



MAILING DATE: November 15, 2019

Ms. Robin Metzger  
Executive Director  
Grove Manor  
1 Woodcrest Circle  
Scottsdale, Pennsylvania 15683

RE: Woodcrest Senior Living Community  
Certificate #: 442120

Dear Ms. Metzger:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 17, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Janine Wenzig". The signature is written in a cursive, flowing style.

Janine Wenzig  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

## Violation Report

### Facility Information

Name: *WOODCREST SENIOR LIVING COMMUNITY*  
Address: *1 WOODCREST CIRCLE,, SCOTTDALE, PA 15683*  
County: *WESTMORELAND*                      Region: *WESTERN*

License Number: 44212

### Administrator

Name: *Robin Metzger*                      Phone: *7248873773*                      Email: *RMETZGER@WOODCREST.CARE*

### Legal Entity

Name: *GROVE MANOR*  
Address: *1 WOODCREST CIRCLE, SCOTTDALE, PA, 15683*

### Certificate(s) of Occupancy

Type: *C-2 LP*                      Date: *07/26/1995*                      Issued By: *L&I*

### Staffing Hours

Resident Support Staff: *0*                      Total Daily Staff: *24*                      Waking Staff: *18*

### Inspection

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

### Inspection Dates and Department Representative

*10/17/2019 - On-Site: Debora McConnell, Amy Duncan*

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: *31*                      Residents Served: *20*

#### Secured Dementia Care Unit

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

#### Hospice

Current Residents: *0*

#### Number of Residents Who:

Receive Supplemental Security Income: *0*                      Are 60 Years of Age or Older: *20*  
Diagnosed with Mental Illness: *3*                      Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *4*                      Have Physical Disability: *0*

*Mark Zome*

26b - Quality Management Plan Content

Regulations

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's quality management review, dated 6/7/19, did not address reportable incident and condition reporting procedures, staff person training and licensing violations and plans of correction.

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 2A OF 11

Legal Entity Representative

*Mark Lane*  
Signature

*MARK LANE Business office mgr*  
Printed Name and Title

*11/14/2019*  
Date

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

The above plan of correction is approved as of  
(Date)

11/13/19  
(Date)

Plan of correction implementation status as of

11/13/19  
(Date)

Implemented

The above plan of correction was approved by

*(initials)*  
(initials)

Not Implemented

## PLAN OF CORRECTION


SITE VISIT 10-17-2019

2600

26b.

1. A QAPI meeting was held 10-23-2019 to reeducate on the QAPI process and to identify and review the annual inspection that occurred 10-17-2019.
2. Going forward QAPI meetings will be held monthly to address new issues, review outstanding issues and develop best practices.
3. Woodcrest management have been educated on the QAPI process on 10-23-2019
4. The QAPI program will be monitored by the Executive Director for effectiveness of the program on a monthly basis. The Executive Director will ensure the quality management review includes all required topics including reportable incident and condition reporting procedures, complaint procedures, staff training, licensing violations and plans of correction, if applicable and resident or family councils, if applicable. - JRW 11/13/19
5. Completion date: 11-15-2019

*Mark Lane*

 11/13/19

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff person A did not receive annual training in any of the topics in accordance with §2600.65g during training year 2018.

Staff person B did not receive annual fire safety training by a fire safety expert or a staff person trained by a fire safety expert during training year 2018.

REPEAT VIOLATION: 1/10/19

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.)

SEE PAGE 3A OF 11

Legal Entity Representative

|           |                        |      |
|-----------|------------------------|------|
| Signature | Printed Name and Title | Date |
|-----------|------------------------|------|

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|  |   |  |                 |
|--|---|--|-----------------|
| The above plan of correction is approved as of | 11/13/19  | Plan of correction implementation status as of | 11/13/19        |
|  | (Date)  |  | (Date)          |
|  |   | XX   | Implemented     |
| The above plan of correction was approved by   | <br>(Initials) |  |                 |
|  |   | <input type="checkbox"/>                       | Not Implemented |

10/17/2019

*Mark Jones*

2600

65.g.

- 1. Staff person A has received training in Fire safety, emergency preparedness, Resident rights, and The Older protective services act.

Staff person B has received annual fire safety training

- 2. A review of all mandatory education for all staff was completed with no further issues identified

- 3. A calendar was developed for monthly educational requirements for the staff to follow


Managers have been educated on training staff once they return from leave for any education that they may have missed

Audits will be done monthly for 12 months to ensure all staff members have been educated on monthly topic

- 4. Findings of audits will be presented to the QAPI committee by the Executive Director for review

- 5. Completion date: 11-15-2019

*Mark Jam*

 11/13/19

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

There are construction and building supplies and piles of dirt, posing a trip/fall hazard, in the back yard beyond the rear patio.

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 11

Legal Entity Representative

Mark Jan  
Signature

MARK LAWE Business Office Mgr 11-11-2019  
Printed Name and Title Date

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The above plan of correction is approved as of 11/13/19  
(Date)

Plan of correction implementation status as of 11/13/19  
(Date)  
 Implemented

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


Not Implemented

2600

100.a.

1. Two fire doors from Chapel area near activities desk were block outside by fence from construction area and there was not a smooth walkway to a safe distance from building was not present. Fence was moved and walkway was built on date of survey.
2. Maintenance Director conducted rounds to ensure there were no further safety hazards at the construction site  
  
Management Staff has been educated on safety hazards during the construction period.
3. Maintenance Director will ensure in his daily rounds that the construction does not pose any hazard.
4. Maintenance Director will audit for any hazards noted on daily rounds and will report to QAPI the issue and remedy at time hazard was noted
5. Completion: 11-15-2019

*Mark Lane*

 11/13/19

103d - Storing Food Off Floor

Regulations

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

Description of Violation

The home's 114 gallons of emergency water is stored on the floor in the outside shed.

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 5A OF 11

Legal Entity Representative

*Mark Lane*

Signature

*Mark Lane Business office mgr*

Printed Name and Title

*11-11-2019*  
Date

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The above plan of correction is approved as of

11/13/19  
(Date)

Plan of correction implementation status as of

11/13/19  
(Date)

Implemented

The above plan of correction was approved by

*(Handwritten initials)*  
(Initials)

Not Implemented

2600


103.D.

- 1. Emergency water supply was stored on the floor. The water was moved to be stored on pallet and elevated off the floor
- 2. A review of storage area was conducted with no further issues.
- 3. Education was provided to the Maintenance Director to ensure that all stored water is stored off the floor and, on a pallet,

Daily rounds conducted by the Maint. Director will include ensuring that water is stored on pallets.

- 4. If there is an issue with delivery not placing water on pallets it will be reported to the QAPI team for review and resolution.
- 5. Completion date: 11-15-2019

*Mark Lane*

 11/13/19

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

The two doors leading from the dining room/chapel to the outside of the home are emergency exits. These doors lead to a patio enclosed in a fence. There is a piece of plywood, measuring approximately 5 'x 8', blocking the exit from the fence.

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 11

Legal Entity Representative

Mark Jan  
Signature

Mark Lane Business Office Mgr  
Printed Name and Title

11-11-19  
Date

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(Date)

Plan of correction implementation status as of 11/13/19  
(Date)

Implemented

The above plan of correction was approved by  
(Initials)

Not Implemented


POC

2600

121.A.

6. Two fire doors from Chapel area near activities desk were block outside by fence from construction area and there was not a smooth walkway to a safe distance from building was not present. There was not a clear path of egress. Fence was moved and walkway was built on date of survey.
7. Maintenance Director conducted rounds to ensure there were no further safety hazards at the construction site and that there is a clear path of egress  
  
Management Staff has been educated on safety hazards during the construction period and clear path of egress.
8. Maintenance Director will ensure in his daily rounds that the construction does not pose any hazard and there is a clear path of egress.
9. Maintenance Director will audit for any hazards noted on daily rounds and will report to QAPI the issue and remedy at time hazard was noted
10. Completion: 11-15-2019

*Mark Sam*

 11/13/19

132g - Fire Drills Days/Times

Regulations

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff persons on the 11:00 pm.-7:00 am. shift. However, the home has not conducted a sleeping hours fire drill with the minimum number of staff in the past 10 months.

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 7A OF 11

Legal Entity Representative

Signature *Mark Lane*

Printed Name and Title *Mark Lane Business Office Mgr*

Date *11-15-19*

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(Date)

Plan of correction implementation status as of 11/13/19  
(Date)

Implemented

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

Not Implemented

POC

2600

132.G.

1. A sleeping hour fire drill will be held in December 2019 and once every 6 months.
2. A review of the fire drill log was conducted, and no other violations were found.
3. All drills will be documented on the fire drill log

A fire drill will be conducted and documented every month, on the months where the sleeping shift is scheduled another shift will also be scheduled for a full evacuation and a silent drill will be conducted on the sleeping shift.

Sleeping hours fire drills will be conducted with the minimum staff usually scheduled during overnight shift participating. - *JRW 11/13/19*

A new fire drill log has been created and includes date of drill, time including am/pm, time to evacuate, exit routes used, number of residents present, number of personal care residents evacuated, number of independent residents evacuated, total residents evacuated, number of staff participating in drill, alarm activated, alarm operational, any problems and any planned corrective action needed.

Education was conducted for Maintenance staff on this new form and procedure. *on 10/13/19.*

*--JRW 11/13/19*

4. Fire drill response and corrective actions needed will be reported to the QAPI team for review
5. Completion: 11-15-2019

*Mark Lane*

*11/13/19*

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

During fire drills, all residents do not exit the home to the designated meeting places, they stop inside the exit doors. The designated meeting places for fire drills are located outside of the building: the front and rear patios and the patio off off 100 & 200 section of the building, as indicated in the letter dated 1/25/19 by a fire safety expert. The home does not have any interior safe areas.

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 8A OF 11

Legal Entity Representative

Mark Lane  
Signature

MARK LANE Business Office Mgr  
Printed Name and Title

11-11-19  
Date

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The above plan of correction is approved as of 11/13/19 (Date) Plan of correction implementation status as of 11/13/19 (Date)

Implemented

The above plan of correction was approved by (Initials)

Not Implemented

POC

2600

132.H. FIRE DRILL WITH FIRE DEPARTMENT WAS CONDUCTED ON 11/5/19 AT 6:30PM.  
ALL RESIDENTS WERE EVACUATED TO THE EXTERIOR FIRE SAFE AREAS. - *JRW 11/13/19*

1. A sleeping hour fire drill will be held in December 2019 and once every 6 months. Evacuating to the fire safe areas designated by the Fire Safety Expert for all future fire drills which are located outside of the home. - *JRW 11/13/19*
2. A review of the fire drill log was conducted, and no other violations were found.
3. All drills will be documented on the fire drill log

A fire drill will be conducted and documented every month, on the months where the sleeping shift is scheduled another shift will also be scheduled for a full evacuation and a silent drill will be conducted on the sleeping shift.

A new fire drill log has been created and includes date of drill, time including am/pm, time to evacuate, exit routes used, number of residents present, number of personal care residents evacuated, number of independent residents evacuated, total residents evacuated, number of staff participating in drill, alarm activated, alarm operational, any problems and any planned corrective action needed.

Education was conducted for all staff on locations of the fire safe areas designated by the Fire Safety Expert.

4. Fire drill response and corrective actions needed will be reported to the QAPI team for review
5. Completion Date: 11-15-2019

*Mark Dan*

*[Signature]* 11/13/19

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 #1 is prescribed the medication Betimol, 0.5% Eye Drops, 1 drop in each eye daily. The medication bottle indicates the medication was opened on 7/3/19. According to the manufacturer's instructions the medication expires 4 weeks after opening. On 10/17/19, the medication was in the resident's medication box and the medication was administered daily from 10/1/19 - 10/17/19, at 8:00 am.

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 11

Legal Entity Representative

*Mark Lane*  
Signature

*MARK LANE BUSINESS OFFICER MYR*  
Printed Name and Title

*11-1-19*  
Date

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The above plan of correction is approved as of 11/13/19  
(Date)

Plan of correction implementation status as of 11/13/19  
(Date)

Implemented

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

Not Implemented

POC

2600


183.E.

1. All medication was reviewed for resident #1, the expired eye drops were immediately changed with a non-expired eye drop bottle.
2. All residents who receive eye drop medication were reviewed, no other expired eye drops were noted.
3. Education was given to RN and care staff on proper labeling and dating for eye drops.

Six (6) random audits will be conducted on all eye drop medication for 12 months by the RN to ensure that all medication is within the limits of expiration

4. Monthly audits will be submitted to the QAPI committee monthly for review and recommendations.
5. Completion date: 11-15-2019

*Mark Lane*

 11/13/19

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:

- 1. The resident's name.
- 2. The name of the medication.
- 3. The date the prescription was issued.
- 4. The prescribed dosage and instructions for administration.
- 5. The name and title of the prescriber.

Description of Violation

Resident #1 is prescribed Latanoprost eye drops, 1 drop in each eye at bedtime; however, the bottle did not have a pharmacy label.

Resident #1 is prescribed Novolin R U-100, three times a day on a sliding scale as follows: 151-175=1 unit, 176-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, The pharmacy label for the medication does not include the sliding scale dosage of 351-400=6 units.

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 10A OF 11

Legal Entity Representative

*Mark Lane*  
Signature

*Mark Lane Business Officer MGR*  
Printed Name and Title

*11-11-19*  
Date

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The above plan of correction is approved as of 11/13/19 Plan of correction implementation status as of 11/13/19  
 (Date) (Date)

Implemented

The above plan of correction was approved by \_\_\_\_\_  
 (Initials)

Not Implemented

POC

2600

184.a.

1. A medication review was conducted for resident #1, a proper label was placed on the eye drops and proper sliding scale was labeled on the Novolin.
2. A review of all resident's medication labels was completed. All "SEE MAR" labels are in place when physicians order is different than bottle instruction
3. Education was completed for the care staff and RN on ensuring that all bottles are labeled when appropriate to follow physician orders.

Six (6) Random audits monthly will be conducted for 12 months by the RN to review all orders with the bottle and the MAR for accuracy

4. All audits will be submitted to the QAPI team for review

*Made Jane*

*J* 11/13/19

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #2 is prescribed Metamucil, 0.52gm, 1 cap daily. The October 2019 medication administration record (MAR), indicates Metamucil, 0.52gm daily as needed.

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 11 OF 11

Legal Entity Representative

*Mark Lane*

Signature

*Mark Lane Business Office Mgr*

Printed Name and Title

*11-11-19*

Date

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The above plan of correction is approved as of 11/13/19  
(Date)

Plan of correction implementation status as of 11/13/19  
(Date)

Implemented

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

Not Implemented

POC

2600

187.a.

1. a review of resident # 2 was conducted, orders clarified, and all medication ordered was administered per the physician's order. There was no harm to the resident.
2. A resident audit was conducted by the RN/designee to ensure that all physicians ordered medication has been accurately reflected on the Medication Administration Record.
3. Care Staff was educated on accurately recording physician orders for medication on the Medication Administration Record by the RN/designee.  
  
6 (six) random audits will be conducted monthly for 12 months thereafter to ensure all medication orders are obtained and accurate.
4. Audit results will be reported to the QAPI committee monthly by the RN/designee for review.
5. Completion date: 11-15-2019

*Mark Jam*

11/13/19

