription, OTC and CAM/Syringes will be completed by 11/1/2019 to assure that all medications are kept in an area or container that is locked.
- Current staff will be in-serviced on regulation 2600.183b by 11/1/2019.
- A letter will be sent out to the residents and their responsible parties to educate them on regulation 2600.183b by 11/1/2019. A copy of this letter will also be posted near the sign in log to the community.
- Education on the regulation was presented to the residents on 10/30/2019 at the Resident Council Meeting.
- The Care Services Manager and/or designee will audit 5 apartments per week x 4 weeks, then 3 apartments a week x 4 weeks, then 1 apartment weekly x 4 weeks, to ensure that medications remain in a locked area and are not accessible to residents. Audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.

- Completion Date: 11/01/2019

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 #2 is prescribed Bumetanide 1 mg-Take 1 tablet by mouth everyday; however, the pharmacy label indicates Bumetanide 1 mg-Take 1 tablet by mouth every other day alternating with 2 mg tablet.

Resident #2 is prescribed Lantus 100 units/ml-Inject 18 units in the morning and 30 units in the evening; however, the pharmacy label indicates to inject 15 units in the morning and 30 units in the evening.

Resident #2 is prescribed Novolog 100 unit/ml-Inject subcutaneously before meals and at bedtime in accordance with sliding scale; however, the pharmacy label indicates Novolog Flexpen 100 unit/ml-Inject 7 units at lunch time and 8 units at dinner time.

REPEAT VIOLATION: 12/18/2018

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.)

See attached

See Page 15A of 15

MAkee ED

184a - Labeling OTC/CAM *(continued)*

Legal Entity Representative

Melissa Hice ED | Melissa Hice ED | 10/30/19
Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 11/4/19 (Date)

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

Plan of correction implementation status as of 11/4/19 (Date)

- [x] Implemented
- [ ] [redacted]
- [ ] [redacted]
- [ ] Not Implemented

2600.84a

- Direction change stickers applied to the medications to indicate the directions were different than the label at time of survey.
- Current orders were sent to the pharmacy to provide for accuracy of the labels on the next fill from pharmacy.
- Medication Technicians will be retrained on the importance of clarifying orders and utilizing the direction change stickers when needed by 11/01/2019.
- The Care Services Manager and/or designee will audit the medication cart -5 residents a week for 4 weeks, 3 residents a week for 4 weeks and 1 resident a week for 4 weeks to ensure the medication labels match the physician's order/MAR. Audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. .
- Completion Date: 11/01/2019