pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: dclymer@enlivant.com
alclicense@enlivant.com

MAILING DATE: March 23, 2020

Mr. Daniel Guill
President / COO
Logan AID OPCO, LLC
180 Craigdell Road
Lower Burrell, Pennsylvania 15068

RE: Logan Place
Certificate #: 444940

Dear Mr. Guill:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 23, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jason Williams
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *LOGAN PLACE* License Number: *44494*
Address: *180 CRAIGDELL ROAD,, LOWER BURRELL, PA 15068*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: *DAVE CLYMER* Phone: *7243340529* Email: *ALCLICENSE@ENLIVANT.COM*

Legal Entity

Name: *LOGAN AID OPCO LLC*
Address: *180 CRAIGDELL ROAD, LOWER BURRELL, PA, 15068*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *04/04/1997* Issued By: *Dept. of L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *58* Waking Staff: *44*

Inspection

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

Inspection Dates and Department Representative

10/23/2019 - On-Site: Jan Cutter, Barbara Barone, Jason Williams

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* Residents Served: *43*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *43*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *15*
Have Physical Disability: *1*

LOGAN PLACE 44494

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The resident privacy coding document was attached to the Licensing Inspection Summary, dated 12/27/2018, and posted on the bulletin board near the office. The privacy coding document included the names of residents #1, #2 and #3.

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 resident privacy coding document was removed immediately at the time of the survey.

On October 23, 2019, an audit was conducted by the Executive Director of common areas to ensure that the privacy coding documents were not present and confidential.

On 10/23/2019, the regulation was reviewed with the Executive Director at the time of the survey, by the DHS surveyor.

The Executive Director or designee will continue to review the binder weekly for three months and then monthly for three months to ensure continued compliance. (attachment A)

Results of the audit will be reviewed in monthly QI. Continued auditing will be based on Sustained compliance for three months. Monitoring will be ongoing.

Legal Entity Representative

Dave Clymer 1/22/20

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 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

65a - FS Orientation 1st Day

Regulations

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Direct care staff person A, whose first day of work was 7/29/2019, did not receive this required orientation until 7/31/2019.

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 October 23, 2019, the executive director audited the current staff training charts to ensure that current staff have received required training 2600.65(a).

The ED received training on 10/23/2019 regarding regulation 2600.65.a. by the surveyor.

The Executive Director or designee will audit five employee files monthly for three months for compliance of initial training.(Attachment B)

Results of the audits will be reviewed at monthly QI meetings. Continued audits will be based on Sustained compliance for three months. Monitoring will be on going.

Please see Audit of 2600.65 (a), page a. showing staff file audits of December 2019 and January 2020.

Legal Entity Representative

DWClymer

Signature | Dave Clymer Printed Name and Title | 1/22/2020 Date

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

The above plan of correction is approved as of 3/12/20 (Date)

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

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

66a - Staff Training Plan

Regulations

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home did not develop a staff training plan for 2019.

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 2020 Staff Training Plan was developed on 12/23/19.

The staff training plan was developed in compliance with 2600.65 f and g.

Any changes to the plan will be recorded on the original training plan.
The ED and/or designee reviewed the regulation with DHS survey team at the time of exit.

The Ed or designee will audit the 2020 staff training binder monthly for three months. (attachment C)

Training was received by the ED and CSM on 10/23/2019 regarding regulation 2600.66.a by the surveying team.

Results of the audit will be in monthly QI. Continued auditing will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature	Printed Name and Title	Date
	Dave Clymer	1/22/20

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

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

103e - Left Overs

Regulations

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 10:10 am, there was an undated 5 pound container of sour cream, 1/3 full, in refrigerator #1.

Repeat violation 12/27/2018

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.)

On 10/23/2019, the container of sour cream was discarded in the presence of the survey team.

On October 23, 2019 and audit was conducted by Executive director and chef to identify any food items in the refrigerator, freezer and storage that were not were found to be dated and labeled appropriately and discarded.

The ED trained the Chef and assistant chef on 10/23/2019 regarding regulation 2600.103.e. (attachment D)

The ED/ and or designee will audit stored food items for proper labeling twice weekly for 30 days and then once weekly for three months. (attachment E)

Results of the audits will be reviewed by the QI committee monthly. Continued auditing will be based on Sustained compliance for three months. Monitoring will be ongoing

Legal Entity Representative

Dave Clymer 1/22/20

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 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

103i - Outdated Food

Regulations

2600.

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

Description of Violation

At 10:05 am, there was an undated and unlabeled plastic bag with 6 breakfast sausage patties and an undated and unlabeled plastic bag with 8 breaded chicken cutlets in freezer #2.

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 Unlabeled products were immediately discarded on 10/23/2019.

On 10/23/2019, the Executive Director completed staff training regarding the dating and labeling of food items. (attachment D)

On 10/23/2019 the chef and assistant chef completed an audit to identify any food items in the refrigerators and storage that were undated and discarded at that time.

The ED and/or designee will audit for stored food items twice a week for 30 days and then weekly for three months. (attachment F)

Results of the audits will be reviewed by the monthly QI committee. Continued auditing will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature | Dave Clymer, Printed Name and Title | 1/22/20, Date

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

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

132b - Safety Inspection/Fire Drill

Regulations

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home had a fire safety inspection and fire drill conducted by a fire safety expert on 8/8/2019. The previous years fire safety inspection and fire drill was held on 7/10/2018.

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.)

Arrangements have been made with the Fire Safety Inspector to conduct the annual fire safety training at Logan Place in July 2020.

The Maintenance tech and ED were educated on 10/23/2019 regarding reg 2600.132.b. by the surveyor.

The 2020 Fire Safety Inspection is scheduled for 7/9/2020.

An audit post training will be completed in July to ensure the components of the Fire safety Inspection and drill were conducted as stated in the regulation.

Legal Entity Representative

Signature	Printed Name and Title	Date
	Dave Clymer	1/22/20

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

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The specific exit route used was not listed on the fire drill log for the following dates;

9/27/2019, 7/28/2019, 6/29/2019, 5/20/2019, 4/22/2019, 3/25/2019, 1/28/2019, 12/31/2018, 11/28/2018 and 10/29/2018. The exit route used column on the form indicated, "Everyone evacuated to fire safe zones" for the above listed dates.

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.)

At the time of inspection, the surveyor and the Maintenance Technician reviewed the fire drill logs confirming drill were conducted properly At that time, they agreed on the coding of specifically designated zone locations of the fire safe areas used as evacuation areas.

November and December 2019 fire drills specify the zones by number as agreed by the survey team, as seen in Page D1 and D2.

A tickler system will be monitored for ensuring different drill locations and appropriate safe area use. (attachment G)

Fire Drills and specifically coded evacuation zones will be audited monthly for three months. Results of the audits will be reviewed by the monthly QI committee. Continued auditing by the committee will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature	Printed Name and Title	Date
DJAClymer	Dave Clymer	1/22/20

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

The above plan of correction is approved as of 3/12/20 (Date)

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

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

141a - Medical Evaluation

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #4 was admitted to the home on 7/17/2019; however, her medical evaluation was completed on 5/8/2019.

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 ED and the CSM received training regarding reg 2600.141.a. on 1/9/20 by Regional Director of Care Services.

Current resident charts were audited on 1/9/2020 to ensure compliance with reg 2600.141.a by CSM and DCSS. (attachment G)

The CSM or designee will audit new resident admissions, within 30 days of the admission for three months to ensure compliance with reg 2600.141.a. (attachment I)

The results of the audits will be presented and reviewed by the monthly QAQI. Continued auditing will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature	Printed Name and Title	Date
	Dave Clymer	1/22/20

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

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

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 #5 is prescribed Albuterol Sulfate HFA AER 90 mcg, inhale 1 puff by mouth every 4 hours as needed; however, the medication was not available in the home.

Repeat Violation 12/27/2018

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.)

On 1/24/2020 a MAR/Cart review was completed for current residents in the home, to ensure that their medications were present and given as prescribed. (attachment J)

On 10/23/19 resident # 5 medication was ordered and delivered by the pharmacy.

On 1/21/20, Med Techs were trained by CSM that medications prescribed must be available in the home and given to residents as prescribed (attachment K)

The CSM and/or designee, is conducting MAR/Cart audits on 5 residents 5x/weekly for three months, followed by once weekly for three months. (attachment L)

Audits results will be reviewed by and presented to the QI team monthly. Continued auditing will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature	Printed Name and Title	Date
	Dave Clymer	1/22/20

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

187d - Follow Prescriber's Orders

Regulations

2600,
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 is prescribed Duloxetine HCL 60 mg, take 1 capsule by mouth every day; however, this medication has not been administered to the resident from October 10, 2019 to the present because the medication was not available 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.)

On 1/24/2020 a MAR/Cart review was completed for current residents in the home, to ensure that their medications were present and given as prescribed. (attachment J)

On 1/21/20, Med Techs were trained by CSM that medications prescribed must be available in the home and given to residents as prescribed (attachment K)

The CSM and/or designee, is conducting MAR/Cart audits on 5 residents 5x/weekly for three months, followed by once weekly for three months. (attachment L)

Audits results will be reviewed by and presented to the QI team monthly. Continued auditing will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature	Printed Name and Title	Date
Dave Clymer	Dave Clymer	1/22/20

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

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

225a - Assessment 15 Days

Regulations

2600.

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

Description of Violation

Resident #4 was admitted on 7/17/2019; however, the resident's assessment was not completed until 8/20/2019.

Resident #7 was admitted on 6/11/2019; however, the resident's assessment was not completed until 7/22/2019.

Repeat Violation 12/27/2018

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.)

On October 24, 2019, the current resident RASP's were reviewed for assessment completion dates by the CSM and ED. (attachment M)

On December 5, 2019, the Regional Director of Care Services re-trained the ED and CSM regarding resident support plan development RASP dates, updates, addendums. (attachment N)

The CSM or designee will review new resident admissions within 30 day of the admission for compliance of RASP dates x 3 months. (attachment O)

The results of the audits will be presented and reviewed by the QI committee monthly. Continued auditing will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature | Printed Name and Title: Dave Clymer | Date: 1/22/20

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

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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

LOGAN PLACE 44494

227a - Support Plan 30 Days

Regulations

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on 7/17/2019; however, the resident's initial support plan was not completed until 8/20/2019.

Resident #4 was admitted on 6/11/2019; however, the residents initial support plan was not completed until 7/22/2019.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On October 24, 2019, the current resident charts were reviewed confirming compliance for completion dates of the initial support plan by the CSM and ED. (attachment P)

On December 5, 2019, the Regional Director of Care Services re-trained the ED and CSM regarding resident support plan development RASP dates, updates, addendums. (attachment N)

The CSM or designee will review new resident admissions within 30 day of the admission for compliance of RASP dates x 3 months. (attachment O)

The results of the audits will be presented and reviewed by the QI committee monthly. Continued audits will be based on Sustained compliance for three months. Monitoring will be on going.

Legal Entity Representative

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX! Dave Clymer 1/22/20

The above plan of correction is approved as of 3/12/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/12/20 (Date)

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