Sent via e-mail: jrlong@stannehome.com

Mailing Date: February 6, 2020

Mr. Jeffrey S. Long
President/CEO
St. Anne Home, Inc.
685 Angela Drive
Greensburg, Pennsylvania 15601

RE: Villa Angela at St. Anne Home
Certificate #: 428040

Dear Mr. Long:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 6, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jody Garvey
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
1/9/2020
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *VILLA ANGELA AT ST. ANNE HOME*
License Number: *42804*
Address: *685 ANGELA DRIVE, GREENSBURG, PA 15601*
County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

Name: *Jennie Long* **Phone:** *7248376070* **Email:** *JLONG@STANNEHOME.ORG*

Legal Entity

Name: *ST ANNE HOME INC*
Address: *685 ANGELA DRIVE, GREENSBURG, PA, 15601*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *12/01/2010* **Issued By:** *I-2 Dept of L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *56* **Waking Staff:** *42*

Inspection

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

Inspection Dates and Department Representative

11/06/2019 - On-Site: Desmond Grace, Josh Hoover

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *54* **Residents Served:** *40*

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: *40*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *16*
Have Physical Disability: *0*

91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

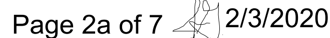
At 9:45 a.m., there were no emergency numbers posted on or near the phone with an outside line in the main kitchen.

Repeat Violation: 12/11/18

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.)

Please see

Exhibit # 1 Page 2a of 7  2/3/2020

Attachment 1A

Attachment 1B

Legal Entity Representative

Signature

Jennie R. Long, BSN, RN, Director — Printed Name and Title

1/8/2020 — Date

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

The above plan of correction is approved as of 2/3/2020 (Date)

Plan of correction implementation status as of 2/3/2020 (Date)

☑ Implemented

☐ Not Implemented

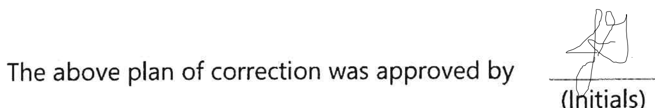
The above plan of correction was approved by  (Initials)

Exhibit # 1

Regulation §2600.91

We were notified in the Exit conference of the phone not having numbers posted beside it. We did explain that the "Main Kitchen" is located in the skilled nursing center of St. Anne Home, not in the personal care center. We did ask why we were going to be sited. They indicated it was because it is where the food for the personal care residents comes from. We thanked the Department representatives for their explanation. It is understood that this regulation to post these specific numbers facilitates a quick response from the appropriate agency in the event of an emergency, and allows residents and staff to contact the DPW to report complaints in private.

In order to correct the violation and to prevent any further occurrences, the following interventions have been or are going to be completed:

- Dining services manager posted the numbers at 1715 on 11/6/2019. **(Attachment 1A)**
- Dietary staff will be educated on the importance of having these Emergency Numbers posted by all outgoing phone lines. They will also be educated where "spares" are kept in the Villa Angela Director's office and that if the one in the kitchen goes missing, it can be easily replaced. **(to be completed by 1-24-2020)**
- The Activities and Housekeeping staff have been responsible for auditing each resident's room and the facility's outside lines weekly to ensure that these numbers are in place since the last inspection's (12-11-2018) plan of correction. We have specifically added the location of the main kitchen to the audit. (**Please see Attachment 1B) (On going)**
- We implemented laminated cards and 3M products to adhere the cards to phone base. For residents that do not have landline phone, but are utilizing a cell phone, we post the laminated card beside the light switch just inside the door to the residents' rooms. (**On going)**

Legal Entity Representative

Signature
11/06/2019

Jennie R. Long, BSN, RN, Director
Printed Name and Title

January 8, 2020
Date

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

At 9:50 a.m., a large wicker patio chair was blocking the egress route from the home's emergency exit near the pantry leaving only an approximate 1-inch opening.

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.)

Please see

Exhibit # 2 See page 3a of 7 2/3/2020

Attachment 2A
Attachment 2B
Attachment 2C

Legal Entity Representative

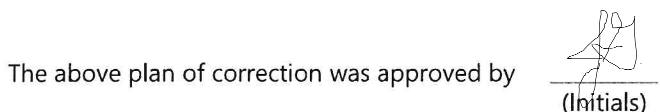
Signature	Printed Name and Title	Date
	Jennie R. Long, BSN, RN, Director	1/8/2020

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

The above plan of correction is approved as of 2/3/2020 (Date)

Plan of correction implementation status as of 2/3/2020 (Date)

☑ Implemented
☐ Not Implemented



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

Exhibit # 2

Regulation §2600.121.a

This regulation is in place to protect resident, guest, and employee safety and to ensure that our facility complies with other applicable laws.

To immediately correct the violation, the director of plant operations moved the chair away from the door to the patio. Staff were immediately verbally educated on the importance of having Stairways, hallways, doorways, passageways and egress routes from rooms and from the building unlocked and unobstructed.

In order to prevent any further occurrences, the following interventions have been or are going to be completed:

- Safety committee will be notified of the violation report results. The committee will audit the egress areas during their monthly safety checks. (**Attachment 2A) (1/9/2020)**
- A safety audit was completed by the Director Immediately following the exit conference to ensure that all of the egresses were unobstructed. (**Attachment 2B) (11/6/2019)**
- Villa Angela staff will be responsible for completing a safety audit of the doorway to the patio when they are in the dining room during meals on a daily basis for a month, then weekly for 3 months, then monthly. (**Attachment 2C) (Effective 1/10/2019 and ongoing)**
- Staff will be educated regarding the importance of all egress routes being unlocked and unobstructed for safe exiting of the building in the event of an emergency during the next staff

Legal Entity Representative

Signature

11/06/2019

Jennie R. Long, BSN, RN, Director
Printed Name and Title

January 8, 2020
Date

141b1 - Annual Medical Evaluation

Regulations

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

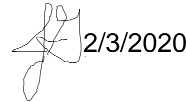
Description of Violation

Resident #1's current medical evaluation was completed on 4/26/19. However, the resident's previous medical evaluation was completed on 3/28/18.

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.)

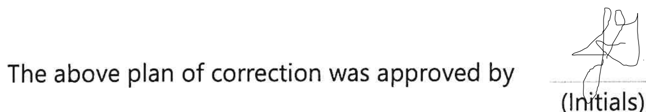
Please see

Exhibit # 3 See 4a of 7  2/3/2020

Attachment 3A
Attachment 3B

Legal Entity Representative

Signature



Jennie R. Long, BSN, RN, Director — Printed Name and Title — 1/8/2020 Date

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

The above plan of correction is approved as of 2/3/2020 (Date)

Plan of correction implementation status as of 2/3/2020 (Date)

☑ Implemented
☐ Not Implemented

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

Exhibit # 3

Regulation §2600.141.b.1

This regulation is in place to ensure that the Accurate, updated medical information on each resident. This helps our facility decide whether a resident's needs can be met at the home, allows us to develop accurate assessments and support plans, and ensures that residents' medical needs will be met by the facility.

In order to correct the violation and to prevent any further occurrences, the following interventions have been or are going to be completed:

- The Department Representatives gave guidance explaining the evaluation date and the form completed dates to determine the annual DME (Documentation of Medical Evaluation) due date during the inspection. **(11/6/19)**
- The Resident Care Coordinator (RCC) audited the DMEs for newly admitted residents in 2019. If the Resident's evaluation date was found to be different than the completion date, the RCC adjusted the facility's Annual DME due date calendar to reflect to use the evaluation date. **(11/7/19)** **(Attachment 3A)**
- The due dates for the completion of the annual DMEs will be based on the date the residents were evaluated and not the date the form was completed. RCCs will be educated on how to schedule due dates for the completion of the Annual DMEs. The director will use "The Preadmission Screening, Medical Evaluation, and Assessment-Support Plan: Best Practices" section of the Regulatory Compliance Guide. **(on or before 1/24/2020)**
- The RCC New Hire orientation Checklist has been updated to include specific information from the RCG. **(Attachment 3B)**

Legal Entity Representative

Signature

Jennie R. Long, BSN, RN, Director
Printed Name and Title

January 8, 2020
Date

162c - Menus Posted

Regulations

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

At 9:40 a.m. on 11/6/19, the menu dated 11/3/2019-11/9/2019 was posted on the bulletin board outside of the 1st floor dining room. However, the menu for 11/10/19-11/16/19 was not posted 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.)

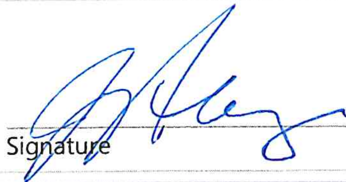
Please see

Exhibit # 4 See page 5a of 7 2/3/2020

Attachment 4A

Attachment 4B

Legal Entity Representative



Signature

Jennie R. Long, BSN, RN, Director — Printed Name and Title

1/8/2020 — Date

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

The above plan of correction is approved as of 2/3/2020 (Date)

Plan of correction implementation status as of 2/3/2020 (Date)

☑ Implemented

☐ Not Implemented

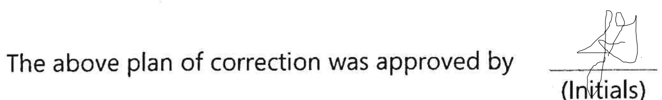
The above plan of correction was approved by  (Initials)

Exhibit # 4

Regulation §2600.162.c

This regulation is in place to ensure the facility has a menu that is prepared one week in advance. This is beneficial for residents so they can plan their meals in advance.

In order to immediately correct the violation the menu dated for November 10-16, 2019 was posted after the exit conference. **(11/6/19)**

In order to prevent any further occurrences, the following interventions have been or are going to be completed:

- The Dining services Manager provided a 5 week rotating menu on 11/7/2019. This provides the residents an at a glance view of the meal options that are going to be provided over the 5 weeks. Changes to the 5 week menu will be made and communicated to the Villa Angela Director with at least an eight day advance notice. **(Attachment 4A)**
- The weekly menus will be updated by the executive secretary no later than 8 days in advance. The Director or Administrative assistant will post the individual weekly menus. **(Ongoing)**
- The Activities staff will audit the boards weekly to ensure that the menus are posted with in the required 1 week time frame. The results will be reported to the Quality Assurance and Performance Improvement quarterly meetings. **(Attachment 4B) (Ongoing)**

Legal Entity Representative

Signature

11/06/2019

Jennie R. Long, BSN, RN, Director
Printed Name and Title

January 8, 2020
Date

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 #2's opened Levemir Flex Touch insulin pen was present in the medication cart; however, the medication was not dated when opened and no expiration date was indicated.

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.)

Please see

Exhibit # 5 See page 6a of 7 2/3/2020

Attachment 5A

Attachment 5B

Legal Entity Representative

Signature

Jennie R. Long, BSN RN, Director — Printed Name and Title

1/8/2020 — Date

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

The above plan of correction is approved as of 2/3/2020 (Date)

Plan of correction implementation status as of 2/3/2020 (Date)

☑ Implemented

☐ Not Implemented

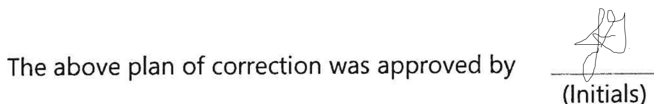
The above plan of correction was approved by  (Initials)

Exhibit # 5
Regulation §2600.183.e

This regulation is in place to ensure that the facility will store medications in a manner that prevents damage or loss.

In order to correct the violation the Resident Care Coordinator (RCC) went back to the medication cart after the exit conference. She found the date open sticker in the bag that was labeled to house the medication for resident #2, in the resident's specific compartment in the med cart. The sticker was reapplied and held in place by clear tape to prevent to it from falling off the pen.

To prevent any further occurrences, the following interventions have been or are going to be completed:

- Pharmacy was notified and a request was made to for information regarding Vial and or pen storage and expiration recommendations. The Director received the information 11/11/2019. The charts were placed in sleeves inside the front covers of the Medication Administration binders. **(11/11/2019) (Attachment 5A)**
- The pens will be dated with a sharpie pen or a date opened sticker secured with clear tape depending on the manufactures' style of pen. **(Ongoing)**
- An initial Quality Assurance and Performance Improvement audit was completed to ensure that all multiuse pens and vials were stored and dated per regulation and policy. **(Completed 11/22/2019)**
- The Resident Care Coordinators will be reeducated on the policy regarding medication storage. **(on or before 1/24/ 2020)**
- Quality Assurance and Performance Improvement audits will be competed on a monthly basis over the next 12 months January 2020 – December 2020. The results will be reported to the quarterly meetings. **(Ongoing) (Attachment 5B)**

Legal Entity Representative

Signature | **Jennie R. Long, BSN, RN, Director** (Printed Name and Title) | January 8, 2020 (Date)

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #3's assessment dated 4/26/19, did not include an assessment of the resident's need for Hospice care services ordered on 4/22/19. The resident also used an enabler bar that was attached to the bed to assist with transferring. However, the resident's assessment did not include an assessment of the resident's need for the use of an enabler bar.

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.)

Please see

Exhibit # 6 See page 7a of 7 2/3/2020

Attachment 6A
Attachment 6B
Attachment 6C
Attachment 6D

Legal Entity Representative

Signature

Jennie R. Long, BSN RN Director — Printed Name and Title

1/8/2020 — Date

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

The above plan of correction is approved as of 2/3/2020 (Date)

Plan of correction implementation status as of 2/3/2020 (Date)

☑ Implemented
☐ Not Implemented

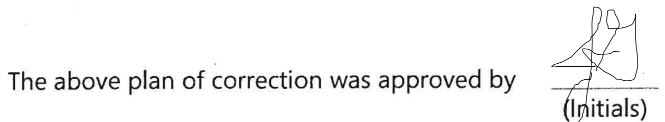
The above plan of correction was approved by  (Initials)

Exhibit # 6
Regulation §2600.225.c

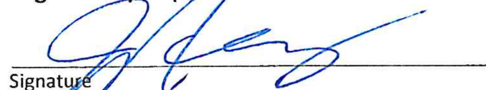
This regulation is in place to ensure that the facility creates a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

In order to correct the violation the RASP for resident #3 was updated to ensure that the hospice services and enabler were specifically addressed to the resident's needs. **(Attachment 6A)**

To prevent any further occurrences, the following interventions have been or are going to be completed:

- Hospice services and enablers were added to the census worksheet. This will allow for easy visibility if the resident is receiving services. **(Attachment 6B)**
- An initial Quality Assurance and Performance Improvement audit was completed to ensure that all residents RASPs reflected that they are receiving hospice services or utilizing enablers. **(11/7/2019)**
- Quality Assurance and Performance Improvement audits will be competed on a monthly basis over the next 12 months January 2020 – December 2020. The results will be reported to the quarterly meetings. **(Ongoing) (Attachment 6C)**
- The RCCs will be reeducated on the practice of updating the RASP regarding what qualifies as a significant change "The Preadmission Screening, Medical Evaluation, and Assessment-Support Plan: Best Practices" section of the Regulatory Compliance Guide significant change triggers the need for a new or revised RASP. **(on or before 1/24/ 2020)**
- The RCC New Hire orientation Checklist has been updated to include specific information from the RCG. **(Attachment 6D)**

Legal Entity Representative



Signature

11/06/2019

Jennie R. Long, BSN, RN, Director
Printed Name and Title

January 8, 2020
Date