pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: aamundson@christthekingmanor.org
eandrulonis@christthekingmanor.org

MAILING DATE: June 29, 2020

Mr. Samuel Zaffuto
Chief Executive Officer
Christ the King Manor, Inc.
Po Box 448
Dubois, Pennsylvania 15801

RE: Christ the King Manor
1100 West Long Avenue
Dubois, Pennsylvania 15801
License #: 448640

Dear Mr. Zaffuto:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 15, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Suzy Quinn
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
4/29/20
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *CHRIST THE KING MANOR* **License Number**: *44864*
Address: *1100 WEST LONG AVENUE,, DUBOIS, PA 15801*
County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

Name: *ANGILA AMUNDSON* **Phone**: *8143713180* **Email**: *Aamundson@christthekingmanor.org*

Legal Entity

Name: *CHRIST THE KING MANOR INC*
Address: *P.O. BOX 448, DUBOIS, PA, 15801*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/16/1997* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection

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

Inspection Dates and Department Representative

01/15/2020 - On-Site: Joe Eveges, Desmond Grace, Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Alzheimer's Unit* **Capacity**: *20* **Residents Served**: *19*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older**: *56*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *20* **Have Physical Disability**: *0*

42e - Telephone Access

Regulations

2600.
42.e. A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

Description of Violation

In order to access an outside telephone line, the number 9 must be dialed on multiple telephones, to include the following; however, directions to operate these phones are not posted on or near these phones:

* Personal care nursing station

* Dementia care nursing station

* Resident bedrooms # 533, #530, and #510

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 page 2a of 9

Legal Entity Representative

Angila A Amundson RN

Angila Amundson RN/PCHA 4-29-20.

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 6/22/20 (Date)

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

Plan of correction implementation status as of 6/22/20 (Date)

☑ Implemented
☐ Not Implemented

License #448640
Regulation 42e

A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

Violation: In order access an outside telephone line, the number 9 must be dialed on multiple telephones, to include the following; however, directions to operate these phones are not posted on or near these phones: personal care nursing station, dementia care nursing station and resident bedrooms 533, 530 and 510.

1. This violation was corrected immediately while the inspectors were still on site. The inspector that found the violation verified and approved our correction before leaving the premises.
2. Staff added to each phone " Outside line press 9". This was placed on every phone in our facility that requires you to dial a 9 to get an outside line before dialing the phone number.
3. Resident bedrooms 533, 530, and 510 do not require a dial out number so that was incorrect information. They have full access to dial any phone number without dialing a 9 prior.
4. The administrator and/or the Care Coordinator will perform audits monthly for the first 6 months and if the audits are sufficient we will decrease the audit to quarterly thereafter for one year. The first audit was perfomed 4-28-2020.
5. The administrator will ensure ongoing compliance and review results at the quality assurance meeting.

See attached audit sheet. First audit was done 4-28-2020 after originally correcting the violation on inspection.

On 1/16/20 and 1/17/20 staff were reeducated regarding the requirements of this regulation.

SE 6/22/20

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

A partially full 1-quart spray bottle of Spic and Span disinfectant cleaner was stored next to 3 1-gallon plastic containers of apple juice concentrate and 3 1-gallon plastic containers of cranberry juice on the 2nd shelf of the food preparation table in the food preparation room.

A partially full 32 ounce spray bottle of Scott Brite Grill cleaner was stored on a shelf next to 2 1-gallon containers of liquid butter and 1 1-gallon container of cooking oil on a shelf across from the stove.

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 #1

See page 3a of 9

Legal Entity Representative

Angila L Amundsen RN. — Signature

Angila L. Amundsen RN. Administrator. — Printed Name and Title

3-27-20 — Date

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Plan of correction implementation status as of 6/22/20 (Date)

- [x] Implemented
- [ ] Not Implemented

#1

82b - Poisonous Material Storage POC:

1.) Poisonous materials removed immediately SE 6/22/20 on 1/16/20 and 1/17/20

2.) Staff training performed immediately with training performed with all new hires

3.) Corrective Action(s) performed with staff involved

4.) Audits performed daily x 2 weeks, weekly x 3 weeks, bi-weekly x 4 weeks and monthly x 3 months.

Audits began 1/20/20. SE 6/22/20

85d - Trash Receptacles

Regulations

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

Description of Violation

There was a 1/2 full, uncovered trash can in the main 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.)

SEE ATTACHED
#2

See page 4a of 9

Legal Entity Representative

Signature | Printed Name and Title: Angila L. Amundson RN Administrator. | Date: 3-27-20

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Plan of correction implementation status as of 6/22/20 (Date)

- [x] Implemented
- [ ] Not Implemented

#2

85d - Trash Receptacles POC

1.) Trash can immediately removed. SE 6/22/20

2.) Staff training performed immediately. on 1/16/20 and 1/17/20

3.) New trash receptacle with a lid was purchased.

4.) Audits performed daily x 2 weeks, weekly x 3 weeks, bi-weekly x 4 weeks and monthly x 3 months.

Audits began 1/20/20. 6/22/20

103c - Food Protected

Regulations

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

8 5-pound bags of beef tips, soaked with and actively leaking blood, were stored uncovered on a baking sheet, in approximately 1" of blood, on the 1st shelf of the main kitchen's walk-in refrigerator.

3 10-pound bags of chicken breast fillets, soaked with and actively leaking blood, were stored uncovered on a baking sheet, in approximately 1" of blood, on the 2nd shelf of the main kitchen's walk-in refrigerator.

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 #3

See page 5a of 9

Legal Entity Representative

Signature: Angela L Amundsen RN

Printed Name and Title: Angela L Amundsen RN Administrator.

Date: 3-27-20

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- [x] Implemented
- [ ] Not Implemented

#3

103 c - Food Protected POC

1.) All items were immediately removed and covered properly before storage on 1/16/20 and 1/17/20 SE 6/22/20

2.) Staff training dome immediately with additional training performed upon hire

3.) Corrective action(s) performed with all staff involved

4.) Audits performed daily x 2 weeks, weekly x 3 weeks, bi-weekly x 4 weeks and monthly x 3 months.

Audits began 1/20/20. SE 6/22/20

103f - Refrigerator/Freezer Temps

Regulations

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:27 a.m. the temperature of the ice cream freezer in the main kitchen was 8 degrees Fahrenheit. At 2:20 p.m. the temperature was 8 degrees Fahrenheit.

At 10:10 a.m., the temperature of the 2 door reach in cooler in the main kitchen's food preparation area was 50 degrees Fahrenheit. At 2:19 p.m. the temperature was 50 degrees Fahrenheit.

Plan of Correction (POC)

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

* See attached.

See page 6a of 9

Legal Entity Representative

Angela L Arnundson RN. — Signature

Angela L. Arnundson RN / PCHA. — Printed Name and Title

4-29-20. — Date

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Plan of correction implementation status as of 6/22/20 (Date)

☑ Implemented
☐ Not Implemented

103 f - Refrigerator / Freezer Temps POC

1.) Reach-In was immediately replaced with a new one.

- All items in reach-in were discarded immediately.

2.) Ice cream was removed and maintenance was performed on ice cream chest

- Ice cream was discarded.

3.) Thermometers placed on top of highest box of ice cream (to ensure porper temps) and in reach-in

- All refrigerators and freezers were checked to ensure a working thermometer was in correct space.
- New temperature sheets were placed on all refrigeration and freezer units.
- Training was performed with all dietary staff on policy and procedures for taking temperatures.
- Individuals were assigned responsibility for daily/weekly/monthly checks of temperatures

4.) Audits performed daily x 2 weeks, weekly x 3 weeks, bi-weekly x 4 weeks and monthly x 3 months.

Audits began 1/20/20.On 1/16/20 and 1/17/20 staff were reeducated regarding the requirements of this regulation.  6/22/20

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's initial medical evaluation, dated 5/29/19, does not indicate the resident's height or ability to self administer medications.

Plan of Correction (POC)

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

* See attached.

See page 7a of 9

Legal Entity Representative

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 6/22/20 (Date)

- [x] Implemented
- [ ] Not Implemented

141a A resident shall have a medical evaluation by a physician physician's assistant or certified registered nurse practitioner documented on a form specified by the Department without 60 days prior to admission or within 30 days after admission.

Violation: Resident #1 initial medical evaluation dated 5-29-19 does not indicate the resident's height or ability to self administer medications.

1. The resident height was measured and added under her identity of 65" tall at the time of admission however it was missed on the DME. The DME was adjusted to indicate her current height on 1-16-2020 by the RN and signed and dated for 1-16-2020. (see attached).
2. The resident was assessed by the preadmission screening to be appropriate to self-administer with assistance in offering meds at prescribed times. This assessment remains appropriate to continue with the DME. The RN spoke to Dr Scott her PCP and Dr Scott remains in agreement with POC to self administer.
3. The RN will ensure that all information on admission on the DME is filled out properly reflecting the residents current ability.
4. The Administrator and/or Care Coordinator will audit quarterly all DME's to ensure ongoing compliance. Results will be reviewed at the quality assurance meeting quarterly. The first audit was done 1-16-2020 and will from this date 4-28-2020 be monitored quarterly. The Administrator completed another audit on the DME 4-28-2020 to ensure we were up to date on all information.

On 1/16/20 and 1/17/20 staff were reeducated regarding the requirements of this regulation.

SE 6/22/20

224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening form, dated 3/28/19, indicates the home cannot meet the needs of the resident.

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 page 8a of 9

Legal Entity Representative

Signature

Angela L. Amundson RN/IPCHA 4-29-20.
Printed Name and Title Date

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

Plan of correction implementation status as of 6/22/20 (Date)

☑ Implemented
☐ Not Implemented

Regulation 224a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home

Violation: Resident#2 preadmission screening form dated 3-28-19 indication the home cannot meet the needs of the resident.

1. On 1-16-2020 The RN made a notation on the screening to indicate an error on the form and that the wrong box was checked. The residents needs can be met as of 3-28-19 and continues to be met by the personal care staff.
2. The Administrator/RN reviewed all other charts to ensure that proper selection and that all residents on this unit needs are being and able to be met by the personal care staff.
3. The Administrator/RN will continue to review preadmission screenings prior to admission to ensure residents are appropriate and their needs can be met by this personal care home.
4. See attached notation.

On 1/16/20 and 1/17/20 staff were reeducated regarding the requirements of this regulation.

6/22/20

231e - No Objection Statement

Regulations

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit on 3/28/19. However, the home has no documentation that the resident and the resident's designated person have not objected to the admission.

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 page 9a of 9

Legal Entity Representative

Angela Amundson RN.

Signature

Angila Amundson RN/DCHHA. 4-29-20.

Printed Name and Title Date

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

Plan of correction implementation status as of 6/22/20 (Date)

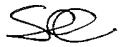
☑ Implemented
☐ Not Implemented

Regulation 231e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Violation: Resident #2 was admitted to the Secured Dementia Unit on 3-28-19. However, the home has no documentation that the resident and the resident's designated person have not objected to the admission.

1. This particular resident does not have any family nor does she have a designated person. She has been with the facility for numerous years related to her diagnosis of schizophrenia. Over the years she did develop dementia and for her safety and with her physicians recommendation she was moved to the secured care dementia unit to better meet her needs. This resident had no objection to moving to this new location and has done well in this environment.
2. On 1-16-2020 after inspection and realizing the consent was not signed, this was explained and the resident consented to signing the consent this day. See attached.
3. The Administrator will have the secretary of personal care review files on each new admission to the unit and/or changes to personal care to ensure all consents are signed. The secretary will initial consent after verifying signatures.
4. The Administrator will review new admission and files quarterly with the quality assurance meetings.

On 1/16/20 and 1/17/20 staff were reeducated regarding the requirements of this regulation.



6/22/20