SENT VIA EMAIL: khammar@srcare.org
ethompson@srcare.org

MAILING DATE: January 31, 2020

Mr. Paul M. Winkler
President/CEO
Presbyterian Senior Care, Inc.
1215 Hulton Road
Oakmont, Pennsylvania 15139

RE: Westminster Place of Oakmont
Certificate #: 429620

Dear Mr. Winkler:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 18, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Larry Mazza
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED

1/15/2020

Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *WESTMINSTER PLACE OF OAKMONT* **License Number:** *42962*
Address: *1215 HULTON ROAD,, OAKMONT, PA 15139*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: *Kathy Hammar* **Phone:** *4128266088* **Email:** *Khammar@SRCARE.ORG*

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*
Address: *1215 HULTON ROAD,, OAKMONT, PA, 15139*

Certificate(s) of Occupancy

Type: *I-2* **Date:** *07/07/2015* **Issued By:** *Borough of Oakmont*
Type: *I-1* **Date:** *12/09/2011* **Issued By:** *Borough of Oakmont*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *89* **Waking Staff:** *67*

Inspection

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

Inspection Dates and Department Representative

12/18/2019 - On-Site: Amy Duncan, Jan Cutter, Barbara Barone

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served:** *87*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *1*
Have Mobility Need: *2*
Are 60 Years of Age or Older: *87*
Diagnosed with Intellectual Disability: *1*
Have Physical Disability: *0*

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:

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Ancillary staff person A, hired on 11/6/07, did not receive training on the following topics during the 2018 training year:

*Emergency preparedness procedures and recognition and response to crises and emergency situations

*Resident rights

*The Older Adult Protective Services Act

*Falls and accident prevention

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.)

65.g- Annual Training

Review of the education tracker for Ancillary team member "A", noted she did not complete her all of her required training in 2018. The team member has completed her annual education requirements for 2019. (SEE Exhibits 1A-E)

(See page 2 attachment for additional steps to correct violation)

See Page 2A of 7

Legal Entity Representative

Kathy Hammar — Signature

Kathy Hammar, Administrator — Printed Name and Title

1-15-2020 — Date

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

The above plan of correction is approved as of 1/27/2020 (Date)

Plan of correction implementation status as of 1/27/2020 (Date)

☑ Implemented

☐ Not Implemented

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

65g- Annual Training Content (attachment for continuation of page 2 or 7)

The administrator shared the survey findings and corrective action plans during December team meetings. Team members are reminded to complete required annual training requirements as required by the end of the year. (See Exhibits 2A-D)

The network educator has developed online ELearning modules with quizzes for team members to access to meet annual training requirements. Necessary Knowledge Part 1 and Part 2 include topics related to Resident Rights, Older Adult Protective Services Act, Fall and Accident and Emergency Preparedness procedures and responses. The Educator will forward a report of ELearning module completion to department managers for tracking purposes. (See Exhibit 3)

Department team meetings, in-services and learning packets may be conducted for alternate learning opportunities.

The Ancillary team manager will utilize an educational tracker to record completion dates of required educational topics and share progress at the Quality Management meetings on a quarterly basis. (See exhibit 4)

Kathy Hamman   Kathy Hamman, Administrator   1-15-2020

127a - Portable Space Heaters

Regulations

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

A portable space heater was in use in resident #1's 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.)

The portable space heater in resident #1 bedroom was removed from the resident's room. The resident and her family were notified on 12/18/2019 that portable space heaters are prohibited. The unit was locked and tagged out, put into storage to prohibited use in the community until the family can pick it up. (SEE Exhibit 5)

The administrator shared the survey findings and corrective action plans during December team meetings. Team members were educated that space heaters are prohibited and encouraged to alert their department manager or administrator of any use of portable space heaters. (See Exhibits 2A-D)

No other resident rooms have portable space heaters. Residents have individual units in their rooms that can be regulated for temperature and fan control.

The resident handbook, which is given to new residents upon admission will be updated to include prohibited use of portable space heaters. Social Services Coordinator will educate residents of the regulation prohibiting use space heaters at the January Resident Relations meeting. (See Exhibits 6A-B)

The Westminster Place Newsletter for January will include an article about prohibited use of space heaters. The newsletter is sent to all residents and family members. (See Exhibit 7)

Legal Entity Representative

Kathy Hammar
Signature

Kathy Hammar, Administrator
Printed Name and Title

1-15-2020
Date

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144c2 - Smoking Area Distance

Regulations

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
   2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

At 10:36 am, there were approximately 10 cigarette butts lying on the ground outside of the ground floor exit door leading to the manager's parking lot, which is not the home's designated smoking area. The home's designated smoking area is located approximately 30 feet from the door.

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 cigarette butts noted lying on the ground outside of the ground floor exit door leading to the manager lot was cleaned up.

The administrator shared the survey findings and corrective action plans during December team meetings, reminding staff that smoking is permitted only in the designated smoking area as per policy. (see Exhibits 2A-D)

(see exhibit 8)

No Smoking Signage has been posted by the back door; directing staff, residents and visitors to the approved designated smoking area. Designated managers to assist with monitoring grounds, reporting any concerns of noncompliance. (See Exhibit 9)

Environmental safety rounds are conduct monthly. Findings are shared at the monthly safety committee for any recommendations or corrective actions. (see Exhibit 10)

Legal Entity Representative

Kathy Hammar	Kathy Hammar, Administrator	1-15-2020
Signature	Printed Name and Title	Date

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- [x] Implemented
- [ ] Not Implemented

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WESTMINSTER PLACE OF OAKMONT

181c - Self-administration Assessment

Regulations

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

At 10:54 am, a tube of Preparation H ointment was present on resident #3's bathroom counter; however, the resident has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding her ability to self-administer and the need for reminders to take medications.

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 is unable to self-administer Preparation H ointment. The medication was supplied by the resident's family for the resident's private caregiver to utilize as needed.

A letter was sent to residents and families, educating them on the regulations for current meds to be kept or stored in the home. Nursing obtained an order to use Preparation H ointment and will apply ointment as directed. (See exhibit 11) (See exhibit 12)

The administrator shared the survey findings and corrective action plans during December team meetings, encouraging team members to monitor meds that are stored in room. Nursing was educated to check meds stored in resident room, comparing with physician orders to make sure they are current. (SEE Exhibits 2A-D)

Nursing will complete quarterly audits x 3 months to ensure compliance. Findings will be shared at the monthly Quality management meeting for any additional recommendations. (See Exhibit 13)

Legal Entity Representative

Kathy Hammar	Kathy Hammar, Administrator	1-15-2020
Signature	Printed Name and Title	Date

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183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

A 17.9 oz. bottle of Miralax, with an expiration date of 4/2019, was located on the shelf in resident #2's bathroom.

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 expired bottle of Miralax noted on the shelf in Resident #2's bathroom was removed on 12/18/2019 and wasted. The resident reported that that her family had brought in for her but she never had a need to use it, nor was it prescribed for her use.

The administrator shared the survey findings and corrective action plans during December team meetings, encouraging team members to monitor meds that are stored in room. Nursing was educated to check meds stored in resident room, comparing with physician orders to make sure they are current. (SEE Exhibits 2A-D)

A letter was sent to residents and families, educating them on the regulations for current meds to be kept or stored in the home. (SEE Exhibits 11 + 14)

Nursing will complete quarterly audits x 3 months to ensure compliance. Findings will be shared at the monthly Quality management meeting for any additional recommendations. (SEE Exhibit 13)

Legal Entity Representative

Kathy Hemman	Kathy Hemman, Administrator	1-15-2020
Signature	Printed Name and Title	Date

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- [x] Implemented
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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 #4 is prescribed Carvedilol 6.25 mg tablet-Take 1 tablet by mouth 2 times a day, do not need to be taken with meals; however, the pharmacy label indicates-Carvedilol 6.25 mg-1 tablet twice daily with meals.

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 #4 medication for Carvedilol 6.25mg was changed on 10/24/19, noting it does no need to be taken with meals. The pharmacy did not receive the order to change the directions. On Dec. 18, 2019; the charge nurse applied a directional change sticker to the pharmacy label to alert staff that the directions were changed. (See Exhibit 15) (See exhibit 16)

The administrator shared survey findings and corrective action plans at December team meetings, regarding comparison of MAR to pharmacy labels. Review of proper procedure and use of directional change stickers was discussed. (See Exhibits 2A-D)

Nursing updated the physician order sheet on 1/9/2020 and transmitted the order change to the pharmacy to correct the pharmacy label, so that all refills of the medication will have pharmacy label directions that matches the MAR. (See exhibit 17)

The progress note, order form has been revised to include a double check process for nursing to compare the pharmacy label to the order at time of delivery to ensure the pharmacy label matches the MAR. Prior to placing the medication in the med cart, a second check will be completed to ensure the pharmacy label matches the MAR. (See Exhibits 18A-B)

The charge nurse will complete a monthly audit x 3 months, noting any discrepancies and share the findings with the Administrator at the monthly Quality Management meeting. (See Exhibit 19)

Legal Entity Representative

Kathy Hammar	Kathy Hammar, Administrator	1/15/2020
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