pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: cdunn.pch@gmail.com
melodymanor@comcast.net

MAILING DATE: June 29, 2020

Mr. Ben Willner
Owner
Melody Manor PCH, LLC
413 North McKean Street
Kittanning, Pennsylvania 16201

RE: Melody Manor
Certificate #: 446760

Dear Mr. Willner:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 7, 2020, 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

Violation Report

Facility Information

Name: *MELODY MANOR*
Address: *413 NORTH MCKEAN STREET, KITTANNING, PA 16201*
County: *ARMSTRONG* Region: *WESTERN*
License Number: *44676*

Administrator

Name: *Marcia Williamson* Phone: *7245451564* Email: *INFO@WHITESTONEHC.COM*

Legal Entity

Name: *MELODY MANOR PCH LLC*
Address: *413 NORTH MCKEAN STREET, KITTANNING, PA, 16201*

Certificate(s) of Occupancy

Type: *Other* Date: *12/20/1983* Issued By: *Labor and Industry*
Type: *C-2 LP* Date: *09/28/1987* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *39* Waking Staff: *29*

Inspection

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

Inspection Dates and Department Representative

01/07/2020 - On-Site: Laurie Garrigan, Amy Duncan, Thomas Smith, Jody Garvey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *43* Residents Served: *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *19*
Diagnosed with Mental Illness: *10*
Have Mobility Need: *2*
Are 60 Years of Age or Older: *30*
Diagnosed with Intellectual Disability: *2*
Have Physical Disability: *0*

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

At 9:46 a.m., there were multiple resident record binders unlocked, unattended and accessible on the dining room table. The binders contained private medical information for multiple residents including transfer sheets, physician orders, lab results, blood work and progress reports, to include emergency transfer sheets for 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.)

On 1-7-2020, the day of inspection, with Inspectors present, the files were moved to a secure area. The files were being taken to the Med room for the House Dr to do rounds. Inspectors entered the building and the files were set down without making it to the intended area. A training was held for all Staff by Administrator on 3-3-2020 on regulation 2600.17 and the importance of all Resident records being confidential. It was also reviewed and understood that the files must always be in the possession of someone permitted to have access. When that person is not with the files, they must be put in a secure area. Confidentiality of records will be addressed at the Quality Management meeting scheduled for 5-12-2020 to be sure the regulation is understood and followed.

2A Attached

Legal Entity Representative

Caroline Dunn Caroline Dunn- Executive Director 4-7-2020

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 4/16/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/25/20 (Date)

☑ Implemented

☐ Not Implemented

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 9/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.

At 10:02 a.m., there was no carbon monoxide detector in close proximity of the gas stove in the kitchen of 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 1-7-2020, the day of inspection, with Inspectors present, the carbon monoxide alarm was put back in the designated outlet where it stays continual, unless the battery needs replaced. It is within the close proximity of the kitchen stove meeting requirements. A training was done by Administrator on 3-3-2020 on regulation 2699.18 on complying with applicable health and safety laws. Executive Director, Administrator or Designee will do weekly monitoring with documentation for 6 months beginning 4-6-2020 to ensure all monitors are in place. Residents were educated on not removing from wall and a reminder was put on the wall above detector. Documentation will be reviewed at Quality Management meeting on 5-12-2020.

This violation is being disputed because the alarm was in the hands of an aide at the time. The alarm was beeping and she removed it to see what was wrong. As she was replacing the batteries to put it back in place, inspectors were looking for it. It was shown to them and put back in place. It is impossible to change the battery without removing it from the wall.

Legal Entity Representative

3A-3B-3C Attached

Caroline Dunn — Caroline Dunn - Executive Director — 4-7-2020

Signature — Printed Name and Title — Date

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☐ Not Implemented

20b3 - Written Receipts

Regulations

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

On 12/26/19, a cash disbursement was made to resident #4. However, the home did not obtain the resident signature verifying receipt of the disbursement.

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 1-7-2020, the day of inspection, Resident #4 signed for the 12-26-19 transaction. A set of headphones was purchased for the Resident on 12–26–2020 at the request of the Resident. A store receipt was kept with the Resident financial file. A training on regulation 2600.20.b and having signatures for all cash disbursements was done between the Executive Director, Administrator & Administrative Assistant on 1-7–2020. They are the only people with access to financial files. All other files were reviewed 1-8-2020 and signed off on by the Residents having cash files.

This violation is being disputed due to the fact that all cash disbursements being signed for at the time of disbursements. All other items that are purchased for Residents include a detailed receipt of what was purchased. Very detailed records are kept and at all inspections have been acceptable and never questioned. It was not a cash disbursement. Beginning 1-8-2020 all transactions will be signed for.

Legal Entity Representative 4A 4B Attached

Caroline Dunn — Caroline Dunn- Executive Director — 4-7-2020

Signature — Printed Name and Title — Date

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☐ Not Implemented

42c - Treatment of Residents

Regulations

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Multiple resident interviews indicated that staff routinely wake residents up at 5:00 a.m. to get dressed and go downstairs for breakfast even though resident's have indicated that they do not wish to wake up that early. All residents are required to get up at 5:00 a.m. when additional staff are present and often do not eat breakfast until after 7:00 a.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.)

On 3-3-2020 a survey with documentation was done with all Residents on what time they prefer to get up in the morning. A new wake up schedule is being done to accommodate all Residents. Any Residents requesting to get up later will be accommodated immediately. It will be determined after a trial basis if meal times need to be changed. A training was done on 3-3-2020 by Administrator on regulation 2600.42.c on dignity and respect. Beginning. 4-6-2020 Residents will be questioned at the time of admission to see if they have a preference on wake up time. A few surveys enclosed. 5A-5F Attached

This violation is being disputed due to the above violation is incorrect. All Residents are not required to get up at 5:00a.m. There are several Residents that have requested a later wake up time and have been accommodated. Some Residents do not get up until much later. Any Residents desiring a later wake up time have already been accommodated, and have been getting up later for years. Administration was unaware that other Residents wanted a later wake up time, due to none of them making their desire known.

Legal Entity Representative

Caroline Dunn — Caroline Dunn- Executive Director — 4-7-2020

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 6/25/20 (Date)

☑ Implemented

☐ Not Implemented

63a - First Aid/CPR Training

Regulations

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 1/5/20 between 7:30 p.m. and 9:00 p.m. and on 1/6/20 between 11:00 p.m. and 7:00 a.m., there were 37 residents present in the home; however, there was no staff person certified in first aid and obstructed airway techniques and CPR present 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.)

A CPR class was in place for the Staff that were not CPR trained for 1-10-2020, a few days after inspection. The Staff members in question were new hires, (one was trained, but had expired 2 months earlier). The CPR Instructors were called as soon as the Staff were hired, but had no openings to train until the time that was scheduled. Beginning 3–9–2020 if a new Staff member is not trained, it will be mandated that someone with the CPR training is working also. The training was done by a CPR instructor for all Employees needing it on 1-10-2020. As new Employee's are hired, the schedules will be reviewed by Administrator or Assistant to be sure each shift has someone CPR trained. The schedules and regulation will also be reviewed at the Quality Management meeting on 5-12-2020.

6 A Attached

Legal Entity Representative

Caroline Dunn Caroline Dunn Executive Director 4-7-2020

Signature Printed Name and Title Date

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☑ Implemented

☐ Not Implemented

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At approximately 11:00 a.m., the 4' X 2' shower mat and the floor underneath of it in the 2nd floor shower room, on the Melody side of the home contained black mold.

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 1-7-2020 the day of inspection with Inspectors present, the shower mat and floor underneath in the 2nd floor shower room were cleaned. It is a shower that doesn't get used anymore, so the mat was damp and collected moisture. A training was done on 3-2-2020 by Administrator on regulation 2600.85.a and the importance of sanitary conditions. Executive Director, Administrator or Designee will do weekly rounds of the Home beginning. 4-6-2020 to monitor any places that may need cleaned. All items found will be addressed with Housekeeping. Documentation will be reviewed at the Quality Management meeting on 5-12-2020..

7A 7B Attached

Legal Entity Representative

Caroline Dunn — Caroline Dunn- Executive Director — 4-7-2020

Signature — Printed Name and Title — Date

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☑ Implemented

☐ Not Implemented

90b - Staff Communication

Regulations

2600.

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency. On 1/7/2020, the home served 37 residents.

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 day after the inspection,January 8, 2020 a training was done by Administrator on regulation 2600.90.b and the importance of having a system of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency. Staff were under the impression if they said they use their phones to contact each other they would be in trouble. All of the staff have cell phones and they all carry them with them as they are working. A set of Walkie talkies was also purchased on 3–5-2020 and put in the med room in the event someone forgets their phone or it is not working. Beginning 4–6-2020 all New Staff will be informed upon hire of this plan Of communication between Staff. This will also be reviewed at the scheduled quality management meeting on 5-12-2020 to be sure it is working the way it should .

8A & B Attached

Legal Entity Representative

Caroline Dunn — Caroline Dunn- Executive Director — 4-7-2020

Signature — Printed Name and Title — Date

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☑ Implemented

☐ Not Implemented

95 - Furniture and Equipment

Regulations

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At 10:30 a.m., the sink in the basement bathroom would not turn off and the water was running constantly.

At 10:36 a.m., the toilet seat in the first floor Cooper bathroom/shower room was detached on the right side and moved approximately 2" from side to side.

At approximately 11:00 a.m., the toilet seat in the second floor bathroom on the Melody side was very loose and moved approximately 1" from side to side.

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. 1-7-2020 the day of inspection, with inspectors present 2 of the above issues were corrected. The following day the sink was fixed. A training was done by the Administrator on 3-2-2020 on regulation 2600.95 and the importance of furniture and equipment being in good repair, clean and free of hazards. Executive Director, Administrator or Designee will do weekly walkthroughs of the Home for 6 months then monthly for 6 more beginning 4-6-2020 to check for items in need of repair. It was also part of the training that Staff are to report to Administration if they see anything in need of repair. The checklists will be reviewed at the Quality Management meeting scheduled for 5-12-2020.

9A 9B Attached

Legal Entity Representative

Caroline Dunn — Caroline Dunn - Executive Director — 4-7-2020

Signature — Printed Name and Title — Date

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Plan of correction implementation status as of 6/25/20 (Date)

☑ Implemented

☐ Not Implemented

101f - Bedroom Window

Regulations

2600.

101.f. Each bedroom must have a window with direct exposure to natural light.

Description of Violation

Bedroom 13 does not have a window that offers direct exposure to natural light.

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 March 7, 2020 a reconstruction of the area surrounding the window in room 113 was started. Pictures are attached. After removing the wooden trim from the bottom of the home, there was still no big change in the amount of light coming into room 113. The next step is to remove some of the land at the bottom of the foundation. On March 6, 2020 a waiver was applied for. A response was given in a very timely manner asking for a few things to be sent as supporting information for the application. If the waiver is not approved, the next step of removing the land will be started. If none of the efforts attempted resolve the issue, the next step is to remove the wall between the 2 adjoining rooms too use the light from the window in that room. If this also is not feasible, the room will have to be given up as part of the capacity. At that point the two residents residing in the room would be given notice and help in finding somewhere else if we do not have another room available. One of the residents is in the hospital at this time, The other resident has signed the requested form (requested for waiver), stating that he would like to stay in this room and he is are aware of this regulation. All efforts and outcomes will be sent as completed.

Attachments 10A - 10H

Legal Entity Representative

Caroline Dunn — Caroline Dunn - Executive Director — 3-9-20

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 3/27/20 (Date)

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

Plan of correction implementation status as of 6/25/20 (Date)

☑ Implemented

☐ Not Implemented

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 10:09 a.m., there was an uncovered, undated cup of cream in a silver pitcher and an undated large plastic container with 8 deli sandwiches in the refrigerator in the kitchen.

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 1-7-2020, the day of inspection, with Inspectors present, the uncovered cup of cream was covered and dated. The sandwiches had just been made for lunch, and were also dated. On 1-9-2020, new covered stainless steel creamers were ordered.(documentation attached). They were delivered and put into use on 1-11-2020. A training was done by the Administrator on 3-3-2020 with all Staff on regulation 2600.103.e and the importance of all food being labeled and dated. Beginning on 4-6-2020, Executive Director, Administrator or Designee will do weekly rounds for 6 months with documentation), then monthly rounds for 6 months to be sure all food is covered, labeled and dated. The documentation will be reviewed at the next Quality Management meeting on 5-12-2020 to review where we may or may not need improvement .

11 A, B, C Attached

Legal Entity Representative

Caroline Dunn Caroline Dunn Executive Director 4-7-2020

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 6/25/20 (Date)

☑ Implemented

☐ Not Implemented

123b - Emergency Procedures Posted

Regulations

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The emergency procedures posted in the home did not include the emergency preparedness plan for the municipality.

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 1-7-2020, the day of inspection with inspectors present, the missing component of the emergency preparedness plan was requested from the municipality. It was sent the same day, and inspectors approved it. The reason it was missing, was because it is only sent if it is requested with the rest of the plan.It is now posted with the rest of the emergency preparedness plan. Administration reviewed the plan with each other on 1-7-2020 as to what is to be included in the plan. A reminder sheet was attached to all plans (including this one), as a reminder to always be sure the municipality part Of the plan is attached when updating. It will be reviewed and signed each year as it is received.

12 A Attached

Legal Entity Representative

Caroline Dunn Caroline Dunn- Executive Director 4-7-2020

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 6/25/20 (Date)

☑ Implemented
☐ Not Implemented

131f - Fire Extinguisher Inspection

Regulations

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher next to bedroom #4, the emergency exit and stairway, had no inspection tag indicating it was inspected by a fire safety expert.

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 1–7-2020, the day of inspection with Inspectors present, JAWCO fire extinguisher inspectors were called to determine if the fire extinguisher next to bedroom# 4 had been inspected with the other extinguishers. They sent receipt the same day, verifying all extinguishers were inspected. A Training was done by Administrator on 3-3-2020 on regulation 2600.131.f to let Staff know if they see an extinguisher without a tag, or find a tag anywhere, it should be repirted to Administration. Executive Director, Administrator or Designee will do weekly rounds beginning 4-6–2020 for 6 months to be sure all fire extinguishers have a tag with acceptable dated tag attached. The new annual inspection was done on 2-13-2020 with new tags placed on all extinguishers. This regulation will be reviewed at the next Quality management meeting on 5-12 -2020 to be sure tags are in place.

This violation is being disputed due to the fact that there is evidence the extinguisher had been inspected. The tag was most likely removed by a Resident without the knowledge of Staff. The purpose of this regulation is for safety reasons. All safety regulations were met. The purpose for the dated tag is to be sure the extinguisher is in compliance, and it was proven to be done. On report from JAWCO, all extinguishers were accounted for.

Legal Entity Representative

Caroline Dunn

Signature

Caroline Dunn Executive Director 4-17-2020

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 6/25/20 (Date)

☑ Implemented

☐ Not Implemented

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's Novolog Flex Pen Syringe was opened on 12/2/19. According to the manufacturer's instructions, the medication expires 28 days after opening. However, resident #5's Novolog Flex Pen was still present on the medication cart and the expired medication was administered to the resident on 1/7/20 as follows:

* 4 units at 7:00 a.m.
* 18 units at 11:00 a.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.)

On 1-7-2020, the day of inspection resident #5's NovoLog flex pen syringe was disposed of. There was a new one already there and it was dated and put in the cart with Inspectors present. A training was done by Administrator on 3-2-2020 on regulation 2600.185.a and the procedures for safe storage,access,security and distribution of medications and medical equipment. Each Monday beginning 4-6-2020 (continuing audits that were already being done), The med cart will be audited by A designated med tech. Executive Director, Administrator or Assistant will begin on April 9, 2020 to do monthly audits for 6 months to check for expired medications. Reviews will be kept and compared with the weekly audits. The documented results will be reviewed at the Quality Management meeting on 5-12-2020 to access the reliability of the audits. New Med Techs will continue to be trained on the importance of this regulation. 14A Attached

Legal Entity Representative

Caroline Dunn Caroline Dunn- Executive Director 4-7-2020

Signature Printed Name and Title Date

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Plan of correction implementation status as of 6/25/20 (Date)

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☐ Not Implemented