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MAILING DATE: April 9, 2020

Mr. Michael Barton  
Executive Vice President  
Merakey Pennsylvania  
4251 Crums Mill Road  
Harrisburg, Pennsylvania 17112

RE: Merakey Pennsylvania  
108 Cedarwood Circle  
Russellton, Pennsylvania 15078  
Certificate #: 438420

Dear Mr. Bolten:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 26, 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, appearing to read "L. Mazza".

Larry Mazza  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

2/21/2020

Violation Report

Western Region Field Office  
Bureau of Human Services Licensing

Facility Information

Name: MERAKEY PENNSYLVANIA  
Address: 108 CEDARWOOD CIRCLE,, RUSSELLTON, PA 15076  
County: ALLEGHENY Region: WESTERN

License Number: 43842

Administrator

Name: Lisa Cialone-Graham Phone: 4122471091 Email: lisacialonegraham@MERAKEY.ORG

Legal Entity

Name: MERAKEY PENNSYLVANIA  
Address: 4251 CRUMS MILL ROAD, HARRISBURG, PA, 17112

Certificate(s) of Occupancy

Type: R-4 Date: 10/04/2017 Issued By: West Deer Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 10 Waking Staff: 8

Inspection

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

Inspection Dates and Department Representative

11/26/2019 - On-Site: Ashley Roser

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 10 Residents Served: 10

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: 3  
Diagnosed with Mental Illness: 7 Diagnosed with Intellectual Disability: 1  
Have Mobility Need: 0 Have Physical Disability: 0

25b - Contract Signatures

Regulations

2600.

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

Description of Violation

Resident #2's resident-home contract, dated 5/8/19, is not signed by the resident or the administrator/designee of the home.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) Upon admission to the PCH in May 2019 the initial home contract was not signed due to human error and the Administrator (at the time) not following the Intake and Admission Checklist. On 11/26/2019 the current Administrator was on leave. Subsequently, there was no certified Administrator that could sign the contract in her absence. When the Administrator is unavailable to sign, then the Residential Director or Assistant Residential Director will sign since they have received certification as a PCH Administrator. A renew contract for this resident was completed on 1/21/2020 which was signed by both the Resident and the current Administrator.	1) Administrator, Assistant Administrator, Residential Director or Assistant Residential Director	1) 1/21/2020	1) Starting 2/21/2020 the Intake and Admission Checklist will be utilized for each admission to ensure that all requirements are being met.
2) The Intake and Admission Checklist has been modified to include a checkbox for the Resident signature and the Administrator signature.	2) Administrator & Assistant Administrator	2) 2/21/2020	2) Starting 2/21/2020 the PCH Home Contract Renewal Checklist will be utilized to ensure that all requirements are being met any time any SSI or SSDI letter is received. These letters are usually received in January but can be received anytime throughout the year if a resident's income changes.
3) The PCH Home Contract Renewal Checklist was developed and will be utilized each time an SSI or SSDI letter is received to ensure that all renewal home contracts have the required signatures necessary.	3) Administrator & Assistant Administrator	3) 2/21/2020	

Legal Entity Representative

*Tennessee Snyder*  
Signature

Tennessee Snyder, Senior VP of ABH 2/21/20  
Printed Name and Title Date

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The above plan of correction was approved by LM (Initials)  Implemented  Not Implemented

65f - Training Topics

Regulations

2600.

- 65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
  4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

Description of Violation

Direct care staff person A did not receive training on following topics during the 2018 training year:

- \* Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- \* Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) The previous Administrator, who is no longer an employee of Merakey, did not review the employee training plans to ensure completion of necessary trainings. The current Administrator identified the deficiency and ensured that the staff completed the trainings on 7/26/2019.	1) Administrator & Assistant Administrator	1) 7/26/2019	1) Outlook reminder will be set up each month to recur on the first Monday of the month.
2) Management is utilizing the BH Training Plan to evaluate what training staff has completed year to date.	2) Administrator & Assistant Administrator	2) 2/3/2020 & on-going	2) As trainings for all staff are identified, management will instruct staff during supervision/staff meeting of the requirement and give a timeframe for completion.
3) Management will review the employee training plans monthly to ensure that required trainings are being completed monthly by all staff.	3) Administrator & Assistant Administrator	3) 3/2/2020 & on-going	
4) Management will assign training during monthly supervision meetings and/or during staff meetings.	4) Administrator & Assistant Administrator	4) 3/2/2020 & on-going	

Legal Entity Representative

*Tinnesia Snyder*  
Signature

*Tinnesia Snyder Senior VP of ABH 2/21/2020*  
Printed Name and Title Date

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(Initials)

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.
3. Resident rights.

Description of Violation

Direct care staff person A did not receive training on following topics during the 2018 training year:

\* 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.

\* Resident rights.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) The previous Administrator, who is no longer an employee of Merakey, did not review the employee training plans to ensure completion of necessary trainings. The current Administrator identified the deficiency and ensured that the staff completed the trainings. Fire Safety completed on 11/1/2019. Resident Rights completed on 8/1/2019.	1) Administrator & Assistant Administrator	1) 11/1/2019 & 8/1/2019	1) Outlook reminder will be set up each month to recur on the first Monday of the month.
2) Management is utilizing the BH Training Plan to evaluate what training staff has completed year to date.	2) Administrator & Assistant Administrator	2) 2/3/2020 & on-going	2) As trainings for all staff are identified, management will instruct staff during supervision/staff meeting of the requirement and give a timeframe for completion.
3) Management will review the employee training plans monthly to ensure that required trainings are being completed monthly by all staff.	3) Administrator & Assistant Administrator	3) 3/2/2020 & on-going	
4) Management will assign training during monthly supervision meetings and/or during staff meetings.	4) Administrator & Assistant Administrator	4) 3/2/2020 & on-going	

Legal Entity Representative

*Tennessee Snyder*  
Signature

Tennessee Snyder Senior VP of ABH 2/21/2020  
Printed Name and Title Date

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2/24/2020

(Date)

*LSM*

(Initials)

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(Date)

- Implemented  
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89b - Hot Water Temperature

Regulations

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At 9:10 a.m., the hot water temperature at the sink in the main living area measured 131.3 degrees Fahrenheit and at 1:20 p.m. it was 145.4 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.)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) Merakey facilities department was immediately notified and the water temperature was turned down to no more than 120°F on the day of licensing.	1) Merakey facilities, Administrator & Assistant Administrator	1) 11/26/2019	1) At the end of the month, Management will review the tracker to ensure all days have been completed.
2) Staff will check water temperature once daily in two different locations of the home. One will be in the front of the house and the second one will be in the back of the house. Results will be recorded on the Water Temperature Tracker.	2) Merakey facilities, Administrator, Assistant Administrator & Staff	2) 2/21/2020	2) There is a note on the tracker to notify Management if the water is over 120°F. Staff are to notify Management by calling the on-call phone if Management is not in the building. If Management is in the building staff are to verbally notify them. Management will then contact Merakey facilities department to correct the issue.

Legal Entity Representative

*Tennessee Snyder*  
Signature

*Tennessee Snyder Senior VP of ABH 2/21/2020*  
Printed Name and Title Date

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105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At 9:12 a.m. there was an approximate 2" accumulation of lint in the lint trap of the dryer next to the washer, and an approximate 1" accumulation of lint in the trap of the stackable washer/dryer.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) On the day of licensing, the lint traps were cleaned immediately. Also, signs were posted on this day directing staff to clean lint traps after each use.	1) Administrator, Assistant Administrator & all PCH Staff	1) 11/26/2019 & on-going	1) Management will check the lint traps during the monthly facility walk through.
2) Checking the lint traps will be added to the Facility Walk Through Checklist. Each day staff will clean and inspect dryers for lint. Facility walk through will be completed the last Wednesday of each month.	2) Administrator, Assistant Administrator	2) 1/29/2020 & on-going	2) Random checks of the lint trap will occur throughout the month by management.
3) Inspecting the dryer for cleanliness will be added to the overnight Shift Assignment Checklist.	3) Administrator, Assistant Administrator & PCH Staff	3) 3/4/2020	3) Administrator or Assistant Administrator will review the overnight Staff Assignment Checklists to ensure that the dryers are inspected and cleaned daily.
4) Staff education on the need for lint trap cleaning to be completed after every use of the dryer will be discussed during the next staff meeting.	4) Administrator, Assistant Administrator	4) Staff meeting scheduled for 3/24/2020	

Legal Entity Representative

*Tinnesia Snyder*  
Signature

Tinnesia Snyder, Senior VP  
Printed Name and Title

3/9/2020  
Date

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(Date)

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(Initials)

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 Not Implemented

132a - Monthly Fire Drill

Regulations

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The fire drill conducted on 11/26/19 at 5:45 a.m. was known in advance by staff person A.

Plan of Correction (POC)

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

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) When a fire drill is planned to occur during an overnight shift, Management will come on site to pull the alarm so that they are not included in the roster of staff participating in the drill. This in turn will ensure that staff do not have advance knowledge that a drill is going to occur.	1) Administrator, Assistant Administrator & all PCH Staff	1) Next planned overnight fire drill date is yet to be determined.	1) Fire drill dates and times will be captured in the local PQI meeting minutes. Management will review the fire drill record prior to the meeting to ensure that the staff participating are clearly identified and there is a minimum of 2 staff that were not aware of the drill being planned.
2) The fire drill record will clearly identify which the number of staff that are pulling the alarm (1) and the number of staff that are participating in the drill (3, 4, 5, etc.). This will clearly identify on the record that the minimum requirement of 2 staff participating in the drill are unaware of the drill happening.	2) Administrator, Assistant Administrator & all PCH Staff	2) 2/29/2020 & on-going	

Legal Entity Representative

*Tennesia Smyler*  
Signature

*Tennesia Smyler Senior VP of ABH 2/21/2020*  
Printed Name and Title Date

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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 fire drill record for the drill conducted on 10/29/19 at 5:47 does not indicate a.m. or p.m.

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.)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) Documentation completeness will be checked by Management each month during the facility walk through.	1) Administrator & Assistant Administrator	1) 2/28/2020	1) Facility checklist. If there is an error Management will notify identified staff to have them correct the form prior to local PQI meeting.
2) Fire drill dates and times will be captured in the local PQI meeting minutes.	2) Residential Director, Administrator, Assistant Administrator & Staff	2) 3 <sup>rd</sup> Tuesday of each month unless the local PQI meeting must be changed.	2) Fire drill dates and times will be captured in the local PQI meeting minutes.

Legal Entity Representative

*Timmie Snyder*  
Signature

Timmie Snyder Senior VP of ABH 2/21/2020  
Printed Name and Title Date

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185a - Implement Storage Procedures

Regulations

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed Lorazepam as needed; however, the medication punch card for the resident had two punches in the card and the punches were sealed with scotch tape.

Resident #2's blood sugar reading on 11/21/19 at 8 a.m. of 160 is not present on the resident's glucometer.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
Resident #1: 1) A PRN medication was opened from its blister pack but was not actually dispensed. The nurse replaced the medication in the blister pack and sealed it with tape. Best practice is to dispose of the medication and record the accidental dispense on the log. Staff will not keep any accidentally dispensed medications but instead follow the above best practice, as well as the standards outlined in Merakey policies: "Adult Behavioral Health Medication Procurement and Storage Policy" and "Adult Behavioral Health Disposal of Medications Policy".	1) Administrator, Assistant Administrator & all Medication Administration trained Staff	1) 11/26/2019 & on-going	1) Nurse that does the weekly MAR and Med Cart audit will review all accidental dispenses by reviewing the disposal record. Any re-sealed blister packs will be removed from med card and disposed of as well as documented on the accidental dispense log. Management will be notified of the incident to discuss with the staff that accidentally dispensed the medication.
2) Staff will be educated on disposal and storage of medications according to above policies during the next staff meeting.	2) Administrator	2) 3/24/2020	2) A glucometer check will be added to the weekly MAR audit. If there are any missing glucometer readings the Nurse will notify Management to try to identify the cause of the missing reading.
Resident #2: 1) Reading was recorded in the MAR but was not present in the glucometer. The root cause is unknown due to the many possible reasons that the reading could have disappeared from the glucometer. Staff will observe the glucometer reading to ensure that it matches the verbal report from the resident prior to entering it into the MAR.	1) Administrator, Assistant Administrator & all Medication Admin trained Staff	1) 3/23/2020	
2) Staff will be educated on the importance of MAR documentation as it pertains to glucometer readings during the next staff meeting.	2) Administrator	2) 3/24/2020	

Legal Entity Representative



Signature

Timesia Snyder, SE VP 3/9/20

Printed Name and Title

Date

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187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Ketoconazole Cream 2%-Apply to both feet twice a day for 4 weeks; however, according to the resident's November 2019 medication administration record (MAR), this medication was not signed off as being administered on 11/10/19 at 8 pm.

Resident #2 is prescribed Novolog 70/30-Inject 32 units subcutaneously at bedtime; however, according to the resident's November 2019 MAR, this medication was not signed off as being administered on 11/10/19.

Resident #4 is prescribed Lisinopril 40 mg-Take 1 tablet by mouth daily; however, according to the resident's November 2019 MAR, this medication was not signed off as being administered on 11/9/19.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) All three residents in this situation did not have staff signatures on the MAR indicating that the medication was dispensed/administered. "Buddy Check System" will be re-implemented to ensure that all MAR documentation is complete.	1) Administrator, Assistant Administrator & all Medication Administration trained Staff	1) March staff meeting on 3/24/20 & on-going	1) "Buddy Check System": - Staff A will administer the medication - Staff B will review the other staff's documentation for accuracy and completeness by the end of each shift. If an error is identified by Staff B they will immediately go to Staff A to notify them of the error. Staff A will then appropriately complete the MAR so Staff B can do one final review. The "Buddy Check Form" will be completed and filed in the back of the MAR. 2) During the weekly MAR and med cart audit, RN will check for MAR documentation accuracy utilizing the MAR Audit Tool. After completion of the weekly MAR Audit Tool, RN will give the completed document to management to review.
2) "Buddy Check Form" will be developed for tracking purposes.	2) Administrator	2) March Staff Meeting on 3/24/20	
3) All staff will be educated on MAR documentation and trained on the buddy system in the next staff meeting.	3) Administrator	3) March Staff Meeting on 3/24/20	

Legal Entity Representative

  
Signature

*Timberia Snyder, SR VP* 3/9/20  
Printed Name and Title Date

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 Not Implemented



225c - Additional Assessment

Regulations

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident# 1's most recent assessment, dated 10/17/19, does not include the resident's diagnosis of diabetes.

Plan of Correction (POC)

Plan of Correction (POC)	Responsible Party	Target Dates	Monitoring Method
1) The missing diagnosis was discovered during the licensing visit and the Nurse immediately added it to the resident's assessment on 11/26/2019. The most current medical evaluation is compared to the RASP during development to ensure that the diagnoses match. This error was human error. Management will provide a double check when the nurse is completing the RASP to ensure that all diagnoses match.	1) Administrator, Assistant Administrator & Nurse	New Admission: 1) Within 15 days of admission date  Existing Residents: 1) Annually 2) As needed depending on significant change	1) Management will read the medical evaluation to the Nurse as she develops the RASP. Upon completion of the RASP, roles will reverse. The Nurse will read the medical evaluation as the Management staff compares to diagnoses to the drafted RASP. Once it is confirmed that the diagnoses match the RASP will be added to the resident chart. 2) Staff will communicate all resident changes via the staff communication book. RN will review the communication book daily to ensure any resident changes are revised in the RASP in a timely manner.
2) All current RASPs will be reviewed to ensure they contain correct diagnoses.	2) Administrator, RN	2) 3/24/20	
3) Staff will be educated on documenting resident changes in the communication book during the next staff meeting.	3) Administrator	3) 3/24/20	

Legal Entity Representative

  
Signature


  
Printed Name and Title

  
Date

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