pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: bwillner@whitestonehc.com
countrymanor@windstream.net
cdunn.pch@gmail.com

MAILING DATE: April 21, 2020

Mr. Ben Willner
Chief Executive Officer
Country Manor, PCH, LP
111 Altmeyer Drive
Kittanning, Pennsylvania 16201

RE: Country Manor
Certificate #: 446290

Dear Mr. Willner:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 13, 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: *COUNTRY MANOR* License Number: *44629*
Address: *111 ALTMEYER DRIVE,, KITTANNING, PA 16201*
County: *ARMSTRONG* Region: *WESTERN*

Administrator

Name: *Kayla Slagle* Phone: *7245457434* Email: *countrymanor@windstream.net*

Legal Entity

Name: *COUNTRY MANOR PCH LP*
Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/20/1996* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *36* Waking Staff: *27*

Inspection

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

Inspection Dates and Department Representative

12/13/2019 - On-Site: Lori Gillette, Joseph Eveges, Tom Smith, Jason Williams

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* Residents Served: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *8*
Are 60 Years of Age or Older: *30*
Diagnosed with Mental Illness: *16*
Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *3*
Have Physical Disability: *1*

COUNTRY MANOR 44629

16b - Incident Policies

Regulations

2600.
16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home's written policy on reportable incidents does not indicate how the home will address the prevention, reporting, notification, investigation and management of reportable incidents.

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 2-24-2020 the current policy was reviewed by administration. On 2-25-2020 a new policy for 2600.16 was written to include the missing components from 16.b on prevention, reporting, notification, investigation and management of reportable incidents. The new policy will be reviewed by all staff to be sure they know the procedures for reporting incidents.

Documentation attached
AS 2A, 2B, 2C, 2D, 2E

Legal Entity Representative

Dawn Slagle — Kayla Slagle LPN/RCHA 2-26-20
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 4/20/20 (Date)

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

Plan of correction implementation status as of 4/20/20 (Date)

☑ Implemented
☐ Not Implemented

COUNTRY MANOR 44629

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 License Inspection Summary, dated 5/6/19, was posted in a public area with the resident privacy coding document attached, to include the name of resident #1.

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.)

Immediately on the day of inspection, the privacy coding page was removed from the inspection report while inspectors will present. Resident number one's name was removed from the document, shown to the inspectors and put back up in a public area. A training was done on 2-21-2020 on regulation 2600.17 stressing the importance of Resident records being kept confidential. A sign off sheet was attached to the report to stay with all future reports that are to be posted. This documentation will indicate the report was inspected to remove any privacy coding. (documentation attached)

Legal Entity Representative

Karla Slagle LPN PCHA — Karla Slagle LPN PCHA — 2-26-20

Signature — Printed Name and Title — Date

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☑ Implemented
☐ Not Implemented

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COUNTRY MANOR 44629

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Staff person A stated resident #3's cigarettes are held for him in the office and he is allowed 1 pack of cigarettes each day at 3:00 pm. The resident has asked for additional cigarettes at other times but staff deny this request and tell him to wait until 3:00 pm for his next pack.

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.)

Resident #3 no longer resides in the Home. Immediately on the day of inspection all cigarettes that were being held for residents were given to them to keep in their rooms. After receiving the violation report and speaking with licensing on this issue, it was determined that the policy that we have in place will be sufficient if it states that the Resident has a right to ask for and receive cigarettes (personal belongings) at any time they wish. If that person has signed the smoking policy, they will need to abide by the rest of it. If during the smoking hours the resident wants to smoke all of their cigarettes, that is their option. It will be determined with an assessment of safety for each individual that smokes whether the cigarettes and lighters are locked up or kept with that individual in their rooms. The new smoking addendum will be signed by all residents and put in their contract. All new residents coming into the facility will be made aware of the policy. All staff were made aware of the new policy, and it is posted in their break room. Administration will monitor all residents to be sure they have access to all possessions when they request them. Training on new Addendum was done on 2-14-2020 Documentation 4A & 4B →

Legal Entity Representative

Signature: Kamm Slagle

Printed Name and Title: Thayla Slagle LPN PCHA

Date: 2-26-20

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☑ Implemented

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COUNTRY MANOR 44629

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 11:00 am, a feces stain measuring approximately 8" by 6" was observed on the bed of resident #2, in the center of the bed sheet. Also, a strong odor of feces was noticed in this bedroom. A feces smear measuring approximately 6" by 4" was observed on the back of the toilet seat in the private bathroom of resident #2. Also, there were multiple smears of feces measuring approximately 1" to 1.5" along the grab bar and under sink in private bathroom of resident #2.

There was a smear of feces approximately 1" by 1" on the shower seat in the left shower stall located in the common shower room next to room #9.

There were 3 smears of feces measuring approximately 1" by 1" on the wall behind the toilet in the shared bedroom bathroom of room #7. Also, there was a used bedpan encrusted with feces and containing a feces covered toothbrush in the shared bathroom cabinet of the vanity in room #7.

At 2:40 pm, a feces stain measuring approximately 24" by 36" was observed on resident #3's bed sheet. Also, a strong odor of feces and urine was in this bedroom.

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.)

Continued to Next Page

Legal Entity Representative

Signature

Printed Name and Title

Date

COUNTRY MANOR 44629

85a - Sanitary Conditions *(continued)*

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☑ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

Immediately on the day of inspection with Inspectors present all of the above areas Were cleaned. All staff were retrained by the Administration on proper sanitary conditions at the monthly Staff meeting on 2-12-2020. It should be noted, on the day of inspection we had several Residents dealing with a virus that had been going around. The housekeeper had called off with the same virus. The staff have always been told the first responsibility is to the residents. Administration monitor the Home at least weekly to ensure sanitary Conditions are maintained.

Documentation
6A

)UNTRY MANOR 44629

)5d - Trash Receptacles

Regulations

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

There was an uncovered trash can in the common shower room next to room #9.

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.)

Immediately on the day of inspection with inspectors present a new trashcan was put in the common shower room next to room #9. A stock of trash cans is Kept in the building in case a lid goes missing Or the can becomes worn out. On this day, the lid was in the laundry room to be washed because someone had thrown up on it due to a virus in the home at that time. A training was held on February 14, 2020 to go over regulation 85.d. All staff were made aware that kitchen and bathroom trash receptacles will need to be covered when not in use. They were trained to report and replace any trash receptacle that does not meet regulation requirements.

Documents
7A 7B
Attached

Legal Entity Representative

[signature] LPN PCHA — Signature

Kayla Slagle LPN PCHA — Printed Name and Title

2-26-20 — Date

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☑ Implemented
☐ Not Implemented

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

)UNTRY MANOR 44629

)1 - 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

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the back hallway by the smoking entrance..

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.)

Immediately on the day of inspection with Inspectors present, The list of required emergency numbers was posted on the wall beside the phone in back hallway. A training was done on February 14, 2020 on regulation 91 and the importance of posting the emergency telephone numbers, with staff being aware that extra emergency # cards are always available in break room if they see one is missing. Moving forward PCHA or Designee will audit resident rooms and all public phones monthly to maintain compliance with these regulatory guidelines and event any future violations.

Documentation
8A & 8B Attached

Legal Entity Representative

Signature Printed Name and Title Date

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☑ Implemented
☐ Not Implemented

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COUNTRY MANOR 44629

92 - Windows

Regulations

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

There was a hole measuring 1" by 2 " in the window screen in room #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.)

Immediately the day after inspection, the screen in room #18 was replaced. (Photo attached). All other window screens were inspected for holes or damage. The staff were trained on 2-14-2020 on the importance of reporting any screens (or other items) in need of repair to the administration. Administration will do monthly rounds Of the home and document any repairs needed and then document when the repair was done

Documentation
9A & 9B
Attached

Legal Entity Representative

Kandeean LPN PCHA — Khayla Sluga LPN PCHA 2-26-20
Signature — Printed Name and Title — Date

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Plan of correction implementation status as of 4/20/20 (Date)

☑ Implemented
☐ Not Implemented

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

COUNTRY MANOR 44629

102i - Soap Dispenser

Regulations

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was no soap available in the bathroom of the common shower room next to room #9.

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.)

Immediately on the day of inspection, with Inspectors present, a soap dispenser was put into the common shower room next to room # nine. The staff had a training on regulation 102.i on 2-14-2020 and are aware that a dispenser with soap shall be provided within reach at each bathroom sink. They also know that a supply to replenish is kept in the laundry room. Administration or Designee will monitor bathrooms Daily to be sure the required soap is available.

Documentation
10A 10B Attached

Legal Entity Representative

Signature | Printed Name and Title | Date

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☑ Implemented
☐ Not Implemented

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

COUNTRY MANOR 44629

125a - Combustible Storage

Regulations

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 10:45am there were two artificial Christmas tree cardboard boxes leaning against the furnace in the rear furnace room across from room #20.

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.)

Immediately on the day of inspection with inspector's present, the two cardboard boxes in the furnace area were removed and taken to a location offsite. Moving forward any items that need storage or either be stored in a room with out heat sources, or taken off site. A training was done on February 14, 2020 on regulation 125A and the importance of not storing anything flammable near heat sources. PCHA or designee will do monthly walk-throughs to be sure this regulation is being met

Legal Entity Representative

Signature | Printed Name and Title: Kayla Slagle LPN PCHA | Date: 2-26-20

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Plan of correction implementation status as of 4/20/20 (Date)

☑ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

COUNTRY MANOR 44629

130e - Hearing Impairment

Regulations

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #7 is unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that resident #7 is alerted in the event of a fire.

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 2-14-2020 The executive director contacted a fire safety expert that works with the homes alarm system. He stated that the most effective solution would be to add a strobe light system wired directly into the system we have. The lights are very bright and circle A large area. He has been contracted to install the service in several areas of the home and completed this task on 2-23-2020. Once it was installed we had a fire drill the same afternoon. Resident #7 was having her afternoon nap. When the alarm sounded and the lights started spinning, she was one of the first people to exit her room. We now know that this is an effective way to alert her in the case of a real fire. The staff were re-trained on regulation 130.e and are aware they need to inform administration of any new hearing problems. Moving forward administration will be observant of any hearing needs and place them in rooms that are closer to where these lights are placed.

Attachments 12A 12B

Legal Entity Representative

Signature: [signature] LPN RCHA

Printed Name and Title: Kayla Slagle LPN RCHA

Date: 2-24-20

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The above plan of correction is approved as of 4/20/20 (Date)

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

Plan of correction implementation status as of 4/20/20 (Date)

☑ Implemented
☐ Not Implemented

132d - Evacuation

Regulations

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 6/20/19 at 1:07pm, there were 33 residents in the home and only 32 residents evacuated; resident #6 did not evacuate.

During the fire drill on 11/20/19 at 5:02am, there were 34 residents in the home and only 33 residents evacuated; resident #5 did not evacuate.

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 a Staff meeting on 2-12-2020 an extensive training was held on regulation 132.d and also to include some other fire drill related subjects. The training included a simulation of how an immobile or Hospice Resident would be evacuated in a real fire. It was also made clear that even though the Dr. had signed an order to not evacuate each of these Residents, because at the time they were actively dying. For future compliance, If the Home wishes to not evacuate a Resident who is actively dying during a fire drill, the Administrator or Designee will ensure all steps of this statement of policy will be followed. Both Residents # 5 & 6 CTB shortly after drills. Moving forward a log sheet is attached to fire drill page to serve as a checklist when having a fire drill.

Legal Entity Representative

Signature | Printed Name and Title | Date

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COUNTRY MANOR 44629

183b - Meds and Syringes Locked

Regulations

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

Description of Violation

At 1:05pm, the medication room was unlocked and unsupervised. The medication cart inside the room was also unlocked with multiple residents' medications inside to include resident #7 and #8.

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.)

Immediately on the day of inspection with inspectors present, The inspectors and Administrator informed the med tech at that time, that The med room must be locked at all times that she is not in it. A training was done on 2-12-2020 with all Staff on the importance of always locking the door when leaving the med room. It was understood that Administration will randomly check the door, and If found to be open it will result in a write up for that Staff member. In addition to the random checking of door, Administrator or Designee will do weekly checks of the door during different times of the day. Documentation of the door checks will be kept in the Administrator's office

Legal Entity Representative

Signature — Printed Name and Title — Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/20/20 (Date)

☑ Implemented
☐ Not Implemented

12/13/2019

COUNTRY MANOR 44629

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:

Description of Violation

Resident #9 is ordered Tylenol Arthritis 650mg, take 1 caplet every 8 hours as needed for pain. However, the pharmacy label indicates to take 2 every 8 hours.

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.)

Immediately on the day of inspection with inspectors present, a change of direction sticker was placed on the above bottle for resident #nine. A new bottle of Tylenol was ordered and delivered on 2-19-2029 with the correct pharmacy label on it to match the MAR. A training was done with all staff on 2-21-2020 on the importance of all labels matching the MAR. Complete MAR audits were done on February 18th 19th and 20th by administration and designee. Documentation kept. Moving forward Monthly audits will be done by Administration or Designee and documented.

Attachments
15A 15B 15C

Legal Entity Representative

Signature: [signature] LPN RCHA — Printed Name and Title: Kayla Slagle LPN RCHA — Date: 2-24-20

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Plan of correction implementation status as of 4/20/20 (Date)

☑ Implemented
☐ Not Implemented

The above plan of correction was approved by [initials]