



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: [pcadmin@questhcd.com](mailto:pcadmin@questhcd.com)  
[pcadmin@loyalhannacc.com](mailto:pcadmin@loyalhannacc.com)

MAILING DATE: June 3, 2020

Mr. Gregory S. Gramm  
Administrator  
Loyalhanna Health Center Associates  
543 McFarland Road  
Latrobe, Pennsylvania 15650

RE: Loyalhanna Health Care Associates  
Certificate #: 446590

Dear Mr. Gramm:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 9, 2020, 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

# Violation Report

## Facility Information

Name: LOYALHANNA HEALTH CARE ASSOCIATES

License Number: 44659

Address: 543 MCFARLAND ROAD,, LATROBE, PA 15650

County: WESTMORELAND

Region: WESTERN

## Administrator

Name: Peggy Konecny

Phone: 7245375500

Email: padmin@loyalhannacc.com

## Legal Entity

Name: LOYALHANNA HEALTH CARE ASSOCIATES

Address: 543 MCFARLAND ROAD, LATROBE, PA, 15650

## Certificate(s) of Occupancy

Type: I-2

Date: 11/30/2014

Issued By: Derry Township

## Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 63

Waking Staff: 47

## Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal

## Inspection Dates and Department Representative

01/09/2020 - On-Site: Ashley Roser, Scott Klein, Thomas Smith

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: 84

Residents Served: 38

### Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

### Hospice

Current Residents: 8

### Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 38

Diagnosed with Mental Illness: 28

Diagnosed with Intellectual Disability: 3

Have Mobility Need: 25

Have Physical Disability: 3

3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home's most recent license inspection summary, dated 9/19/19, was not posted in a conspicuous and public place in the home.

Plan of Correction (POC)

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

*Please see attached*

See Page 2A of 24

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title *Peggy Komeny*

Date *4/14/2020*

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

The above plan of correction is approved as of *4/16/2020*  
(Date)

Plan of correction implementation status as of *5/26/2020*  
(Date)

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

Implemented  
 Not Implemented

Corrections LSS Citation Report DHS Survey 1/9/2020  
Loyalhanna Health Care Associates / Loyalhanna Senior Suites  
License Number 446590

\*Page 2a of 24

3c - Post Current License Regulations 2600. 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation: The home's most recent license inspection summary, dated 9/19/19, was not posted in a conspicuous and public place in the home.

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**Immediate Action:**

A copy of the most recent License Summary dated 9/19/19 was placed in the public binder on 1/9/2020.

Education was provided to primary administrative assistance on need for most recent license inspection summary.

**Ongoing Oversight:**

The Administrator and or the Primary administrative assistance will place a copy of the most recent license inspection summary

The administrator and or designee will have a copy of the most current license inspection place in public binder with-in 24 hours of receiving.

Audit tool

**Time Line:**

**1/9/2020** Corrected – placing a copy of the most recent License Summary dated 9/19/19 was placed in the public binder.

**Attachments:**

Page 2b, 2b1: Education sheet

Page 2c: Audit Tool

Page 2d: Picture of "pink book" near license

*Peggy Konecny - Peggy Konecny PCHA 4/6/2020*

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 Standards Act, enacted 6/23/16, requires batteries to be replaced at least annually in all battery-operated carbon monoxide detectors, as well labeled with the date of battery installation. However, the carbon monoxide detector near the home's bar did not include the date of battery installation, so it is unable to be determined if the batteries have been replaced within the past year.

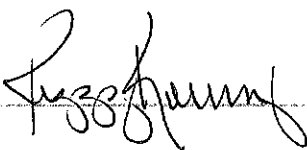
Plan of Correction (POC)

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

*Please see attached*

Legal Entity Representative

See Page 3A of 24


Signature 

Printed Name and Title *Jessy Konecny*

Date *4/14/2020*

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(Initials)

Plan of correction implementation status as of 5/26/2020  
(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 Standards Act, enacted 6/23/16, requires batteries to be replaced at least annually in all battery-operated carbon monoxide detectors, as well labeled with the date of battery installation.

However, the carbon monoxide detector near the home's bar did not include the date of battery installation, so it is unable to be determined if the batteries have been replaced within the past year.

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Immediate Actions:

- 3/31/2020 All Batteries where changes in all Carbon Monoxide Alarms in the building
- Bar area, 2. Dining room, 3. 1<sup>st</sup> floor laundry, 4. Kitchen hall, 5. 2<sup>nd</sup> floor laundry,
- 6. Library, 7. Game Room, 8. 3<sup>rd</sup> floor laundry, 9. 4<sup>th</sup> floor laundry

Ongoing Oversight:

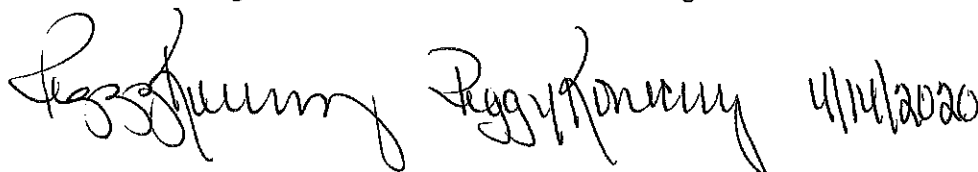
- Education of maintenance staff on regulation related to regulation 2600.18 Compliance with laws
  - Batteries will be changed every 6 months and a log will be completed by staff who change out the Batteries
- The batteries shall be labeled with the date of installation in accordance with the Care Facility Carbon Monoxide Alarm Standards Act. ~~At~~ 4/16/2020

Times Line:

- 3/31/2020: Battery for Carbon Monoxide Alarm above the bar area were changed on
- Log will be updated every 6 months with batteries and next date for scheduled battery change
- 4/1/2020: Audit to start and reviewed by PCHA &/or designee within 1week task completion
- 4/1/2020: Audit will be on going every 6 months
- PCHA or designee will sign off Audit tool

Attachments

- Page: 3b: Replacement Audit tool
- Page: 3c: Completed Battery replacement and audit
- Page: 3d: Education
- Page: 3e: Picture of battery in Bar Area
- Page: 3f: Picture of Bar Area near dining room

Handwritten signatures and date: 4/14/2020

65e - 12 Hours Annual Training

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A, hired on 4/24/15, only received 9 hours of annual training during the 2019 training year.

Direct care staff person B, hired on 5/13/15, only received only 8 hours of annual training during the 2019 training year.

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.)

See Pages 4A and 4B of 24

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title *[Handwritten Name]*

Date *4/14/2020*

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(Date)

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(Initials)

Implemented  
 Not Implemented

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

65e - 12 Hours Annual Training

Page 4a of 24

Regulations 2600. 65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

**Description of Violation:**

Direct care staff person A, hired on 4/24/15, only received 9 hours of annual training during the 2019 training year.  
Direct care staff person B, hired on 5/13/15, only received only 8 hours of annual training during the 2019 training year.

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**Immediate Actions:**

- 1/9/2020: Looking for education records for 2019 (due to changes in Admin.)
- Records found and included in this report
- Education for Staff person(s) A and B were located and included this report

**Staff Person A: Edu for 2019**

- 10/24/2019: Transfers / Body Mechanics –
- 3/2019: Abuse, neglect, & domestic violence / Older adult protective services
- 1/31/19: Emergency Prep
- 4/7/10: Abuse
- 2/22/19: OSHA
- 1/2019: Resident Rights
- 9/2019: Alzheimer's/dementia behavior Mgt.
- 8/2019: Accidents, Falls & injury prevention
- 7/2019: Communication effectively
- 6/2019: MH / MR Behaviors
- 5/2019: Care of residents with MI
- 2/2019: OSHA, Blood borne Pathogens, infection control, TB, Nutrition, Dehydration, UTI

**Staff Person B Edu for 2019**

- 10/24/2019: Transfers / Body Mechanics –
- 3/2019: Abuse, neglect, & domestic violence / Older adult protective services
- 1/31/19: Emergency Prep
- 4/7/10: Abuse
- 2/22/19: OSHA
- 1/2019: Resident Rights
- 9/2019: Alzheimer's/dementia behavior Mgt.
- 8/2019: Accidents, Falls & injury prevention
- 7/2019: Communication effectively
- 6/2019: MH / MR Behaviors
- 5/2019: Care of residents with MI
- 2/2019: OSHA, Blood borne Pathogens, infection control, TB, Nutrition, Dehydration, UTI

*Peggy Penning* *Peggy Penning* 4/14/2020

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

Page 4B of 24

Ongoing Oversight:

- A position for an Educator has been established and will monitor all education for all departments thru monthly audits for 12 hours of training
- PCHA and or designee will also assist with audits as needed

Times Line:

- Educator will audit education session to assist in meeting regulation 2600.65e
- Those who miss the initial education session will "make up" the session to meet DHS guidelines. Which will also be part pf the audit process
- 5/1/2020: Audit(s) will be on going

Attachments

- Page 4a, 4a1
- Page: 4b: Audit form
- Page: 4c: Staff Member A
- Page: 4d: Staff Member B
- Page: 4e: Edu. Notice

Immediately: A designated staff person shall review all 2019 training documents for staff persons A and B to determine if each staff member received at least 12 hours of training related to their job duties during the 2019 training year. If each staff person has not received 12 hours of annual training during the 2019 training year, then additional training related to their job duties shall be provided within 30 days of receipt of the plan of correction. Documentation of the education shall be kept. *AM* 4/16/2020

*Responsible Person* 4/16/2020

## 65f - Training Topics

## Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
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.
5. Personal care service needs of the resident.
6. Safe management techniques.

## Description of Violation

Direct care staff person A, hired on 4/24/15, did not receive annual training on the following topics during the 2019 training year:

\*Medication self-administration training

\*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

\*Personal care service needs of the resident

Direct care staff person B, hired on 5/13/15, did not receive training on the following topics during the 2019 training year:

\*Medication self-administration training

\*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

\*Personal care service needs of the resident

\*Safe management techniques

## 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.)

*See attached*

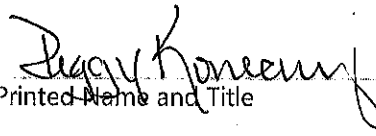
See Pages 5A and 5B of 24

*Peggy Koncinski, PCHA 4/14/2020*

65f - Training Topics (continued)

Legal Entity Representative

Signature 

Printed Name and Title 

Date 4/14/2020

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The above plan of correction is approved as of 4/16/2020

Plan of correction implementation status as of 5/26/2020



- Implemented
- Not Implemented

The above plan of correction was approved by (Initials)

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

Page 5a of 24

65f - Training Topics Regulations:

- . Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
  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.
  5. Personal care service needs of the resident.
  6. Safe management techniques.

Description of Violation

Direct care staff person A, hired on 4/24/15, did not receive annual training on the following topics during the 2019 training year: \*Medication self-administration training \*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 \*Personal care service needs of the resident

Direct care staff person B, hired on 5/13/15, did not receive training on the following topics during the 2019 training year: \*Medication self-administration training \*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 \*Personal care service needs of the resident \*Safe management techniques

Immediate Action:

1/9/2020: Looking for education records for 2019

4/1/2020: Auditing all education records of current staff for this survey inspection

**Staff Member "A" Education**

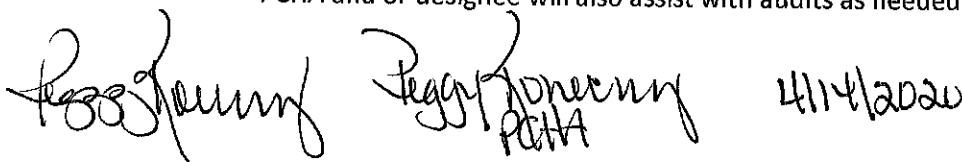
1. 4/10/2020 - Medication self-administration training. "Make Up"
2. 3/16/2020 - Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. "Make Up"
3. 2/2019 - OSHA, Blood borne pathogens, infection control, TB, Nutrition, dehydration and UTI
4. 4/9/2020 - Personal Care & Hygiene/D.U. prevention service needs for the resident. "Make Up"
5. 2/29/2019 & 2/22/2019 - OSHA, Blood borne pathogens, infection control, TB, Nutrition, dehydration and UTI

**Staff Member "B" Education**

1. 3/11/2020 - Medication self-administration training. "Make Up"
2. 3/11/2020 - Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. "Make Up"
3. 3/11/2020 - Personal care & hygiene/D.U. service needs for the resident. "Make Up"
4. 2/2019 - OSHA, Blood borne pathogens, infection control, TB, Nutrition, dehydration and UTI
5. 4/11/2020 - Safe Management Technique's "Make-up"

Ongoing Oversight:

- A position for an Educator has been established and will monitor all education for all departments thru monthly audits
- Staff person(s) A & B will complete mentioned education for 2019 as "makeup" By 4/30/2020
- PCHA and or designee will also assist with audits as needed

  
4/14/2020

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

Page 5B of 24

Time Line:

- Educator will audit education session to assist in meeting regulation 2600.65f
- Other Staff indicated as missing education will makeup 2019 education needs
- 6/1/2020: Audit will be on going

Attachments:

- Page: 5b; Audit form
- Page: 5c; Education Staff Member A
- Page: 5d; Education Staff Member

*Peggy Kneeling* 4/14/2020

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Direct care staff person A, hired on 4/24/15, did not receive annual training on following topics during the 2019 training year:

- \*Fire safety by a fire safety expert or staff trained by a fire safety expert
- \*Emergency preparedness procedures

Direct care staff person B, hired on 5/13/15, did not receive annual training on emergency preparedness procedures during the 2019 training year.

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.)


See Page 7A of 24

Legal Entity Representative

Signature  Printed Name and Title  Date 4/14/2020

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The above plan of correction is approved as of 4/16/2020 (Date) Plan of correction implementation status as of 5/26/2020 (Date)

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

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

Page 7a of 24

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Direct care staff person A, hired on 4/24/15, did not receive annual training on following topics during the 2019 training year: \*Fire safety by a fire safety expert or staff trained by a fire safety expert \*Emergency preparedness procedures

Direct care staff person B, hired on 5/13/15, did not receive annual training on emergency preparedness procedures during the 2019 training year

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Immediate Action:

- 1/9/2020 Looking for education records for 2019
- 4/1/2020: Educational material found & are being audited for 2019 completeness

Staff person A: Fire safety expert emergency preparedness procedure: make up

1. Add Staff person A received fire safety training by a fire safety expert on 4/13/20 ~~4/13/20~~ 4/16/2020

Staff Person B: emergency preparedness procedures during the 2019 training year make up

1. 1/30/2019 - Emergency preparedness procedures

Ongoing Oversight:

- A position for an Educator has been established and will monitor all education for all departments thru monthly audits
- PCHA and or designee will also assist with audits as needed

Time Line:

- Educator will audit education session to assist in meeting regulation 2600.65g
- Those who miss the initial education session will "make up" the session to meet DHS guidelines.
- 4/30/2020: Staff person(s) A & B will make up 2600.65g for 2019
- 6/1/2020 other staff missing education if applicable will have also received 2600.65g education
- Audit will be on going;

Attachments:

- Page 7a, 7a1
- Page: 7b; Audit form

 4/14/2020

82a - Poisonous Materials

Regulations

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

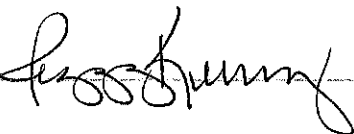
At 10:52 a.m., there was a bag of miracle grow feeder, approximately 3/4 full, present in the activity room closet which was not in it's original box.

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.)

See Page 8A of 24

Legal Entity Representative

Signature 


Printed Name and Title 

Date 4/14/2020

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Implemented  
 Not Implemented

82a - Poisonous Materials Regulations

2600. 82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation At 10:52 a.m., there was a bag of miracle grow feeder, approximately 3/4 full, present in the activity room closet which was not in it's original box.

---

**Immediate Action:**

1/9/2020: Director of Activities was instructed to remove miracle grow feeder from closet and throw away remaining amount since original box was not present. Also discussed labeling and storage Regulation 2600.82a

**Ongoing Oversight:**

1/10/2020 – Education provided to Director of Activities and assistant on poisonous materials and proper storage

Copy of Copy of PA Code title 55 Human Services Chapter 2600 PCH and the RCG was provided to Activity department for reference and use.


Audit of building will occur monthly of activity area and rest of building related to poisonous material, storage and location by designated staff person

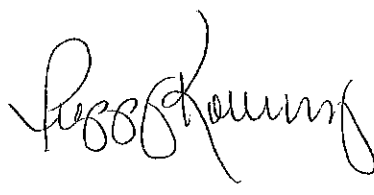
**Time Line:**

4/1/2020 audits will start of poisonous material – on going  
Information will be used for Safety Meeting to assist with any trending

**Attachments:**

Audit tool 7b

Within 30 days of receipt of the plan of correction: All staff persons shall be educated that poisonous materials shall be stored in their original, labeled containers. Documentation of the education shall be kept.  4/16/2020

  PCH  
4/16/2020

82b - Poisonous Material Storage

Regulations

2600.

82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

At 10:54 a.m., there were multiple food items to include Twinkies, a container of vanilla wafers and a box of crackers stored next to multiple poisonous materials in the activity room closet.

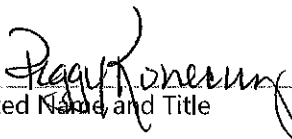
Plan of Correction (POC)

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See Page 9A of 24

Legal Entity Representative

Signature 

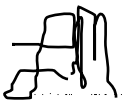
Printed Name and Title 

Date 4/14/2020

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(Date)

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(Initials)

Implemented  
 Not Implemented

82b - Poisonous Material Storage Regulations

2600. 82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation:

At 10:54 a.m., there were multiple food items to include Twinkies, a container of vanilla wafers and a box of crackers stored next to multiple poisonous materials in the activity room closet.

---

**Immediate Action:**

1/9/2020: Poisonous materials where removed from closet where food was stored

**Ongoing Oversight:**


Education provided to Director of activities and assistant on storing food and poisonous materials  
Audit of area will be conducted monthly by PCHA or Designee  
Information will be used at safety committee


**Time line:**

4/4/2020 – initial audit will be started  
Audits will be completed monthly by assigned designee (designee will change as to allow for new  
Set of eyes to evaluate area(s))

**Attachments:**

Page 9a  
Page 9b: audit tool

Within 30 days of receipt of the plan of correction: All staff persons shall be educated that poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces. Documentation of the education shall be kept.  4/16/2020

 Peggy Konecny PCHA 4/16/2020

82c - Locking Poisonous Materials

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At 10:52 a.m. the following poisonous materials, with manufacturer's labels indicating, "call poison control or physician if ingested" were unlocked, unattended and accessible to residents in the activity room closet:

- \* A 13 oz. full bottle of oven cleaner
- \* A 1 lb. 3 oz. full bottle Vista Clear glass cleaner
- \* (2) 1 quart bottles of Betco AF 79, each approximately 1/4 full

Not all the residents in the home, including residents #1 and #2, have been assessed capable of recognizing and using poisons safely.


Plan of Correction (POC)


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

Please see attached

See Page 10A of 24

Legal Entity Representative

Signature 


Printed Name and Title 

Date 4/14/2020

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The above plan of correction is approved as of 4/16/2020 (Date)

Plan of correction implementation status as of 5/26/2020 (Date)

The above plan of correction was approved by  (Initials)

Implemented  
 Not Implemented

82c - Locking Poisonous Materials Regulations

2600. 82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation At 10:52 a.m. the following poisonous materials, with manufacturer's labels indicating, "call poison control or physician if ingested" were unlocked, unattended and accessible to residents in the activity room closet:

- \* A 13 oz. full bottle of oven cleaner
- \* A 1 lb. 3 oz. full bottle Vista Cleer glass cleaner
- \* (2) 1 quart bottles of Betco AF 79, each approximately ¼ full Not all the residents in the home, including residents #1 and #2, have been assessed capable of recognizing and using poisons safely.

---

**Immediate Action:**

- 1/9/2020: Poisonous materials where removed from closet were food was stored
- 4/13/2020: Audit tool will be started and ongoing monthly
- 1/9/2020: Education provided to Director of activities and assistant on storing food storage and poisonous materials

**Ongoing Oversight:**

- Educator position has been established for ongoing education needs and compliance
- Education will be included in yearly staff education poisonous materials
- Weekly walk thru will include poison
- 4/13/2020: Audit tool will be started and ongoing monthly
- 4/13/2020 Audit of are will be conducted monthly by PCHA and or designee
- Information will be used for safety committee Meeting

**Timeline:**

- Initial resolution 1/9/2020
- On-going month audits to start by 4/13/2020
- Competed by PCH and or designee

**Attachments:**

- Page: 10a
- Page: 10b; Audit tool

Within 30 days of receipt of the plan of correction: All staff persons shall be educated that poisonous materials shall be stored in their original, labeled containers. Documentation of the education shall be kept. *AM* 4/16/2020

Immediately: A designated staff person shall inspect the home daily, including the activity room, to ensure all poisonous materials are kept in an area that is locked. *AM* 4/16/2020

*Signature* 4/14/2020

85e - Trash Outside Home

Regulations

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11:18 a.m., the right lid to the dumpster, which was full of trash, was open.

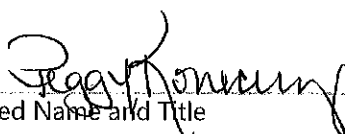
Plan of Correction (POC)

(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.)

See Page 11A of 24

Legal Entity Representative

Signature 


Printed Name and Title 

Date 

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(Date)

The above plan of correction was approved by   
(Initials)

Implemented  
 Not Implemented

85e - Trash Outside Home Regulations

2600. 85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation At 11:18 a.m., the right lid to the dumpster, which was full of trash, was open.

---

**Immediate Action:**

1/9/2020: NHA for Loyalhanna Care Center was contacted about her staff keeping trash receptacle lids down once her staff was done placing garbage in receptacles.

NHA designee was to contact service provided for side entry trash receptacles

Site is shared by PCH and SNF – common area

1/9/2020: Housekeeping and Dietary staff were educated on closing trash receptacle lids and information was sought as to why they cannot shut lids.

**Ongoing Oversight:**

1/13/2020: Discussed with maintenance department indicated tools needed to close trash receptacles  
A garbage can with a long pole was added to the trash receptacle site to assist staff with opening lids and closing lids of large trash receptacle lid and opening lids.

4/4/2020: Audit tool will be used to check thru out day that lids are closed or need closed. Will be completed by PCH and or designee. Location of log will be at front desk so all staff has access. Ongoing

**Time line:**

4/1/2020: audits will start and be on going –

Completed by PCH and designated staff as observed

**Attachments:**

Page 11b: Audit tool –

*Rosemary* *Peggy Konecny PCH*  
*4/16/2020*

91 - Telephone Numbers

Regulations

2600.

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

Description of Violation

At 2:40 p.m, there were no emergency telephone numbers posted on or near the telephone located on resident #3's end table.

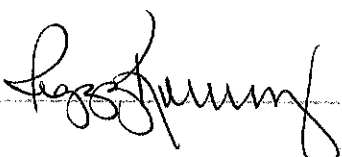
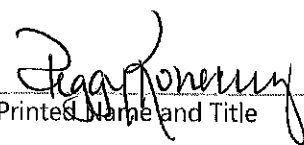
At 3:40 p.m., there were no emergency telephone numbers posted on or near the telephone located on the end table in the 4th floor kitchenette.

Plan of Correction (POC)

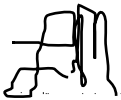
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See Page 12A of 24

Legal Entity Representative

Signature		Printed Name and Title		Date	4/14/2020
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The above plan of correction was approved by	 (Initials)	<input checked="" type="checkbox"/> Implemented <input type="checkbox"/> Not Implemented	

91 - Telephone Numbers Regulations

2600.91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation: At 2:40 p.m. there were no emergency telephone numbers posted on or near the telephone located on resident #3's end table. At 3:40 p.m., there were no emergency telephone numbers posted on or near the telephone located on the end table in the 4th floor kitchenette.

---

**Immediate Action:**

1/9/2020: Administrative Assistant was asked to update emergent phone number list for phone  
1/28/2020: Order to be placed for coiled ring holder to attach emergent phone list to all phone in Loyalhanna Senior Suites

**Ongoing oversight:**

AI Immediately: Housekeeping will monitor resident rooms for emergent phone list to be attached to resident who have phone with outside line service  
Will report to Administrative Assistant for emergent phone number card and spring ring attachment for phone in room if missing  
Housekeeping will add to phone in room per resident contract / outside line phone services request

Immediately: A designated staff person shall inspect all telephones with an outside line monthly to ensure all telephone numbers indicated in 2600.91 are present on or near each telephone. AI 4/16/2020

**Timeline:**

Ongoing monitoring

**Attachments**

Page: 12b; Invoice of order  
Page: 12c; Photo of emergent card with phone numbers and coiled place holder  
Page: 12d; Housekeeping audit form  
Page: 12e; enlarged phone number list

*Peggy Konecny* Peggy Konecny RCHA  
4/16/2020

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 10:54 a.m., there was an unlabeled and undated ziplock bag of peanut butter, which was approximately 1/2 full.

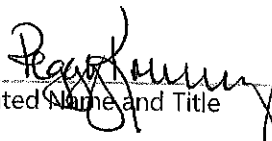
Plan of Correction (POC)

(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.)

See Page 13A of 24

Legal Entity Representative

Signature 

Printed Name and Title 

Date 4/14/2020

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5/26/2020

(Date)

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(Initials)

Implemented

Not Implemented

01/09/2020

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 10:54 a.m., there was an unlabeled and undated zip lock bag of peanut butter, which was approximately 1/2 full.

---

**Immediate Action:**

- 3/31/2020: reviewed Citation with Activities department, need to label and date food taken for scheduled activity
- Activities department staff will label ingredients received from food service department for activities
- 4/9/2020: Education provided to Activities staff on: 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.

**Ongoing oversight:**

- Educator will include regulation 2600.13e in yearly education for staff related to left overs being labeled and dated
- 4/13/2020 Audit will begin to activities department for labeling and dating food for scheduled activities The audits shall occur at least monthly. ~~4/13/2020~~ 4/16/2020
- Activities will complete form indicating ingredient supplied from food service to meet planned activity: Form will identify items and that they have been labeled and dated along with identified task
- PCHA and or designee will monitor

**Timeline:**

4/13/2020 Activities Department will use tracking form to assist in labeling and dating foods in /or for activities department. A binder will be kept for reference  
Ongoing monitoring

**Attachments:**

Page 13a  
Page 13b – Label / Date Audit form  
Page 13c

*Luzo Kourmy* *Peggy Kourmy* PCHA 4/14/2020

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 records do not indicate the date the fire drill was conducted in February 2019 at 11:00am.

The fire drill records do not indicate the number of staff that participated in the fire drill on 4/29/19 at 7:28am.

The fire drill records do not indicate the number of staff participating, if the alarm was activated, if the alarm was operative and if there were any problems during the fire drill on 8/17/19 at 3:52pm.

The fire drill records do not indicate the exact evacuation time in minutes and seconds for the monthly fire drills conducted from 1/3/19 through 12/3/19.

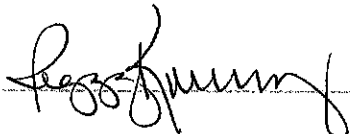
Plan of Correction (POC)

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

Please see attached

See Page 14A of 23

Legal Entity Representative

Signature 


Printed Name and Title 

Date 4/14/2020

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The above plan of correction was approved by  (Initials)

Implemented  
 Not Implemented

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 records do not indicate the date the fire drill was conducted in February 2019 at 11:00am.

The fire drill records do not indicate the number of staff that participated in the fire drill on 4/29/19 at 7:28am.

The fire drill records do not indicate the number of staff participating, if the alarm was activated, if the alarm was operative and if there were any problems during the fire drill on 8/17/19 at 3:52pm.

The fire drill records do not indicate the exact evacuation time in minutes and seconds for the monthly fire drills conducted from 1/3/19 through 12/3/19

---

Immediate Action:

1/9/2020: Fire Safety Form was reviewed by PCH 1/9/2020 to staff doing fire drills

4/10/2020: Education was provided to Maintenance staff on form completion

4/10/2020: Education on fire drill form signed off by maintenance:

4/1/2020: Fire Drill record being maintained by Administrative assistant for consistency

Ongoing oversight:

4/13/2020: Educator and maintenance staff will provide education yearly on fire drills

1/9/2020: Administrative Assistance will complete Fire drill form for thoroughness and correct information

Audit will be completed by PCHA and or designee for accuracy and review monthly  
PCHA will sign off on right side of the form at line for audit of completeness

Time Line:

Immediate

Ongoing

Attachments:

Page: 14a

Page: 14b: fire drill record

Page: 14c: Certificate of completion

Page: 14d: fire drill addendum

*Kristina M. Pegg, PCH 4/14/2020*

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

The fire drill records indicate no residents were evacuated during the monthly fire drills from 1/3/19 through 12/3/19.

The maximum safe evacuation time, as indicated in writing on 12/3/19 by a fire safety expert, is 6 minutes. However, the home exceeded the maximum safe evacuation time during the following fire drills:

<u>Date/Time of fire drill</u>	<u>Evacuation Time</u>
*1/3/19 at 5:30am	11 minutes
*February, 2019 at 11:00am	10 minutes
*3/29/19 at 5:15am	8 minutes
*4/29/19 at 7:28am	10 minutes
*5/19/19 at 8:21am	10 minutes
*6/11/19 at 5:38pm	8 minutes
*7/30/19 at 5:00am	10 minutes
*8/17/19 at 3:52pm	9 minutes
*9/11/19 7:47am	10 minutes
*10/16/19 at 6:15am	9 minutes
*11/26/19 at 4:00pm	10 minutes
*12/3/19 3:30pm	8 minutes

Plan of Correction (POC)

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

*Please see attached*

See Page 15A of 24

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title *[Handwritten Signature]*

Date *4/11/2020*

01/09/2020

132d - Evacuation (*continued*)

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(Date)

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5/26/2020

(Date)

The above plan of correction was approved by



(Initials)

Implemented

Not Implemented

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

Page: 15a of 24

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 The fire drill records indicate no residents were evacuated during the monthly fire drills from 1/3/19 through 12/3/19. The maximum safe evacuation time, as indicated in writing on 12/3/19 by a fire safety expert, is 6 minutes. However, the home exceeded the maximum safe evacuation time during the following fire drills:

Date/Time of fire drill	Evacuation Time
*1/3/19 at 5:30am	11 minutes
*February, 2019 at 11:00am	10 minutes
*3/29/19 at 5:15am	8 minutes
*4/29/19 at 7:28am	10 minutes
*5/19/19 at 8:21am	10 minutes
*6/11/19 at 5:38pm	8 minutes
*7/30/19 at 5:00am	10 minutes
*8/17/19 at 3:52pm	9 minutes
*9/11/19 7:47am	10 minutes
*10/16/19 at 6:15am	9 minutes
*11/26/19 at 4:00pm	10 minutes
*12/3/19 3:30pm	8 minutes

**Immediate Action:**

1/9/2020: Form was reviewed by PCHA with maintenance staff and Administrative Assistance

1/10/2020: Education provided to Maintenance Staff on DHS recommended form, also provided copy to Maintenance staff and Administrative Assistant/staff

1/22/2019: DHS Fire Drill Form started to be used for January Fire drill – 5 min. 30 sec

2/25/2020: February Fire Drill - 4 min. 58 sec.

3/11/2020: March Fire Drill – 5 min.

**Ongoing Oversight:**

1/10/2020 Administrative Assistance will complete Fire drill form for thoroughness and correct information

PCHA will sign off on right side of form at line for audit of completeness

**Timeline:**

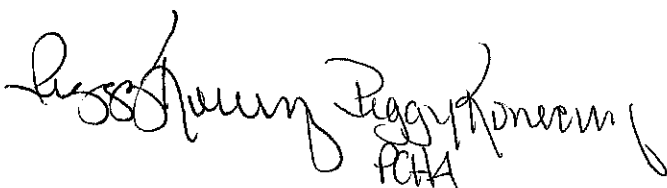
Immediate and on going

**Attachments:**

15a

15b – copy of fire drill form

15c – completed fire Drill form from 1/2020 to 3/2020

  
PCHH 4/14/2020

Immediately: A designated staff person shall review the home's fire drill records monthly to ensure all residents 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 time specified in writing within the past year by a fire safety expert. If the evacuation exceeds the maximum safe evacuation time, immediate remedial action shall occur to determine the root cause. Another fire drill shall occur within 5 days of the unsuccessful fire drill and documented on the home's fire drill records. AM 4/16/2020

132f - Alternate Exit Routes

Regulations

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The fire drill records for the monthly fire drills conducted from 1/3/19 through 12/3/19 indicate 'N/A' for the exit route(s) used, so it is unable to be determined if alternate exits were used during each of the monthly fire drills.

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.)

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Legal Entity Representative

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		<input checked="" type="checkbox"/> Implemented	
The above plan of correction was approved by	(Initials)	<input type="checkbox"/> Not Implemented	

132f - Alternate Exit Routes Regulations

2600. 132.f. Alternate exit routes shall be used during fire drills.

Description of Violation The fire drill records for the monthly fire drills conducted from 1/3/19 through 12/3/19 indicate 'N/A' for the exit route(s) used, so it is unable to be determined if alternate exits were used during each of the monthly fire drills

---

Immediate Action:

Form was reviewed by PCH 1/9/2020

DHS recommended form provided to Maintenance staff – instructions on need to complete form completely and correctly

Ongoing Oversight:

PCHA and or Administrative assistant will monitor Fire Drill paper work for completeness and alternating exits for fire drill process

PCHA and or Administrative assistance will initial by each line for audit process, per month, per fire drill.

Timeline:

1/10/2020 Started January Fire drill

Will be ongoing

Attachments:

Page: 17a

Page: 17b; Fire drill form

*Peggy Konecny - Peggy Konecny PCHA 4/26/2020*  
*(PK)*

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 10:53 a.m. a bottle of Ibuprofen-200mg was unlocked, unattended and accessible in the activity room closet.


REPEAT VIOLATION: 1/11/2019

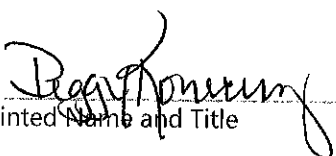
Plan of Correction (POC)

(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.)

See Page 18A of 24

Legal Entity Representative

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The above plan of correction was approved by  (Initials)

Implemented  
 Not Implemented

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 10:53 a.m. a bottle of Ibuprofen-200mg was unlocked, unattended and accessible in the activity room closet. REPEAT VIOLATION: 1/11/2019

Immediate Action:

1/9/2020: spoke w Activities Director – asked that Personal Ibuprofen be removed form room/building and be kept in car. Ibuprofen was removed to car  
Education provided that no OTC medication can be left in resident areas

Ongoing Oversight:

Activity room/Activity office will be locked when staff not present in room  
4/2/2020: Locked added to room door allowing room with office, kitchen to be locked when staff out of area  
Reviewed regulation above with Activity Director and staff

Timeline:

4/2/2020: PCHA will audit area weekly for 1 month related to OTH medications being unlocked and in building by activity staff

Attachments:

Page 18a  
Page 18b'audit tool  
Page 18c, c1; pictures

*Ricky Konecny* *Ricky Konecny* PCHA 4/16/2020

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 #1 is prescribed Metoprolol Tartrate 75mg-Take 1 tablet by mouth 2 times daily; however, the pharmacy label indicates Metoprolol Tartrate 50mg-Take 1.5 tablets by mouth 2 times daily.


Resident #2 is prescribed Novolog 100/unit ml-Inject subcutaneously before meals and at bedtime in accordance with sliding scale; however, the sliding scale instructions are not indicated on the pharmacy label.


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.)

See Page 19A of 24

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Implemented  
 Not Implemented

Correction POC for DHS Inspection 1/9/2020  
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License # 446590\*

Page: 19a of 24

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 #1 is prescribed Metoprolol Tartrate 75mg-Take 1 tablet by mouth 2 times daily; however, the pharmacy label indicates Metoprolol Tartrate 50mg-Take 1.5 tablets by mouth 2 times daily.

Resident #2 is prescribed Novolog 100/unit ml-Inject subcutaneously before meals and at bedtime in accordance with sliding scale; however, the sliding scale instructions are not indicated on the pharmacy label.

---

**Immediate Action:**

- 1/9/2020: Care Coordinator/LPN reviewed EMAR – contacted pharmacy about resident 1 & 2 and need to have labels read correctly per MD order(s)
- 1/9/2020 (Resident #1): Pharmacy had sent 50mg Tablet and packed 1.5mg tablet to = 75mg (metoprolol does not come in a 75mg tablet)
- 1/9/2020: (Resident #2) Novolog label was corrected – Pharmacy has been instructed to place sliding scale on each script/refill
- 4/10/2020; (Resident #1) Corrected order for Metoprolol.

**Ongoing Oversight:**

- LPN and lead med tech/trainer will audit all new orders in EMAR –
- Audit tool will be use and kept in binder on unit
- One per new order per resident
- Audit tool remain active until pharmacy provides correct information per medication requirement

**Timeline:**

- 4/6/2020 start date for audit tool to confirm correct labeling form Pharmacy and that medication has been filled correctly per MD orders Audits shall occur at least monthly for all resident medication to ensure accurate pharmacy labels and medication administration records in accordance with prescribers' orders. *AM* 4/16/2020

**Attachments:**

Page: 19 a  
Page: 19 b  
Page: 19 c; Resident 2  
Page: 19 d, d1, d2, d3, d4; Resident 1

*Luzo G... 4/14/2020*

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is prescribed Coumadin 1mg-Give 1.5 tablets by mouth daily; however, the resident's January 2020 medication administration record (MAR) indicates, Coumadin 1.5mg-Give 1.5 tablets by mouth daily.

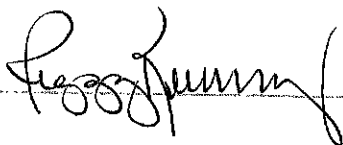
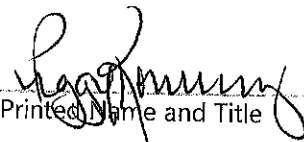
Plan of Correction (POC)

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

*please see attached*


See Page 20A of 24

Legal Entity Representative

Signature  Printed Name and Title  Date *4/14/2020*

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The above plan of correction is approved as of 4/16/2020 (Date) Plan of correction implementation status as of 5/26/2020 (Date)

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

187a - Medication Record Regulations

2600. 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation Resident #1 is prescribed Coumadin 1mg-Give 1.5 tablets by mouth daily; however, the resident's January 2020 medication administration record (MAR) indicates, Coumadin 1.5mg-Give 1.5 tablets by mouth daily.

**Immediate Action:**

- 1/9/2020: Coumadin orders were reviewed on date of survey
- 1/9/2020, 1/13/2020: Education was provided to Care Coordinator and Evening LPN
- 3/2020: Evening LPN was terminated due to continued medication error 3/2020
- 4/13/2020: LPN and lead med tech/trainer will audit all new orders in EMAR –

**Ongoing Oversight:**

- 4/2020: Audit tool will be used and kept in binder on unit
- 4/2020: One Audit sheet per new order per resident One
- Note: Audit tool remain active until pharmacy provides correct information per medication order

Immediately, then monthly thereafter: A designated staff person shall audit all medication administration records for accuracy in accordance with prescribers' orders and dosage of medication dispensed by the pharmacy. *AM* 4/16/2020

**Timeline:**

- 4/13/2020 to start, then ongoing
- 5 audits a week will be completed by Care Coordinator and / or Lead Med Tech
- PCHA and designee will review and sign off

**Attachments:**

Page: 20a  
Page: 20 b; audit tool  
Page: 20c; Edu.

Within 5 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated on proper medication administration procedures, which includes ensuring the medication administration record and pharmacy label match prior to medication administration. Documentation of the education shall be kept. *AM* 4/16/2020

*Lizzy Perry* *Lizzy Perry* 4/14/2020

187d - Follow Prescriber's Orders

Regulations

2600.

187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed blood sugar checks 4 times a day; however, on 1/3/20, 1/6/20 and 1/8/20, the resident's blood sugars were only checked 3 times each day.

Resident #2 is prescribed Metoprolol Tartrate 100 mg-Take 1/2 tablet by mouth two times a day. The 100mg tablets in the bottle were cut in half; however, were unevenly cut and were not cut along the scored line on the pill, so it is unable to be determined if the resident received the proper dose.



REPEAT VIOLATION: 1/11/2019

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.)


See Page 21A of 24

Legal Entity Representative

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187d - Follow Prescriber's Orders Regulations

2600. 187.d. The home shall follow the directions of the prescriber.

Description of Violation Resident #2 is prescribed blood sugar checks 4 times a day; however, on 1/3/20, 1/6/20 and 1/8/20, the resident's blood sugars were only checked 3 times each day.

Resident #2 is prescribed Metoprolol Tartrate 100 mg-Take ½ tablet by mouth two times a day. The 100mg tablets in the bottle were cut in half; however, were unevenly cut and were not cut along the scored line on the pill, so it is unable to be determined if the resident received the proper dose. REPEAT VIOLATION: 1/11/2019

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**Immediate Action:**

1/9/2020 Reviewed orders with nursing staff  
Discussed blood sugars and dialysis residents with Lead med tech and Care Coordinator  
Education provided on pill cut and proper them of cutting pill in ½

**Ongoing Oversight:**

Evening LPN was terminated due to continued medication error(s) 3/2020  
LPN and lead med tech/trainer will audit all new orders in EMAR –  
Audit tool will be use and kept in binder on unit  
One per new order per resident  
4/2/2020: education provide to med techs, LPN new pill cutters and importance of cutting  
meds correctly  
Audit tool remain active until pharmacy provides correct information per medication requirement

**Timeline:**

4/6/2020 to start, then ongoing  
5 audits a week will be completed by Care Coordinator and / or Lead Med Tech  
PCHA and/or designee will also review and sign off

**Attachments:**

Page: 21a  
Page: 21b; Audit tool  
Page: 21c Education form  
Page; 21d Medline order for cutters  
Page: 21e Resident

Within 5 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated on proper blood sugar testing and documentation on resident medication administration records in accordance with prescribers' orders. Documentation of the education shall be kept. *AM* 4/16/2020

Immediately: A designated staff person shall review the medication administration records for all residents who are prescribed blood sugar checks weekly to ensure blood sugars are checked and documented in accordance with prescribers' orders. *AM* 4/16/2020

*Peggy Koummy Peggy Koummy PCHA 4/16/2020*

190a - Completion Medication Course

Regulations

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A has not successfully completed the annual practicum in accordance with Department-approved medication administration course since 12/6/16. Staff person A administered numerous medications to numerous residents, including to resident #2 on 1/1/20 through 1/9/20.


Staff person B has not successfully completed the annual practicum in accordance with Department-approved medication administration course since 8/18/17. Staff person B administered numerous medications to numerous residents, including to residents #1 and #2 on 1/1/20 through 1/5/20.

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.)

See Page 22A of 24

Legal Entity Representative

Signature 


Printed Name and Title 

Date 4/16/2020

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Plan of correction implementation status as of 5/26/2020 (Date)

The above plan of correction was approved by  (Initials)

Implemented  
 Not Implemented

Correction POC for DHS Inspection 1/9/2020  
Loyalhanna Healthcare Associates / Loyalhanna Senior Suites  
License # 446590\*

Page 22a of 24

190a - Completion Medication Course Regulations

2600. 190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A has not successfully completed the annual practicum in accordance with Department-approved medication administration course since 12/6/16.

Staff person A administered numerous medication to numerous residents, including to resident #2 on 1/1/20 through 1/9/20.

Staff person B has not successfully completed the annual practicum in accordance with Department-approved medication administration course since 8/18/17.

Staff person B administered numerous medications to numerous residents, including to residents #1 and #2 on 1/1/20 through 1/5/20.

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**Immediate Action:**

1/9/2020 Attempted to locate staff training

4/2020: An Educator position has been established to monitor and keep education up to date

All Training have been reviewed and separated into manageable binders

Educator to keep all required trainings up to date

Staff Person A

8/28/2017 most recent update - (currently off medication until clarification can be obtained on training)

Staff Person B

8/1/2017 Initial Medication administration training

3/29/2020 Medication Administration

**Ongoing Oversight:**

Trainer/Educator will monitor education and all trainings for all staff

All Training have been reviewed and separated into manageable binders

Trainer/Educator keep all required trainings up to date

**Timeline:**

4/1/2020: Trainer Educator will audit 5 employees per Month for appropriate training and schedule "make up session" to keep employees and facility in compliance

On going

**Attachments:**

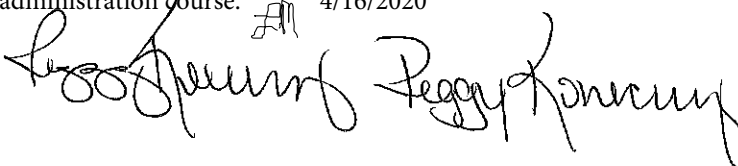
Page: 22a

Page: 22b1, 22b2, 22b3 of audit tool

Page 22c staff training plan

Page 22d, 22 d1; annual practicum

Immediately: Staff persons A and B shall not administer medications until they have successfully completed the Department-approved medications administration course. 4/16/2020

 Peggy Korman 4/14/2020

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

Page 3 of resident #3's most recent assessment, dated 2/20/19, is not present in the home.

REPEAT VIOLATION: 1/11/2019

Plan of Correction (POC)

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

*Please see attached*

See Page 23A of 24

Legal Entity Representative

Signature

Printed Name and Title

4/14/2020  
Date

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4/16/2020

(Date)

Plan of correction implementation status as of

5/26/2020

(Date)

The above plan of correction was approved by

(Initials)

Implemented

Not Implemented

225c - Additional Assessment Regulations

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 Page 3 of resident #3's most recent assessment, dated 2/20/19, is not present in the home. REPEAT VIOLATION: 1/11/2019

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**Immediate Action:**

- 1/9/2020: Reviewed with surveyors on site
- 1/17/2020: 3<sup>rd</sup> page of RASP was located and placed on/in resident chart
- 1/20/2020: New RASP was completed in PCC for this resident # 3
- 3/15/2020 All RASP assessment will be updated and completed for each resident

**Ongoing Oversight:**


- 1/15/2020: reviewed with Care Coordinator/LPN. Need to use Point Click Care (PCC) for RASP assessments
- No more paper assessment – unless there are extenuating events

**Timeline:**

- Effective 1/15/2020 Initial, Annual and significant changes RASP assessment will be timely per regulation
- ~~PCHA and /or designee will audit PCC for completed timely RASP Assessment being completed, 3 per Month starting 4/1/2020~~ (unacceptable plan of correction) 4/16/2020 

**Attachments:**

- Page: 23a
- Page: 23b; Resident list
- Page: 23c; Resident 3
- Page: 23d; New RASP
- Page: 23e; missing page # 3

Within 7 days of receipt of the plan of correction: A designated staff person shall review all resident records to ensure each resident has an assessment, completed in its entirety, at least annually. 4/16/2020 

 Peggy Konecny 4/14/2020

251b - Record Entries Legible

Regulations

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation



Correction fluid was used on the fire drill records for the drills conducted on 9/11/19 at 7:47 a.m., 10/16/19 at 6:15 a.m., and 11/26/19 at 4 p.m.

Plan of Correction (POC)

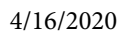
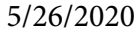
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See Page 24A of 24

Legal Entity Representative

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251b - Record Entries Legible Regulations

2600. 251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation Correction fluid was used on the fire drill records for the drills conducted on 9/11/19 at 7:47 a.m., 10/16/19 at 6:15 a.m., and 11/26/19 at 4 p.m.

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**Immediate Action:**

1/9/2020 – All White out was thrown away in the building in the clinical areas

**Ongoing Oversight:**

1/10/2020: spoke with Maintenance staff – completion of fire drill logs will be done by Administrative assistance, who will also keep records at her/his desk  
PCHA and or Administrative Assistant will also audit logs monthly see page14b

**Timeline:**

1/10/2020: Immediate and on going

**Attachments:**

Page: 24a

Page: 24b

Within 15 days of receipt of the plan of correction: All staff persons shall be educated that the use of correction fluid is not permitted.

4/16/2020



*Peggy Honey - Peggy Honey PCHA 4/16/2020*