



pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: b.harvanek@yahoo.com

MAILING DATE: June 8, 2020

Ms. Leah C. Ilgenfritz
Owner
Leah C. Ilgenfritz
521 Park Avenue
Scottdale, Pennsylvania 15683

RE: Leah's Victorian Cottage I
511 Park Avenue
Scottdale, Pennsylvania 15683
Certificate #: 429351

Dear Ms. Ilgenfritz:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on January 30, 2020, found violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The enclosed Licensing Inspection Summary (LIS) specifies the violations.

On 02/18/2020, we emailed the LIS and requested that you complete a plan to correct the violations. On 04/23/2020, we returned your plans of correction via email because your plans were not acceptable. To date, we have not received an acceptable plan to correct the violations. Therefore, we have attached a directed plan to correct the violations.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you have any questions, please contact me at 724-972-2879.

Sincerely,

A handwritten signature in black ink, appearing to read "Suzy Quinn".

Suzy Quinn
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED

5/1/20

Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *LEAH'S VICTORIAN COTTAGE I*

License Number: 42935

Address: *511 PARK AVENUE,, SCOTTDALE, PA 15683*

County: *WESTMORELAND*

Region: *WESTERN*

Administrator

Name: *Leah Ilgenfritz*

Phone: *7248873920*

Email:

Legal Entity

Name: *LEAH C ILGENFRITZ*

Address: *521 PARK AVENUE, SCOTTDALE, PA, 15683*

Certificate(s) of Occupancy

Type: *C-2 LP*

Date: *07/26/1995*

Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *22*

Waking Staff: *17*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal,Provisional*

Inspection Dates and Department Representative

01/30/2020 - On-Site: Joe Eveges, Laurie Garrigan, Deb McConnell

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30*

Residents Served: *22*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *21*

Are 60 Years of Age or Older: *16*

Diagnosed with Mental Illness: *22*

Diagnosed with Intellectual Disability: *2*

Have Mobility Need: *0*

Have Physical Disability: *0*

3c - Post Current License

MAY 01 2020

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

Chapter 2600 regulations were 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.)

1-30-20 Chapter 2600 regulations were Immediately posted. In A public and conspicuous Area. By Administrator

2-3-20 Administrator will monitor on a monthly basis to insure 2600 regulations are kept in dedicated Area

Documentation of monitoring shall be kept for Department review SE 6/5/20

Within 30 days of receipt of the plan of correction: All staff shall be reeducated regarding the requirement that the home shall post the current license, a copy of the current licensing inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home. Documentation of education shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah C. Ilgenfritz

Signature

OWNER - Administrator

Leah Ilgenfritz 4-29-2020

Printed Name and Title

Date

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

The above plan of correction is approved as of

6/5/20 (Date)

Plan of correction implementation status as of

(Date)

The above plan of correction was approved by

SE (Initials)

Implemented

Not Implemented

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The privacy coding document for the licensing inspection summary dated 9/5/19 was publicly posted on the bulletin board in the home's office area and listed multiple resident names to include resident #1, resident #2 and resident #3.

Repeat Violation: 06/18/2019

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.)

1-30-20 Names were removed Immediately from Inspection summary By Administrator
2-3-20 A Bulletin was placed to remind staff resident's names must be kept confidential. Administrator will monitor on a monthly Basis to ensure Anything posted is kept confidential

Immediately, then at least daily, the administrator or designated staff person shall inspect all areas of the home to ensure resident records and documentation are kept confidential and inaccessible. Documentation of inspections shall be kept for Department review.

SE 6/5/20

Within 30 days of receipt of the plan of correction: All staff persons shall be educated regarding confidentiality of resident records and the procedures for maintaining resident records in a secure location. Documentation of education should be kept for Department review. SE 6/5/20

Legal Entity Representative

OWNER Administrator

(owner) Administrator

Leah C. Gentry

LEAH ILSENFRITZ 4-29-2020

Signature

Printed Name and Title

Date

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(Date)

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SE
(Initials)

26b - Quality Management Plan Content

Regulations

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

- 4. Licensing violations and plans of correction, if applicable.

Description of Violation

The home's quality management plan does not include the periodic review and evaluation of licensing violations and plans of correction.

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.)

2-3-20 A Quality management plan outline was placed in Binder. - By Administrator Administrator will monitor on a quarterly basis.
 2. After any state inspection's to ensure plan's of correction are included.

The home's quality management plan outline was updated to include the periodic review and evaluation of licensing violations and plans of correction. Immediately, the administrator shall ensure the home addresses and reviews all elements in their quality management plan outline at each quality management meeting. Documentation of all meetings shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah C. Ilgenfritz
Signature

owner - Administrator

Leah C. Ilgenfritz

Printed Name and Title

Date

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51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff A, hired 12/24/06, does not have a Pennsylvania State Police criminal background check in his/her file.

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.)

2-3-20 A copy of Direct care staff state Police Background check was placed in staff A's File - By Administrator Administrator checked all staff files to ensure all staff files contained Back Ground check's

4-3-20 Staff files will be reviewed on a quarterly basis. By Assistant Administrator to ensure Background checks are in Files

Within 30 days of receipt of the plan of correction: The administrator or designated staff person shall audit all current staff records to ensure a completed criminal history check is on file. Any missing criminal history checks shall immediately be obtained. Documentation of the initial and quarterly audits shall be kept for Department review.

SE 6/5/20

Within 30 days of receipt of the plan of correction: All staff involved in the hiring process shall be reeducated regarding the requirement that criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (relating to protective services for older adults). Documentation of education shall be kept for Department review. SE 6/5/20

Legal Entity Representative

Leah C Ilgenfritz

Signature

(owner) Administrator

Leah Ilgenfritz 4-29-2020

Printed Name and Title

Date

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SE (Initials)

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 A, hired 12/24/06, received only 10 hours of annual training during the January 1, 2019 - December 31, 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.)

2-4-20 Direct care staff completed Training Certificate was placed in staff A's Training file. - By Asst Administrator

4-3-20 Administrator will monitor staff Training files on a Quarterly basis to ensure Annual Training is current And upto date. Documentation shall be kept for Department review. SE 6/5/20

Within 30 days of receipt of the plan of correction: The administrator shall develop and implement policy and procedures to ensure all direct care staff persons receive at least 12 hours of annual training relating to their job duties.

SE 6/5/20

Within 30 days of receipt of the plan of correction: The Administrator or designated staff person shall audit all direct care staff training records to ensure all staff persons received at least 12 hours of annual training during the 2019 training year, in accordance with §2600.65(e). Any missing trainings shall immediately be completed. Documentation of audits shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah C. Ilgenfritz
Signature

owner-Administrator
LEAH Ilgenfritz 4-29-2020
Printed Name and Title Date

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SE
(Initials)

Not Implemented

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.

Description of Violation

Direct care staff B, hired 12/24/06, did not receive training in medication self administration during the January 1, 2019 - December 31, 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.)

2-2-20 Direct care staff completed mandatory required Training. Certificate was placed in staff B's file. By Administrator

Asst Administrator will monitor staff Training files on a Quarterly basis To ensure all staff receive Required Training

Quarterly monitoring shall begin within 30 days of receipt of the plan of correction and documentation shall be kept for Department review. SE 6/5/20

Within 30 days of receipt of the plan of correction: The administrator shall develop and implement policy and procedures to ensure all direct care staff persons receive training in all topics, in accordance with §2600.65(f)(1-7). SE 6/5/20

Within 30 days of receipt of the plan of correction: The administrator or designee shall audit all staff records to ensure that during the 2019 training year, all direct care staff received training in all topics, in accordance with §2600.65(f)(1-7). Any missing trainings shall immediately be completed. Documentation of the audit shall be kept for Department review. SE 6/5/20

Legal Entity Representative

Lead Ilgenfritz
Signature

owner- Administrator
LEAH ILGENFRITZ 4-29-2020
Printed Name and Title Date

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(Date)

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(Initials)

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:

- 5. Falls and accident prevention.

Description of Violation

Direct care staff C, hired 3/1/06, did not receive training in falls and accident prevention during the January 1, 2019 - December 31, 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.)

2-3-20 Direct care staff Training is completed Certificate was placed in staff's file.

Asst Administrator will monitor staff Training files on a Quarterly basis to ensure all staff receive Required training

Quarterly monitoring shall begin within 30 days of receipt of the plan of correction and documentation shall be kept for Department review.

SE 6/5/20

Within 30 days of receipt of the plan of correction: The administrator shall develop and implement policy and procedures to ensure all direct care staff persons receive training in all topics, in accordance with §2600.65(g)(1-6).

SE 6/5/20

Within 30 days of receipt of the plan of correction: The administrator or designee shall audit all staff records to ensure that during the 2019 training year, all direct care staff received training in all topics, in accordance with §2600.65(g)(1-6). Any missing trainings shall immediately be completed. Documentation of the audit shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenritz
Signature

owner - Administrator
LEAH Ilgenritz 4-29-2020
Printed Name and Title Date

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(Date)

Implemented

Not Implemented

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SE
(Initials)

66a - Staff Training Plan

Regulations

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for the January 1, 2020 - December 31, 2020 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.)

2-4-20 A staff Training plan was placed
IN Training folder By Administrator

4-3-20 Administrator will monitor Binder
 on a Quarterly basis to ensure
 Training plan is kept up to date.
 & A plan is developed Annually
 Documentation shall be kept for Department review. SE 6/5/20

Within 30 days of receipt of the plan of correction: The home shall add the following items to the annual staff training plan:

- (1) The name, position and duties of each direct care staff person
- (2) The required training courses for each staff person
- (3) The dates, times and locations of the scheduled training for each staff person for the upcoming training year.
- (4) Fire Safety Training

Documentation shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

owner - Administrator
 LEAH ILGENFRITZ 4-29-2020
 Printed Name and Title Date

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(Date)

Implemented

Not Implemented

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SE
(Initials)

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

There were 2 dead mice directly outside the door leading from the staff office to the outside smoking area.
There were multiple dead insects in the hallway light fixture between bedroom #6 and bedroom #7.

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.)

1-30-20 Dead mice were Immediately removed from side walk. Insects were cleaned and removed from hallway light fixture (By Maintenance)

2-26-20 A staff meeting was held to train maintenance & staff to ensure sanitary conditions are maintained (By Administrator)
meeting held
Daily inspections to monitor sanitary conditions will be done (By Maintenance)

Documentation of inspections shall be kept for Department review. SE 6/5/20

Legal Entity Representative

Lead Ilgenfritz
Signature

owner Administrator
Lead Ilgenfritz
Printed Name and Title Date

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(Date)

Implemented

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SE
(Initials)

Not Implemented

88a - Surfaces

Regulations

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The door knob is loose and unsecured on the emergency exit door in the staff office area.

The door knob is missing on the emergency exit double doors leading from the staff office to the rear of the building.

The carpet in bedroom #3 contains a hole spanning 6" X 2 1/2" outside the door and 6" X 3" inside the door, posing a trip/fall hazard.

The metal transition strip on the floor between bedroom #3 and bedroom #4 is bent up approximately 1" at the end nearest to the wall, posing a trip/fall/skin tear hazard.

The floor vent in bathroom #6 is not the correct size, creating a 4" X 1/2" gap on both sides of the vent, posing a trip/fall hazard.

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.)

2-3-20 Immediately A designated staff person shall inspect all operable doors for loose & missing knobs. And replace ANY damaged parts

Immediately A designated staff person shall inspect all door way carpets for holes & tears. And repair or replace carpet.

Immediately All metal strips in doorways shall be inspected and repaired if needed

2-3-20 Floor vent in bathroom #6 was replaced

2-26-20 A Training was held on reporting repairs

Legal Entity Representative

Immediately, then at least weekly, the administrator or designated staff person shall inspect the home to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Any deficiencies discovered shall immediately be repaired or replaced. Documentation of inspections shall be kept for Department review. SE 6/5/20

Leah J. Gentrif
Signature

owner Administrator
LEAH J. GENTRIF 4-29-2020
Printed Name and Title Date

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The above plan of correction is approved as of 6/5/20 (Date) Plan of correction implementation status as of (Date)

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

96a - First Aid Kit

Regulations

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

There was no thermometer in the home's first aid kit.

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.)

1-3-20 Immediately a Thermometer was placed IN First Aid Kit

A Trained staff person will monitor First Aid Kit on a weekly basis to ENSURE KIT ENCLUDES ALL required Items
~~THE~~ A List of required Items ARE labeled ON Lid of First Aid Kit

Documentation of inspections shall be kept for Department review. *SE* 6/5/20

Within 30 days of receipt of the plan of correction: All staff persons shall be reeducated regarding the requirement that the home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. Documentation of education shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

OWNER - Administrator

Leah Ilgenfritz 4-29-2020
Printed Name and Title Date

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The above plan of correction is approved as of 6/5/20 (Date)

Plan of correction implementation status as of (Date)

- Implemented
- Not Implemented

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

100a - Exterior - Free of Hazards

Regulations

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

2 uncovered pipe holes, approximately 2 1/2" x 2 1/2" and 4 1/2" x 5" are in the sidewalk outside of the door near the dining room, posing a trip/fall hazard.

The asphalt sidewalk is cracked and broken into 4 large, uneven, loose and unstable pieces at the corner of the building outside the kitchen/dining area, posing a slip/trip/fall hazard.

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.)

2020 (months) - All repairs in Asphalt, sidewalks, Summer & Spring will be completed. By Maintenance Administrator - A written update will be submitted to Department of Human Services. Repairs will be completed on a timely schedule.

Within 30 days of receipt of the plan of correction: The 2 uncovered pipe holes in the sidewalk outside of the door near the dining room, and the damaged asphalt sidewalk at the corner of the building outside the kitchen/dining area shall be repaired. Documentation shall be kept for Department review.

SE 6/5/20

Within 30 days of receipt of the plan of correction: All staff shall be reeducated regarding the requirement that the exterior of the building and building grounds or yard must be in good repair and free of hazards. Documentation of education shall be kept for Department review.

SE 6/5/20

Immediately, then at least weekly, the administrator or designated staff person shall inspect the exterior of the building, building grounds and yard, to ensure all areas are in good repair and free of hazards. Any deficiencies discovered shall immediately be repaired or replaced. Documentation of inspections shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Handwritten signature of Leah Hill

Signature

owner - Administrator

LEAH HILL 4-29-2020

Printed Name and Title

Date

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(Date)

Implemented

The above plan of correction was approved by

SE (Initials)

Not Implemented

101r - Bedroom - shades/drapes/window covering

Regulations

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

There were multiple broken slats in the venetian blinds in bedroom #6.

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.)

2-10-20 - Bedroom #6 Blind was replaced with curtains - By Administrator

2-26-20 Staff Training Included Awareness And Reporting Repairs in PCH.

Immediately, then at least weekly, a designated staff person shall inspect all bedrooms to ensure the drapes, shades, curtains, blinds or shutters on the bedroom windows are clean, in good repair, provide privacy and cover the entire window when drawn. Any deficiencies discovered shall immediately be reported to the administrator and immediately repaired or replaced. Documentation of inspections shall be kept for Department review. SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

owner - Administrator
Leah Ilgenfritz 4-29-2020
Printed Name and Title Date

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(Date)

Implemented

Not Implemented

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SE
(Initials)

103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

2 unsealed boxes of cereal were on the top left shelf in the pantry.

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.)

2-30-20 - All cereal was placed in a sealed containers.
Administration will inform all staff cereal must be sealed after use.
Trained staff will monitor on daily basis.

Within 30 days of receipt of the plan of correction: All staff persons involved in food preparation, serving and storage shall be reeducated on the requirement to store food in closed or sealed containers. Documentation of education shall be kept for Department review.

SE 6/5/20

Immediately, then at least daily, a designated staff person shall inspect all food storage areas to ensure food is stored in closed or sealed containers. Documentation of inspections shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

owner- Administrator
Leah Ilgenfritz 4-29-2020
Printed Name and Title Date

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Plan of correction implementation status as of (Date)

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

Implemented
 Not Implemented

107a - Emergency Preparedness

Regulations

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home does not have a copy of the emergency preparedness plan for their municipality or county.

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.)

1-30-20 Immediately A copy of emergency preparedness plan was placed in dedicated Area. Administrator will monitor on a monthly basis to insure emergency preparedness plan is kept in dedicated Area and is posted in a public and conspicuous place. Documentation of monitoring shall be kept for Department review. *SE* 6/5/20

Legal Entity Representative

Leah Ilgenritz
Signature

OWNER - Administrator

LEAH Ilgenritz 4-29-2020
Printed Name and Title Date

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 Not Implemented

121a - Unobstructed Egress

Regulations

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

A cinder block blocked the outside of the emergency exit double doors leading from the office to the rear of the building and the door knob was missing.

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.)

1-30-20 - Immediately, CINDER block was removed ~~and~~ And door KNOB WAS replaced.
2-26-20 - STAFF TRAINING ON reporting repairs WAS Held by Administrator.

Immediately, then at least daily, the administrator or designated staff person shall inspect all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed. Documentation of inspections shall be kept for Department review. SE 6/5/20

Legal Entity Representative

Leah J Genfritz
Signature

OWNER - Administrator

LEAH J Genfritz 4-29-2020
Printed Name and Title Date

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The above plan of correction is approved as of 6/5/20
(Date)

Plan of correction implementation status as of _____
(Date)

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

Implemented
 Not Implemented

132d - Evacuation

Regulations

2600.

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

Description of Violation

On 12/12/19 at 7:15 p.m. the home conducted a fire drill with and evacuation time of 2 minutes and 48 seconds. However, the home's minimum safe evacuation time is 2 minutes 30 seconds.

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.)

2-26-20 Administrator held a training with CARE STAFF on Fire Drill evacuation Times

On 1/1/20 at 1:30 AM, the home conducted a fire drill with an evacuation time of 2 minutes and 5 seconds. SE 6/5/20

Due to COVID-19, Governor Wolf signed an Emergency Disaster Declaration on 3/6/20. As a result, regulation §2600.132(d) was suspended. The suspension shall end when Governor Wolf ends the Disaster Proclamation, unless OLTL has stated a different time or unless OLTL later sets another time. Immediately after the suspension is lifted, and monthly thereafter, the administrator or designated staff person shall conduct fire drills to evacuate all residents to a public thoroughfare or a designated fire-safe area within the time specified in writing by the fire safety expert within the past year. Documentation of all fire drills shall be kept in accordance with §2600.132(c).

SE 6/5/20

Immediately following each fire drill, the administrator or designated staff person shall review the fire drill record to ensure all residents evacuate to a public thoroughfare or a designated fire-safe area within the time specified in writing by the fire safety expert within the past year. If the home exceeds the safe evacuation time specified in writing by a fire safety expert within the past year, the home shall add additional staff to the regular schedule and maintain the increased staffing level at all times and, if applicable, relocate residents who require special assistance with evacuation closer to exits or designated fire safe areas. Documentation of fire drill log reviews shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

OWNER Administrator

LEAH ILGENFRITZ 4-29-2020
Printed Name and Title Date

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132e - Fire Drill Sleeping Hours

Regulations

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 5/9/19 at 12:30 a.m.

Repeat Violation: 06/18/2019

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.)

1-1-20 - A sleeping Fire drill was held By Administration
2-26-20. Training of Fire Safety. Staff was Educated on Fire Safety and drill procedure.

Due to COVID-19, Governor Wolf signed an Emergency Disaster Declaration on 3/6/20. As a result, regulation §2600.132(d) was suspended. The suspension shall end when Governor Wolf ends the Disaster Proclamation, unless OLTL has stated a different time or unless OLTL later sets another time. Immediately after the suspension is lifted, the administrator or designated staff person shall conduct fire drills monthly and sleeping hour fire drills every six months, to evacuate all residents to a public thoroughfare or a designated fire-safe area within the time specified in writing by the fire safety expert within the past year. Documentation of all fire drills shall be kept in accordance with §2600.132(c).

SE 6/5/20

Immediately, then monthly, the administrator or designated staff person shall monitor the home's fire drill record to ensure a sleeping hour fire drill is conducted at least every six months.

SE 6/5/20

Legal Entity Representative

Leah J Gerfny
Signature

owner- Administrator
LEAH J Gerfny 4-29-2020
Printed Name and Title Date

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133.1 - Exit Signs

Regulations

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

On 1/3/20 the home served 22 residents; however, exit signs were not posted in the following locations:

- * Emergency exit door leading from the staff office area to the outside smoking area
- * Emergency exit door leading from the staff office area to the rear of the building
- * Emergency exit #5

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.)

1-30-20 Immediately Exit SIGNS were posted In The following Locations.

1. Emergency Exit in office
2. Above all doors in office.
3. Exit #5

Administrator will monitor all Exit's SIGN'S on a Quarterly basis. to ensure Exit SIGNS Are in place.

Administrator and Trained staff will monitor MONTHLY AS PART of FIRE Drill procedure.

Documentation of monitoring shall be kept for Department review. *SE* 6/5/20

Legal Entity Representative

Leah Ilgenritz
Signature

owner- Administrator
Leah Ilgenritz 4-29-2020
Printed Name and Title Date

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133.2 - Exit Signs Direction

Regulations

2600.

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

Bedroom #5, bedroom #8, bedroom #9, bedroom #11 and the common bathroom do not have a direct visual line to the nearest exit. There are no signs marking the line of travel to the exits. On 1/3/20 the home served 22 residents.

Plan of Correction (POC)

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

1-30-20 Immediately All Exit Signs And Arrows were placed to Indicating travel line to nearest Exit
Administrator and Staff will monitor Exit travel is marked
Monthly when fire drills are held
1-30-20 A reminder was placed in fire log

Documentation of monitoring shall be kept for Department review. SE 6/5/20

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Signature

owner- Administrator
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141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's annual medical evaluation was completed 6/26/19; however, her previous medical evaluation was completed 5/15/18. In addition, section 7- Medications indicates "See Attached"; however no document is attached.

Repeat Violation: 09/05/2019, 06/18/2019

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.)

2-22-20 Resident #2 Evaluation date was corrected By Physician. to comply

2-10-20 The home developed and Implemented A SYSTEM Designated staff person's=(Trained STAFF) will monitor Assigned Resident's FILES. to ensure medical Evaluation's are completed Annually.

Within 30 days of receipt of the plan of correction and at least monthly thereafter: The administrator or designated staff person shall audit all resident records to ensue an initial medical evaluation is completed within 60 days prior or within 30 days after admission. The audit shall also include ensuring all required information is accurate and complete. Missing or incomplete medical evaluations shall immediately be returned to the physician for completion or new medical evaluations shall be scheduled. Documentation of the audits shall be kept Department review. SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

(owner) Administrator
Leah Ilgenfritz 4-29-2020
Printed Name and Title Date

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162c - Menus Posted

Regulations

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 1/30/20, the last date on the menu posted in the dining area was 1/31/20.

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.)

2-3-20 A week advanced menu was posted
A Trained staff person will monitor
menus and make sure they are posted
IN HOME.

Immediately, then at least weekly, the administrator or designated staff person shall ensure weekly menus are posted 1 week in advance in a conspicuous and public place in the home. Documentation shall be kept for Department review.

SE 6/5/20

Within 30 days of receipt of the plan of correction: All staff shall be reeducated regarding the requirement that menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home. Documentation of education shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

owner-Administrator
LEAH ILGENFRITZ 4-20-2020
Printed Name and Title Date

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184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #2 is prescribed Basaglar 100IU Kwikpen – inject 25 nits sub q daily. However, this medication was not stored with the medication label attached to the injector or stored in a labeled bag.

Resident #2 is prescribed Novolog 15ml Flexpen – inject 10 units sub q before each meal at 8am,noon and 5pm. However, this medication was not stored with the medication label attached to the injector or stored in a labeled bag.

Resident #3 is prescribed Basaglar 100IU Kwikpen – inject 18 units sub q daily at bedtime. However, this medication was not stored with the medication label attached to the injector or stored in a labeled bag.

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.)

01-11-20 Resident #2 BASAGLAR KIKPEN was placed in A pharmacy Labeled medication BAG.

01-15-20 Resident #2 Novolog Flex pen was placed in A pharmacy Labeled medication BAG

Within 30 days of receipt of the plan of correction: All staff qualified to administer medication shall be reeducated regarding the requirement that the original container for prescription medications shall be labeled with a pharmacy label that includes the resident's name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration and the name and title of the prescriber. Documentation of training shall be kept for Department review. se 6/5/20

Immediately, then daily a designated Trained STAFF PERSON SHALL REVIEW ALL Insulin pens to ensure Insulin pens are Labeled & stored correctly.

Immediately, then at least monthly, a designated staff person qualified to administer medications shall audit prescription medications to ensure they are stored in their original container and labeled with a pharmacy label in accordance with 2600.184a. The pharmacy label and the MAR shall be compared to the prescriber's order. Any discrepancies discovered shall be verified with the prescriber and immediately corrected. Documentation of audits shall be kept for Department review. se 6/5/20

Legal Entity Representative

Leah Ilgenfritz
Signature

owner - Administrator

LEAH ILGENFRITZ 4 29 2020
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225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4's initial medical evaluation, dated 3/19/19, indicates multiple diagnoses to include: chronic obstructive pulmonary disease, diabetes mellitus type 2, hyperlipidemia, psoriasis, essential hypertension and edema. However, his initial assessment, dated 3/27/19, Section 2: Medical, Dental, Dietary and Sensory Needs: indicates "see attached" and there is no attachment.

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.)

2-20-20 A new medical evaluation was completed By physician.

3-20-20 A new Assessment was completed A designated staff person will monitor and review Resident's records, and ensure Assessments are complete

Within 15 days of receipt of the plan of correction: The home shall develop and implement a system to ensure each resident has an initial assessment, completed in its entirety, within 15 days of admission. Documentation of the system shall be kept for Department review.

SE 6/5/20

Within 15 days of receipt of the plan of correction: The administrator or designated staff person shall audit all resident records to ensure a current assessment is completed, accurate and present in each resident's record. Documentation of the audit shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

Leah Ilgenfritz

Signature

owner- Administrator

Leah Ilgenfritz 4-29-2020

Printed Name and Title

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SE (Initials)

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.

Description of Violation

Resident #3's annual assessment, dated 9/1/19, does not assess her ability to self administer medication. This section is blank.

Resident #3's annual medical evaluation, dated 11/6/19, includes a diagnosis of gastroesophageal reflux disorder and chronic obstructive pulmonary disease. However, her annual support plan, dated 9/1/19, was not updated to include these changes.

Resident #5's annual assessment, dated 1/23/19, indicates he has minimal supervision needs; however, there is no description of his supervision needs.

Repeat Violation: 09/05/2019, 06/18/2019

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.)

2-3-20 - Resident #3 Assessment dated 9/1/19 was updated
 All medication's self Administered ARE documented

2-3-20 - Resident #3 Support Plan was updated and
 Includes CHANGES

2-3-20 Resident #5 Does not need Supervision
 Assessment was corrected.
 Designated staff person's will REVIEW
 resident's records to ENSURE Assessments
 ARE completed and correct.

Within 15 days of receipt of the plan of correction: The home shall develop and implement a system to ensure each resident has an assessment, completed in its entirety, at least annually. Documentation of the system shall be kept. SE 6/5/20

Within 15 days of receipt of the plan of correction and at least monthly thereafter: The administrator or designated staff person shall audit all resident records to ensure all assessments are completed within the required time frame and are accurate, including all resident diagnoses. Documentation of the audit shall be kept

Legal Entity Representative for Department review: SE 6/5/20

owner Administrator
 Leah J Genfrity 4-29-2020
 Printed Name and Title Date

Leah J Genfrity
 Signature

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 (Initials) Not Implemented

227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3's annual assessment, dated 9/1/19, indicates a diagnosis of type II diabetes and HTN. However, her annual support plan, dated 9/1/19, does not indicate how the home will meet these needs.

Resident #5's annual assessment, dated 1/23/19, indicates a diagnosis of epilepsy. However, his annual support plan, dated 1/23/19, does not address the frequency of his seizures, steps staff should take to prevent or monitor for seizures and what to do if he has a seizure. The support plan only indicates "takes prescribed meds".

Plan of Correction (POC)

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

Resident #3 Assessment dated 9/1/19 Indicated THE Following: DR Visit Every 3 MONTH'S SHE check's her Glucose with monitor 3-20-19 All staff That Administer medication ARE Trained Yearly ON Diabetes and Insulin Injections Resident #5 HAS NO History of SEIZURES AT LEAH'S PCH

Immediately, resident #3's RASP shall be updated to indicate how the home will meet her diabetic and seizure needs. Documentation shall be kept for Department review. SE 6/5/20

3-2-20- Administer held a training of Epilepsy. Within 15 days of receipt of the plan of correction: The administrator or designated staff person shall audit all resident support plans to ensure they are complete, accurate and indicate the care and services the home will provide to the resident. The administrator shall be notified immediately of any missing, outdated or inaccurate information discovered and the support plan shall immediately be updated. Documentation of the audit shall be kept for Department review. SE 6/5/20

Within 30 days of receipt of the plan of correction: All staff involved in the completion of resident support plans shall be reeducated regarding the requirement that the home must develop a plan to meet the needs of the resident and is accountable for meeting those needs. Documentation of education shall be kept for Department review. SE 6/5/20

Legal Entity Representative

Leah Ilgenfretz
Signature

OWNER - Administrator
LEAH ILGENFRETZ 4-29-2020
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227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's annual support plan, dated 9/1/19, is not signed by the assessor or the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #5's annual support plan, dated 1/23/19, is not signed by the assessor or the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

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.)

2-28-20 - Resident #3 support plan 9/1/19 Are signed By the resident And Assessor
2-28-20 - Resident #5 Support Plan dated 1/23/19 Are signed By the resident And Assessor
2-1-2020 - A designated staff person will monitor And review Resident's records. Trained STAFF ~~WILL~~ ARE responsible TO monitor Assigned Resident Files

Within 15 days of receipt of the plan of correction and monthly thereafter: The administrator or designated staff person shall audit all support plans to ensure completion, including signatures of those involved in the development of the plan. Documentation of the audits shall be kept for Department review.

SE 6/5/20

Within 15 days of receipt of the plan of correction: All staff involved in completing support plans shall be reeducated regarding the requirement that Individuals who participate in the development of the support plan shall sign and date the support plan. Documentation of education shall be kept for Department review.

SE 6/5/20

Legal Entity Representative

owee - Administration

Leah Ilgenfritz
Signature

LEAH Ilgenfritz 4-29-2020
Printed Name and Title Date

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