



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to PREMIER OAKWOOD TERRACE OPERATING LLC
LEGAL ENTITY

To operate OAKWOOD TERRACE
NAME OF FACILITY OR AGENCY

Located at 400 GLEASON DRIVE, MOOSIC, PA 18507
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

To provide Personal Care Homes
TYPE OF SERVICES TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 58
MAXIMUM CAPACITY
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 13

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from February 3, 2020 until August 3, 2020,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226611**

Robert E. Robinson
ISSUING OFFICER

[Signature]
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: February 3, 2020

Mr. Wayne Kaplan
Managing Member
Premier Oakwood Terrace Operating LLC
400 Glenson Drive
Moosic, Pennsylvania 18507

RE: Oakwood Terrace
License #: 226611

Dear Mr. Kaplan:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 17, 2019, September 18, 2019, September 26, 2019, November 6, 2019, November 7, 2019 and December 23, 2019 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (226610) dated November 22, 2019 to November 22, 2020 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated November 22, 2019 to November 22, 2020 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 3, 2020 to August 3, 2020.

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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
185a	II	48	\$5	\$240	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

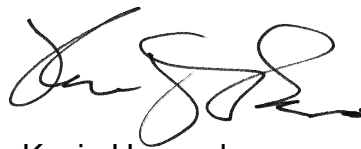
Mr. Kaplan

3

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written in a cursive style.

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

Violation Report

Facility Information

Name: OAKWOOD TERRACE

License Number: 22661

Address: 400 GLEASON DRIVE, MOOSIC, PA 18507

County: LACKAWANNA

Region: NORTHEAST

Administrator

Name: Amy Hasak

Phone: 5704513171

Email: ahasak@psigroupplc.com

Legal Entity

Name: PREMIER OAKWOOD TERRACE OPERATING LLC

Address: 245 PARK AVENUE, 39TH FLOOR, NEW YORK, NY, 10167

Certificate(s) of Occupancy

Type: C-2 LP

Date:

Issued By:

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 55

Waking Staff: 41

Inspection

Type: Partial

BHA Docket #:

Notice: Unannounced

Reason: Complaint, XXXXX

Inspection Dates and Department Representative

09/17/2019 - On-Site: Ryan Yankowy, Ann O'Haire

09/18/2019 - On-Site: Ryan Yankowy, Ann O'Haire

09/20/2019 - Off-Site: Ryan Yankowy

09/26/2019 - On-Site: Ryan Yankowy, Ann O'Haire

09/30/2019 - Off-Site: Ryon Yankowy

10/16/2019 - Off-Site: Ryan Yankowy

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 58

Residents Served: 48

Secured Dementia Care Unit

In Home: Yes

Area: Pine

Capacity: 13

Residents Served: 7

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 48

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 7

Have Physical Disability: 0

15a - Resident Abuse Report

Regulations:

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P.S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 9/5/19 Resident #1 allegedly sexually harassed other residents in the home. During this incident Staff member A allegedly also hit Resident #1 in the face. The home did not report the alleged abuse to the local area agency on aging until 9/11/19.

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.)

See Attached

Legal Entity Representative

Micholene Gianacopoulos
Signature

Micholene Gianacopoulos *Oct 28, 2019*
Printed Name and Title Date
Administrater

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

The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

15A.

Immediate Action:

Resident #1: 9/7/2019 transferred to Moses Taylor Hospital, then discharged to SNF Mountain City

Staff Member A: Suspended immediately, then Terminated on 9/11/2019

Administrator Resigned Effective Immediately on 9/14/2019

All Staff Training to be completed on November 21, 2019 to include overview of Mandatory Reporters / Protocol set forth by Administrator:

1. Immediate State Reportable To DHS: 2600.15
2. Immediate phone call to AAA, followed by ACT 13 (attach to DHS Report)
3. Update RASP
4. Educate Staff on updated RASP (s)
5. Immediately Obtain Staff Statements
6. AAA ACT 13 All Staff In-Service: completed by November 21, 2019

Michelene Giannacopoulos
Michelene Giannacopoulos
Administrator
October 28, 2019

2 Ag 31

12-23-19

15 a Continued

Staff Training to be completed by November 21, 2019

Preventing & Dealing with Resident-to-Resident Aggression in Dementia:

To include, but not limited to: factors, causal factors & triggers for Resident-to-Resident Aggression in Dementia, and interventions for sexually inappropriate behavior dementia

Michelene Gianacopoulos
Michelene Gianacopoulos
Administrator

October 28, 2019

2Bq31

12-23-19

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 9/5/19 Resident #1 allegedly sexually harassed other residents in the home. During this incident Staff member A allegedly also hit Resident #1 in the face. The home did not report the alleged abuse to the Department until 9/11/19.

Resident #2's ranitidine daily was not administered on 9/13/19. The home did not submit an incident report to the Department regarding the medication error.

Resident #3 prednisone daily was not administered on 9/5/19. The home did not submit an incident report to the Department regarding the medication error.

Resident #2 fell on the floor on 7/26/19 and was sent to the emergency room. The resident returned to the facility with 5 staples in the residents head. The injury was not reported to the Department.

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

The Adm will ensure that all staff are trained on all 19 aspects of reportable incidents.

Legal Entity Representative

Michelene Giannacopoulos
Signature

Michelene Giannacopoulos
Printed Name and Title
October 28, 2019
Date

12-23-19

16c - Written Incident Report (continued)

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(Date)

Plan of correction implementation status as of 10-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress 12-23-19
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.16 c

Written Incident Report

The Home shall immediately adhere to (c) reporting the incident or condition to DHS within 24 hours, (d) the home shall submit a final report, immediately following the conclusion of the investigation, (e) if the home's final report validates the occurrence of the alleged incident or condition, the affected resident and other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation.

The exception to reporting within 24 hours, 2600.15 Abuse Covered by Law

(a) The Home shall immediately report suspected abuse of a Resident served in the Home in accordance with OAPSA and 6 Pa. Code 15.21-15.27 (relating to reporting suspected abuse) and comply with the requirements regarding on staff persons). (b) an immediate plan of suspension or supervision of the staff person involved in the alleged incident, (c) DHS must be immediately notified of the plan for the staff person (s) involved (d) the home shall immediately notify the Resident and the Resident's designated person of a report of suspected abuse or neglect involving the Resident.

2600.16 (a-e) immediately to be adhered to by Interim Wellness Director, under the direction of the Administrator, in the absence of the Wellness Director, sole responsibility is to the Administrator to adhere to, effective immediately and ongoing with quarterly Q/A meetings to audit:

2019: Q/A Home's internal audit meeting set on: November 25, 2019 at 10 a.m.

2020: Q/A Home's internal audit meeting set on: January 20, 2019 at 10 a.m., April 6, 2020 at 10am, July 13, 2020 at 10a.m., October 26, 2020 at 10 a.m.

Micheline Gianaopoulos
Michèlewe Gianaopoulos
Administratrix

October 28, 2019

4A g 31

12-23-19

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 9/5/19 Resident #1 exposed the residents' genitals to Resident #'s 3, 4 & 5. It has also been determined through staff interviews that Resident #1 has also exposed the resident's genitals to Resident #'s 5 & 6 in the past on other occasions. Resident #1 is sexually harassing the above noted residents.

On 9/7/19 Resident #1 was found in Resident #3's room standing next to the resident's bed. Resident #1 was found with pants down and an erection by Staff member D. Resident #3 was found lying in bed with the residents brief off. Resident #1 responded that the resident had touched Resident #3 with these 3 fingers and it felt good. Resident #1 sexually assaulted Resident #3.

Resident #3 sustained 22 falls while residing at the home. Two falls resulted in hip fractures. Due to the Resident #3's behavior issues the home was not able to provide adequate supervision to meet the resident's care needs.

The home failed to provide the goods or services which are necessary to maintain the resident's physical health.

Resident #7 was pushed by a family member of Resident #8. Resident #7 fell to the ground and hit the residents head on the floor. The fall resulted in a subdural hematoma. The family member of Resident #8 physically abused Resident #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.)

see attached

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos
Printed Name and Title
Administrator

October 28, 2019
Date

42b - Abuse (continued)

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

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(Date)

Plan of correction implementation status as of 1-13-2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.42.b

Immediate action:

Resident #1 Resident was transferred to hospital then to SNF

Resident #3 Resident transferred to SNF

Family Member of Resident #8 is a police matter

Staff persons must be vigilant in order to detect signs of potential abuse. Training and education staff shall be ongoing and continuous to detect and report to the Administrator immediately: any signs of bruises, lacerations, pain, suspicion of a broken bone, sudden changes in personality and behavior, depression, and or agitation with any of the Residents of the home, or any inappropriate behaviors of any visitors to the Home.

Administrator initiated all staff mandatory meetings on the third Thursday of every month at 2 p.m. This training is continuous and ongoing daily as well as during monthly meetings

Michelle Cianac
Michelle Cianac
Administrator

Oct 28 2019

10-23-19

6A931

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff member B hired 6/11/19 has a high school diploma from Stone Coast Academy. The diploma is not accredited by the Department of Education.

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

Legal Entity Representative

Michelene Cianacopoulos
Signature

Michelene Cianacopoulos
Printed Name and Title
Administrator

12/23/19
Date

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(Initials)

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- Partially Implemented - Inadequate Progress
- Not Implemented

54 a

Direct Care staff person B; hired on 6/11/2019, terminated on 6/24/2019

Ongoing & Continuous: Business Office Manager shall verify high school diplomas are accredited by The Department of Education. Administrator will audit

Micheline Giana
Micheline Giana
Administrator
Oct. 28, 2019.

12-23-19 *CP*

7A931

56 - Admin 20 Hours/Week

Regulations

2600.

56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week in each calendar month.

Description of Violation

The home's previous Administrator resigned from the home on 9/13/19. The home does not have a qualified Administrator working in the home at least 20 hours per week.

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

Legal Entity Representative

Michele Giannopoulos
Signature

Michelle Giannopoulos
Printed Name and Title

12-28-19
Date

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(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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(Initials)

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- Partially Implemented - Inadequate Progress
- Not Implemented

56a

Current administrator is qualified and works inside the home at a minimum of 40 hours a week, which now brings the home into compliance as well as receiving 24 annual credit hours CEU's through PALA

64 a see attached

Micheline Gianacopoulos
Micheline Gianacopoulos
Administrator

64a - Admin Training

Regulations

2600.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

Description of Violation

Staff person C, who was the home's administrator, has not successfully completed the Department approved competency based training with a passing score and the orientation program administered by the Department.

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

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos October 28, 2019
Printed Name and Title Date

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- Not Implemented

P. 9 of 31
4

64 (a)

Staff Member C was hired 4/1/2019-Resigned without notice on 9/14/2019

Current Administrator: successfully completed the Department approved competency-based training with a passing score and the orientation program administered by the Department, as well as completed 2019 annual 24 hours of training

Michelene Gianacopoulos

*Michelene Gianacopoulos
Administrator.
October 29, 2019*

12-23-19.

65a - FS Orientation 1st Day

Regulations:

2600:

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff member B hired 6/11/19 did not complete the 1st day fire safety orientation.

Direct care staff member A hired 4/30/19 did not complete the 1st day fire safety orientation.

Direct care staff member E hired 8/21/19 did not complete the 1st day fire safety orientation.

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

Legal Entity Representative

Micheline Giannopoulos
Signature

Micheline Giannopoulos
Printed Name and Title
Administrators

10/29/2019
Date

12-23-19. Q

65a - FS Orientation 1st Day (continued)

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The above plan of correction is approved as of

11-21-19
(Date)

Plan of correction implementation status as of

12-23-19
(Date)

The above plan of correction was approved by

ag
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Michelene Gianacopolis
Michelene Gianacopolis
Admin
 10-29-2019.

2600.65 (a) & (b)

Administrator initiated a new Orientation protocol and procedure that must be completed First Day:

1. Evacuation Procedures
2. Staff Duties & Responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable
3. The designated meeting place outside the building or within the fire-safe area
4. Smoking safety procedures, the homes smoking policy and location of smoking areas, if applicable
5. The location and use of fire extinguishers
6. Smoke Detectors and fire alarms
7. Telephone use and notification of emergency services

Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, volunteers, and substitute personnel shall have orientation that includes the following:

1. Resident Rights
2. Emergency Medical Plan
3. Reporting of Reportable incidents and conditions

Business Office Manager, Maintenance Director and Administrator will assure the training is conducted. Administrator will assure it is completed with an initial audit when a new hire is onboarded. Then monthly audits thereafter of all employee records.

Michelene Gianacopoulos
Michelene Gianacopoulos
Administrator.

Oct 31, 2019.

10-31-19

65b - Rights/Abuse 40 Hours

Regulations

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

- 1. Resident rights.
- 2. Emergency medical plan.
- 4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff member A hired 4/30/19 and E hired 8/21/19 did not receive training in resident rights, emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

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

Legal Entity Representative

Michelle Giannacopoulos
Signature

Michelle Giannacopoulos
Printed Name and Title
10-29-19
Date
Administrator

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The above plan of correction is approved as of 11-21-19
(Date)

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(Date)

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(Initials)

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2600.65 (a) & (b)

Administrator initiated a new Orientation protocol and procedure that must be completed First Day:

1. Evacuation Procedures
2. Staff Duties & Responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable
3. The designated meeting place outside the building or within the fire-safe area
4. Smoking safety procedures, the homes smoking policy and location of smoking areas, if applicable
5. The location and use of fire extinguishers
6. Smoke Detectors and fire alarms
7. Telephone use and notification of emergency services

Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, volunteers, and substitute personnel shall have orientation that includes the following:

1. Resident Rights
2. Emergency Medical Plan
3. Reporting of Reportable incidents and conditions

Business Office Manager, Maintenance Director and Administrator will assure the training is conducted. Administrator will assure it is completed with an initial audit when a new hire is onboarded. Then monthly audits thereafter of all employee records.

Michelene Gianacopoulos
Michelene GIANACPOULOS
Administrator.

Oct 31, 2019.

81b - Resident Personal Equipment

Regulations:

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

An enabler bar was found in resident room # 3 in the Oak House. The enabler bar had no covering allowing for possible hazard of entrapment of a limb.

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

Legal Entity Representative

Signature *Micheline Giannopoulos*

Printed Name and Title *Micheline Giannopoulos* Date *10/29/2019*
Administrator

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(Date)

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- Not Implemented

Immediate Action: Oak House Room #3 a covering was placed over the enabler

Administrator audited Resident's rooms to ensure wheelchairs, walkers, prosthetic devices and other apparatus used by Residents are clean, in good repair, and free of hazards completed on 10/29/2019

Ongoing auditing by Administrator, upon admission of a new Resident, at the time of a change of condition in a Resident's status, and quarterly at Q/A meetings

Micheline G. Anacopoulos
Micheline G. Anacopoulos
Administrator
10/29/2019

2600. 81. b.

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A 8

12-23-19 #3

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 #2's DME dated 9/12/19 does not include pulse, allergies, medications, immunization history, ability to self-administer medications, body positioning, mobility needs and is not signed by the person completing the form.

Resident #1's DME that was signed by the physician on 07/30/19 had the following elements that were not completed: The form did not state the purpose of this DME, resident evaluation date was not stated and the date the form was completed was not indicated. The DME did not have the following elements completed: Sections 4,7,8 and 9.

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.

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos
Printed Name and Title
Administrators

Date
10/29/2019

12-23-19

141a 1-10 Medical Evaluation Information (continued)

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

The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.141.a

DME : Administrator re-educated staff on the proper manner to complete a DME within 60 days prior to admission, or within 30 days after admission, a medical evaluation is to be completed at least annually and upon a change in condition.

Administrator will audit periodically, as well as on established Q/A quarterly meeting dates established

Micheline Gianopoulos
Micheline Gianopoulos
Administrative

10/29/2019

P15 8931
A. 6

P. 14

12-23-19

182b - Prescription Medication

Regulations

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 9/7/19 from 1:18 am to 6:30 am and on 9/8/19 from 1:41 am to 6:30 am the home did not have anyone in the home trained to pass medications. The home serves residents that have PRN 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.

Legal Entity Representative

Micheline Cianacopoulos
Signature

Micheline Cianacopoulos
Printed Name and Title Date

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The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

182.b

Staffing Scheduling

Administrator will assure the staffing schedule covers all shifts with a trained person to pass medications, if an unplanned occurrence arises it is the Administrator's responsibility to have a trained person in the home.

Michelene Gimnacopoulos
Michelene Gimnacopoulos
ADMINISTRATOR
10/29/2019

12-23-19

16A § 31

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

Direct care staff member F found a packet of Resident #2's medications on the floor outside the willow house on 9/4/19.

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.)

See Attached

Legal Entity Representative

Michael Comacopoulos
Signature

Michael Comacopoulos
Printed Name and Title
Administ

Oct 28, 2019
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 11-18-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.a., 184.a., 185.a., 183.e., 183.b.

Medications:

Re-training and Education of proper protocol of staff persons who administer medications:
Med-Tech's and Nurses, ongoing

Switching from Primecare to Danville Pharmacy LLC, LTC pharmacy for improved compliance
through their support services of audits, staff education and training

Administrator and/ or Wellness Director will monitor daily

Micheline Giannopoulos
Micheline Giannopoulos
Administrator

08/30/2019

12-23-19

17 Aug 31

183e - Storing Medications

Regulations

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #9's novolog flex pen was not dated when the pen was opened, the manufacturer's instructions read the medication expires 28 days after opening the pen.

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.

Legal Entity Representative

Michele Canacopul
Signature

Michele Canacopul *Adminstrator* *Oct 28*
Printed Name and Title Date 2019

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The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.a., 184.a., 185.a., 183.e., 183.b.

Medications:

Re-training and Education of proper protocol of staff persons who administer medications:

Med-Tech's and Nurses, ongoing

Switching from Primecare to Danville Pharmacy LLC, LTC pharmacy for improved compliance through their support services of audits, staff education and training

Administrator and/ or Wellness Director will monitor daily

Michelene Giannopoulos
Michelene Giannopoulos
Administrator

01/30/2019

12-23-19

18 Ag 31

184a - Labeling OTC/CAM

Regulations

2500.

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

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #10 has an order for 2 units of humalog with meals 3 times daily and per a sliding scale. The label to the humalog does not include the 2 units 3 times 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.)

see attached

Legal Entity Representative

Michelle Granados
Signature

Michelle Granados
Printed Name and Title
ADMINISTRATOR

Oct 29 2017
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-23
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.a., 184.a., 185.a., 183.e., 183.b.

Medications:

Re-training and Education of proper protocol of staff persons who administer medications:
Med-Tech's and Nurses, ongoing

Switching from Primecare to Danville Pharmacy LLC, LTC pharmacy for improved compliance
through their support services of audits, staff education and training

Administrator and/ or Wellness Director will monitor daily

Micheline Gianopoulos,
Micheline Gianopoulos
Administrator

01/30/2019

19A931

185a - Implement Storage Procedures**Regulations**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 9/5/19 Resident #11's ativan, Resident #12's 1/2 tablet of tramadol, Resident #13's 50 mg of tramadol and Resident #2's klonopin were missing out of the residents med-packs.

It was discovered on 9/18/19 that 36 pills of Resident #13's PRN ativan were missing from the narcotic drawer. The blister packs and count sheets were missing.

It was discovered on 9/18/19 that direct care staff member E ordered Resident #11's PRN ativan from the pharmacy on 8/30/19. The medications were delivered and signed by staff member E. The blister pack of 30 narcotics is missing from the home.

Resident #3's PRN morphine syringes was 17 total on 9/4/19, Direct care staff member administered a syringe to the resident. When the staff returned to the medication room only 15 syringes were left.

The homes narcotic policy is to count the narcotics at change of shifts and sign the narcotic sign out verification sheet. On the following dates the staff members did not count or sign the sheets: 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/10, 9/12, 9/14, 9/15 & 9/16/19.

Resident #3's PRN tylenol and milk of magnesium were not available at the time of the inspection.

Resident #2's PRN tylenol and al Hydroxine were not available at the time of the inspection.

Repeat Violation: 11/6/18

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.)

185a - Implement Storage Procedures (continued)

Legal Entity Representative

Michèle Gianacopolu
Signature

Michèle Gianacopolu *Oct 28, 2019*
Printed Name and Title *Administ* Date

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The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 1-13-2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.a., 184.a., 185.a., 183.e., 183.b.

Medications:

Re-training and Education of proper protocol of staff persons who administer medications:
Med-Tech's and Nurses, ongoing

Switching from Primecare to Danville Pharmacy LLC, LTC pharmacy for improved compliance
through their support services of audits, staff education and training

Administrator and/ or Wellness Director will monitor daily

Michelene Gianacopoulos
Michelene Gianacopoulos
Administrator

10/30/2019

12-23-19

21 Aug 31

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:

- 14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2 & #3's 8pm medications were not initialed as administered on 9/4/19.

Resident #2's mematine was not initialed as administered on 9/13-9/14/19 at 8am.

Resident #3's mematine was not initialed as administered on 9/1/19 at 8am and 9/2/19 at 5pm.

Resident #3's omeprazole was not initialed as administered on 9/1/19 at 11am and the rivaroxaban was not initialed as administered on 9/2/19 at 5pm.

Repeat Violation: 11/8/18

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.

Legal Entity Representative

Micheline GIANACopoulos
Signature

Micheline GIANACopoulos ^{10/30/19}
Printed Name and Title *Administratrix* Date *2d9.*

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The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 1-13-2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.a., 184.a., 185.a., 183.e., 183.b.

Medications:

Re-training and Education of proper protocol of staff persons who administer medications:

Med-Tech's and Nurses, ongoing

Switching from Primecare to Danville Pharmacy LLC, LTC pharmacy for improved compliance through their support services of audits, staff education and training

Administrator and/ or Wellness Director will monitor daily

Michelene Gianacopoulos
Michelene Gianacopoulos
Administrator

10/30/2019

12-23-19
22 Ag 31

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2's 8pm and 4pm medications were initialed as administered on the MAR on 9/5/19, the resident did not receive the medications.

Resident #3's 8am and 11am medications were administered on 9/18/19, the MAR was not initialed as administered at the time of administration.

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

Legal Entity Representative

Michelle Granacepaul
Signature

Michelle Granacepaul
Printed Name and Title
Administra
Date
10/30/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-03-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.b

The date and time of medication administration and the name and initials of the staff person administering the medication

The Med-Techs and LPN's will document at the time of the medication administration, the Wellness Director/ and or Administrator to daily monitor

Michelle Giannini
Michelle Giannini
Administrator

23. Aug 31

12-23-19

187c - Refusal of Medication

Regulations

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #3 refused divalproex sprinkles and memantine on 9/6 and 9/11/19 at 8am. The resident also refused prednisone on 9/6/19. The doctor was not notified regarding the refusals.

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.

Legal Entity Representative

Micheline Gianacopolis
Signature

Micheline Gianacopolis
Printed Name and Title
Administrates

Date
10/29/2019

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The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187.c.

Refusal of Medication

If a Resident refuses to take a prescribed medication, the refusal shall be documented in the Resident's record and on the MAR. The refusal shall be reported to the prescriber.

Med-Techs and LPN's shall follow the protocol set forth in the regulation. Staff are to report same to Wellness Director

Michèle Gianacopoulos
Michèle Gianacopoulos
Administrator.

10/29/2019.

D. 12-23-19
24.A § 31

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

At approximately 9:28am 7 residents did not receive their 8am medications. The 8am medications were not finished being administered until 10:45am. This was on discovered on 9-18-19.

Resident #2's ranitidine daily was not administered on 9/13/19.

Resident #3 prednisone daily was not administered on 9/5/19.

Resident #3 has an order for metoprolol ER 100mg daily. Hold if systolic blood pressure is less than 100 or heart rate less than 60. On the following days the medication was administered when it should have been held: 9/18/19 BP 94/70, 9/17/19 BP 97/63, 9/16/19 BP 95/52 and 9/13/19 BP 85/53.

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

Legal Entity Representative

Micheline Giannopoulos
Signature

Micheline Giannopoulos
Printed Name and Title *Administrater* Date *10/29/19*

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

The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.187 .d.

Administrator will assure the directions of the prescriber are adhered to, lead med-tech and LPN will assure to audit daily and immediately report any discrepancies to Administrator

Micheline Giannopoulos
Micheline Giannopoulos
Administrates

10/29/2019

12-23-19
25. Ag 31

188b - Medication Error Reporting

Regulations

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #2's ranitidine daily was not administered on 9/13/19. The home did not notify the prescriber regarding the medication error.

Resident #3 prednisone daily was not administered on 9/5/19. The home did not notify the prescriber regarding the medication error.

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.

Legal Entity Representative

Micheline Canacopoulos
Signature

Micheline Canacopoulos
Printed Name and Title
Date

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

10/28/2019

The above plan of correction is approved as of 11-19-19
(Date)


Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.188.b.

Administrator will assure a medication error is properly addressed and reported to DHS. A medication error shall be immediately reported to the Resident, the Resident's designated person and the prescriber. Health Care Staff will immediately report to Administrator if a medication error should occur.

12-23-19 
26. Ag 31

202 - Prohibitions

Regulations

2600.

202. The following procedures are prohibited:

- 5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.

Description of Violation

It has been determined through interviews that Resident #5 & #14 would often go to the front door of the building and try to wander outside. When these behaviors occurred the staff members would put the residents in the Pine unit which is a secure dementia unit. Neither resident would be able to operate the locking device to unlock the door and leave the unit. Mechanical restraints are prohibited.

It has been determined through interviews that Resident #15 would be put on the Pine unit which is the homes secure dementia unit for meals. Resident #15 would not be able to operate the locking mechanism to exit the unit independently. Mechanical restraints are prohibited.

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.

Legal Entity Representative


 Signature: *Michelene Giannopoulos*
 Printed Name and Title: *Michelene Giannopoulos*
 Date: *10/29/19*
Administrative

202 - Prohibitions (continued)

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The above plan of correction is approved as of 11-18-19
(Date)

Plan of correction implementation status as of 12/20/19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.202

Re-trained staff on admission process to Secured Dementia Care Unit/ Pine

Admission to SCDU is to be treated as a new admission to the Home (DME,
Preadmission Screen etc.)

Administrator will assess, along with Nursing Department Resident's status and need
for admission to SCDU/ Pine ongoing

Micheline Ciannacopun
Micheline Ciannacopun
Administrator

Oct 31, 2019

12-23-19

27

28 Aug 31

227d - Support Plan Medical/Dental

Regulations

22600.

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

Through staff interviews and record review it was determine that resident #15 receives meals in the home's secured dementia unit due to the need for one to one attention during meals. The resident's issues with eating were not addressed in the RASP.

Resident #14 has issues with wandering into other resident rooms and his RASP dated 10/09/18 does not address this behavior.

Resident #3's RASP dated 01-03-19 did not address resident's frequent falls and increased supervision needs due to her behaviors. This resident was admitted into hospice services and this resident change was not addressed on the resident's RASP.

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.

Legal Entity Representative

Micheline Giannopoulos
Signature

Micheline Giannopoulos
Printed Name and Title
Administrator

Date
Oct 30,
2019

227d - Support Plan Medical/Dental (continued)

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

The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.227.d.

2600.227.h

10/30/2019 Initiated auditing RASP's: to be completed by November 21, 2019

Re-educated and provided training for key Nursing Personnel

Calendar established to track due dates etc.

Administrator and/or Director of Wellness to monitor

Michelene Gianacopoulos
Michelene Gianacopoulos
ADMINISTRATOR
10/30/2019

12-23-19

P30A931

227h - Support Plan Refuse Sign

Regulations

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's RASP dated 8/12/19 was not signed by the resident or the inability or refusal of the resident 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.)

See attached.

Legal Entity Representative

Micheline Giannopoulos
Signature

Micheline Giannopoulos 10/30/2019
Printed Name and Title Date

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The above plan of correction is approved as of 11-19-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2600.227.d.

2600.227.h

10/30/2019 Initiated auditing RASP's: to be completed by November 21, 2019

Re-educated and provided training for key Nursing Personnel

Calendar established to track due dates etc.

Administrator and/or Director of Wellness to monitor

Michelene Gianopoulos
Michelene Gianopoulos
ADMINISTRATOR
10/30/2019

P 31 A g 31

Violation Report

Facility Information

Name: OAKWOOD TERRACE

License Number: 22661

Address: 400 GLEASON DRIVE,, MOOSIC, PA 18507

County: LACKAWANNA

Region: NORTHEAST

Administrator

Name: Michelene Gianacopoulos

Phone: 5704513171

Email: mgianacopoulos@pslgroupllc.com

Legal Entity

Name: PREMIER OAKWOOD TERRACE OPERATING LLC

Address: 245 PARK AVENUE, 39TH FLOOR, NEW YORK, NY, 10167

Certificate(s) of Occupancy

Type: C-2 LP

Date: 01/03/1997

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 58

Waking Staff: 44

Inspection

Type: Full, Renewal

BHA Docket #:

Notice: Unannounced

Reason: Complaint, ~~Interix~~

Inspection Dates and Department Representative

11/06/2019 - On-Site: Ryan Yankow, Gerald Dumas

11/07/2019 - On-Site: Ryan Yankow, Gerald Dumas

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 58

Residents Served: 45

Secured Dementia Care Unit

In Home: Yes

Area: Pine

Capacity: 13

Residents Served: 8

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 45

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 13

Have Physical Disability: 0

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/19/19 the fire alarms were activated in the kitchen due to smoke from cooking food. The local fire department was dispatched to the home, the home did not report the incident to the Department.

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

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos
Executive Director
12/9/2019
Printed Name and Title Date

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

The above plan of correction is approved as of 12-18-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

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

Fully Implemented

Not Implemented

16c

10/19/2019

P24g24

The Carbon Monoxide detector located outside the kitchen door, within the bistro area, was malfunctioning and triggered the fire alarm to sound. The Simplex technician was dispatched to Oakwood Terrace and found the CO cartridge to be defective, he then replaced with a new CO cartridge to resolve the problem. Since resolving the problem, the fire alarm has not been triggered and system is operating efficiently.

2600.16 c (11) An incident requiring the services of an emergency management agency, fire department or law enforcement agency, except for false alarms

1. For the Safety & Well-being of the Residents, the Administrator will retrain all staff on December 19, 2019 at 2pm and ongoing on all 19 State Reportable Incidents.
2. RCG Appendix B will be in serviced upon hire and annually
3. Administrator & Wellness Director will review Incident Reports at morning meeting and in addition on Monday mornings after the weekend (The manager on duty for the weekend will comply with communication via internal incident report to Administrator and Wellness Director).
4. After a comprehensive review all reportable events will be reported to the Department
5. Administrator and Wellness Director will monitor

Micheline Giannopoulos
Micheline Giannopoulos
Administrator

12/13/2019.

P.20124

Q.
12-18-19

P30824

2600.26 (b)

Administrator immediately added 26.b.4. to The Quality Management Plan and immediately began to implement (see attached)

In order to prevent omissions of the Quality Management Plan for the Home, all attendees will be trained on all the required elements that must be contained in the Homes Quality Management Plan when preparing for the next meeting to implement a plan for 2020

The next Quality Management Plan for 2020 is scheduled for January 27, 2020 at 10am: The Management team will be present at this meeting to formulate a new plan for the homes assessment of the areas needing improvement and that are identified during the periodic review and evaluation

Currently for the next 90 days the Quality Management Plan is reviewed weekly by the Administrator and The Wellness Director on Friday's at 10am

Michelene Canary
Michelene CANARY
Executive Director.
12-13-19

P.30824

60a - Staff/Support Plan

Regulations

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home serves 45 residents, 13 of those residents have mobility needs in the event of an emergency. 1 resident requires a 2 person assist, 8 residents require constant cuing and supervision due to their cognitive decline and 4 residents require a 1 person assist. On 10/26/19 & 10/27/19 only 2 staff persons worked in the home from 10:30pm - 6:30am. The home does not have enough staff on the overnight shift to meet the residents needs in the event of an emergency based on the residents RASPS.

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.

Legal Entity Representative

<i>Micheline Gianacopoulos</i>	<i>Micheline Gianacopoulos</i>	
Signature	Printed Name and Title	Date
	<i>Administrator</i>	<i>12/13/2019</i>

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The above plan of correction is approved as of 12-18-19
(Date)

Plan of correction implementation status as of 12-23-19
(Date)

Fully Implemented

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

Not Implemented

P4A824

2600.60.a

Administrator & Corporate immediately signed with DNA staffing agency to fulfill the Home's nursing schedule needs

Staffing shall be provided every shift 24/7 to meet the needs of The Residents as specified in their RASP, an immediate audit of The RASP was performed, and mobility needs were assessed

Wellness Director & Lead Med-tech devised a flow chart with every residents mobility needs, as well as well as 24 hour shift to shift report was implemented

Front office continues to recruit, hire and implement training for new permanent hires for staffing

Wellness Director will daily review and audit the nursing schedule to assure the staffing needs are met in accordance with all Residents needs on their RASP as well as with any change of condition with our Residents that would require additional staffing requirements

Micheline Gianacopoulos
Micheline Gianacopoulos
12/13/2019.

p. 4 of 24

12-23-19

63a - First Aid/CPR Training

Regulations

2600.

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

Description of Violation



The home served 45 residents from 10/25-10/27/19. At a minimum the home is required to have 1 person certified in First Aid and CPR at all times. On 10/25/19 no one was certified from 4:15pm-10:10pm. On 10/26/19 no one was certified from 7am-10:30am and 2pm-10:35pm. On 10/27/19 no one was certified from 7am-10:35pm.

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

Legal Entity Representative



 Signature Printed Name and Title
 Executive Director
 12/13/2019 Date

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The above plan of correction is approved as of 12-18-19 Plan of correction implementation status as of 12-23-19
 (Date) (Date)

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

2600.63. A

An immediate audit was performed of all staff's CPR/ First Aide certifications to determine who were not currently certified

Class was scheduled with Jim Ebersole 610-256-0148 / Jim.ebersole@redcross.org to perform CPR/ First Aide training for certification for first quarter of 2020, awaiting an exact date for the required American Red Cross Training/ First Aide for adults, the certifications are valid for 2 years once trained

Training for All staff for CPR/ First Aide will be completed by end of first quarter 2020

Wellness Director initiated POLST for all Resident charts at this time as well

Micholene Granapoulos
Micholene Granapoulos
Administrator
Dec 13, 2019

P. SA07 29

12-23-19
Q.

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.

- 1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

Description of Violation

Direct care staff member A hired 7/13/15 received 10 of the required 12 hours of annual training for 2018.

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

Legal Entity Representative

Micheline Granacopoulos

Signature: *Micheline Granacopoulos*

Printed Name and Title: *Executive Director*

Date: *12/13/2019*

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(Date)

Fully Implemented

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

Not Implemented

65e

Immediately upon exit of regulators for survey an audit of all 2018 training was performed for all staff members. Staff member A's: 2 hours of missing training was discovered and submitted to the Department for immediate correction

Monthly All Staff meetings were initiated & scheduled on the third Thursday of every month at 2pm to assure all staff's annual trainings are current and in accordance with the department's requirements for annual training

In addition, corporate online training through Relias is mandatory at Oakwood Terrace and require, which directly aligns with the department's courses annual trainings for every employee and is completed with a printed certification

Michelene Gianacopoulos
Michelene Gianacopoulos
Administrator
12/13/2019

P. BA of 24

12-23-19
EP

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.
- 3. Care for residents with dementia and cognitive impairments.
- 5. Personal care service needs of the resident.
- 6. Safe management techniques.

Description of Violation

Direct care staff member A hired 7/13/15 and B hired 4/11/16 did not receive training in medication self administration, meeting the needs of the residents as per the DME and RASP, care for residents with dementia, personal care needs of the resident and safe management techniques for 2018.

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

Legal Entity Representative

Micheline Gianacopoulos *Executive Director*
 Signature Printed Name and Title
 Date 12/13/2019

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Fully Implemented

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

Not Implemented

2600.65.f.

Immediate action audit of all staff files for annual training was performed and missing trainings were conducted to bring current for 2018

2019 audits were conducted

2020 annual monthly trainings are being scheduled monthly through online corporate trainings with Relias and monthly all staff meetings on the third Thursday of every month at 2pm

Monthly audits of all employees' files to be conducted in order to assure compliance and missing trainings will be scheduled and completed, trainings will be monitored going forward on a calendar year

Micheline Gnanapaul's
Micheline Gnanapaul
Administrative
12-13-19

p. 7A of 24.

12-23-19 @

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

Ancillary staff member C hired 8/18/16, Direct care staff member A hired 7/13/15 and B hired 4/11/16 did not receive training in fire safety and emergency preparedness in 2018.

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

Legal Entity Representative

Micheline Gianacopoulos

Micheline Gianacopoulos
Signature

Executive Director
Printed Name and Title
12/13/2019
Date

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(Date)

Fully Implemented

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(Initials)

Not Implemented

2600.65.g

Immediate correction: all staff were in serviced on fire safety and emergency preparedness


An audit was performed to assure all trainings were completed for 2018 to current date for all current employees

2020 calendar year trainings are outlined by the department and scheduled monthly to assure all staff receive their required annual trainings both on site and online through Relias

Monthly audits of all employee trainings will be performed, and trainings will be concluded by all staff persons monthly and monitored for completion by Administrator

Micheline Gianacopoulos
Micheline Gianacopoulos
Administrator
12/13/2019.

P 8A 9 27

12-23-19 

65 g.

All trainings will be scheduled through Relias and monthly standing meetings for all new hires and current staff

All trainings for all staff will be completed upon hire following the departments regulation and annually

In order to assure the new hire training and annual trainings are completed in a timely manner a monthly audit of all employee files will be conducted at the conclusion of the monthly all staff meeting and on a calendar year

Michelle Ciamm
Michelle Ciamm
Administrative.

12/13/2019.

P8B g 24

12-23-19 QP

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/6/19, at approximately 11:45 a.m. upon entering the Willow neighborhood, a strong urine odor could be detected throughout the entire unit. Secondly, in inspecting the Spa/ Resident's Bathroom, a foul smell of fecal, urine and body odor permeated the entire room. Dirty clothing was observed on the bathroom sink as well as used towels and other resident's soiled clothing on the floor of the room. Housekeeping had already cleaned the toilet and toilet area reportedly yet, the room remained odorous.

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.

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos

Executive Director
Printed Name and Title

12/13/2019
Date

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(Date)

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(Date)

Fully Implemented

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

Not Implemented

85a

Immediate action: Willow House was thoroughly cleaned, as well as the Resident's Spa/ Bathroom

A lidded laundry container was immediately placed in the Spa/ Bathroom of Willow House and remaining Houses within the community

Willow House is ^{now} ~~not~~ closed for deep cleaning and painting, Residents have been moved to other Houses within facility (with POA consent prior and all Residents immediately adjusted to the move)

Spa/ Resident bathrooms are now inspected at the change of every shift, administrator and wellness director make daily morning rounds and random checks of Spa / Resident Bathrooms to ensure cleanliness

Maintenance Director oversees housekeeping department and is also inspecting

Micheline Ganacopoulos
Micheline Ganacopoulos
Administrate

12/13/2019.

P. 9^A of 24

12-23-19 *EP*

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

The telephone located next to Room #5 in Birch and the telephone located in OAK did not have to personal care home complaint hotline number posted on or near the telephone.

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

Legal Entity Representative

Micholene Giannopoulos
Signature

Micholene Giannopoulos
Executive Director
Printed Name and Title
12/13/2019 Date

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(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented

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

Not Implemented

2600.91

Immediate Action: phone list was immediately replaced with all mandatory emergency numbers at the location of the violation

An immediate inspection was performed throughout the home on all phones with an outside line to assure emergency telephone numbers were posted

Maintenance Director will perform weekly inspections of all phones with an outside line and replace the emergency list as needed, the report of inspection will be announced on the following day at morning stand up meeting with administrator

Administrator will oversee the Maintenance Director

Micheline Gianacopoulos
Micheline Gianacopoulos
ADMINISTRATOR
12/13/2019.

B-10 of 24

12-23-19

96c - First Aid Accessible

Regulations

2600.

96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

The home's first aid kit is stored in the Wellness Director's Office. In an interview with the Wellness Director staff member D, it was acknowledged, that the door is locked and that the first aid kit is not accessible to staff when the Wellness Director is not in the building. The first aid kit must be in a location that is easily accessible to staff persons.

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.

Legal Entity Representative

Micheline Giannacopoulos
Signature

Micheline Giannacopoulos
Executive Director.
Printed Name and Title
12/13/2019 Date

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(Date)

Plan of correction implementation status as of 12-23-19
(Date)

Fully Implemented

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

Not Implemented

96c

Immediate action:

The First Aid kit was immediately moved to the all staff break room to a table under the time clock, this room is always accessible

Maintenance Director will assure daily, as well as weekend Manager on Duty that the First aid kit is always in this location

All staff were educated on the new location of the First Aid kit and were instructed to immediately report to the wellness director and the maintenance director if the kit is not there

Administrator will oversee Directors

Michelle Giam
Michelle Giam
Account
Doc B, 2019

P. 11^A of 29

12-23-19 CP

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The bed located closest to the wall in Room #7 had a lamp but it was not accessible from the bedside.

Repeat Violation: 11/8/18

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

Legal Entity Representative

Micheline Grana
Signature

Micheline Grana

Executive Director
Printed Name and Title
12/13/2019 Date

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(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented.

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

Not Implemented

101j7

Immediate action:

An operable lamp was placed at resident's bedside within reach

Maintenance Director immediately inspected all Resident rooms to assure an operable lamp was placed bedside within reach for all Resident's living within the home

All Resident bedrooms will be inspected weekly, when Maintenance Director is performing phone audits within the Home

Micholene Gianacor
Admin
Dec 13, 2019
P. 12 of 24
-A

12-23-19 OP

103g - Storing Food

Regulations

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

Description of Violation

A bag of opened chips was located in the cabinet of the homes memory care unit. The bag was not sealed.

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

Legal Entity Representative

Michelene Giannopoulos
Signature

Michelene Giannopoulos
Executive Director.
Printed Name and Title
12/13/2019 Date

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(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented

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

Not Implemented

103g

Immediate Action: The bag of opened chips was immediately removed from the home's memory care unit

Maintenance Director performed an immediate inspection to assure all food within the home was stored in closed and/ or sealed containers

Staff was retrained on this regulation to assure compliance going forward

Unannounced inspections shall be performed within the home as well as upon daily rounds by administrator, wellness director and maintenance director

Micheline Gianacchi
Micheline Gianacchi
ADMINISTRATOR
Dec. 13, 2019

P. 13 of 24
A

12-23-19 Q

124 - Notice to Fire Department

Regulations

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

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

Legal Entity Representative

Micheline Giannacopoulos
Signature

Micheline Giannacopoulos

Executive Director

Printed Name and Title

12/13/2019 Date

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(Date)

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(Date)

Fully Implemented

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

Not Implemented

124

12/09/2019 notice to the fire department was crafted and mailed to the Moosic Fire Chief

Michelene Cianacop
Michelene Cianacop
Administrater.

Dec. 13, 2019

P. 14 of 24
A

12-23-19 (1)

125a - Combustible Storage

Regulations

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A pair of rubber gloves was located behind the dryer in the laundry room under the dryer duct, posing a possible fire 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.)

See attached

Legal Entity Representative

Michelene Gianacopoulos *Executive Director*
 Signature Printed Name and Title
 Date *12/13/19.*

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 (Date) (Date)

Fully Implemented

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

Not Implemented

125a

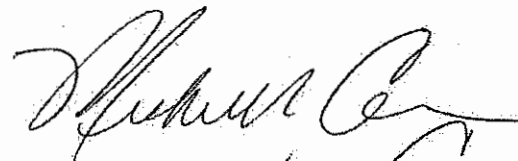
Immediate Action:

Rubber Glove was immediately removed

A daily check and cleaning are performed of the laundry room

New audit forms were initiated and now being enforced by
Maintenance Director (see attached forms)

Administrator will oversee the Maintenance Director


M. Chelene Crow
Administrator

Dec 13, 2019

p. 15A of 29

12-23-19 CP

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

The medical evaluation (D.M.E.) for resident #1 dated 6/21/19 did not include the resident's medications or special diet (if any).

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

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline GIANACOPULOS

Executive Director
Printed Name and Title

Date

12/13/2019

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(Date)

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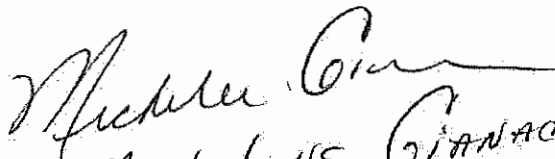
The above plan of correction was approved by *[Signature]*
(Initials)

Not Implemented

141 a-10

Immediate action: Immediately audited all DME's

1. Scheduled DME's on calendar for yearly updates
2. Retrained staff on required elements of change of condition
3. Wellness Director updates and Administrator reviews before being placed in the record
4. Q & A Monthly audits are scheduled


Michelle Ginn
ADMINISTRATOR
12/13/2019

P-16A of 24

12-2319 EQ

183a - Original Containers and Injections

Regulations

2600.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

An interview with staff member E indicated the following: if a resident has blister packs for medications and leave the facility the medication is popped out of its original container into a baggie and given to the family for administration later.

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

Legal Entity Representative

Micheline GIANACOPOLIS

Micheline Gianacopolis
Signature

Executive Director
Printed Name and Title

12/13/2019
Date

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MG
(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented

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

Not Implemented

183 a

Immediate Action:

All Med-Techs were retrained on the proper procedure when a Resident leaves the home with medications

When Resident is leaving the building all blister packs and pre-filled medication envelopes from the pharmacy will be sent with responsible party, will sign amount taken and amount returned

Wellness Director and Lead Med-Tech will audit

The Home is providing Med-Tech Training January 17, 2020 with certified Med-Tech Trainer Randall Evans

Micheline Gianacopoulos
Micheline Gianacopoulos
ADMINISTRATOR

Dec 13, 2019

p. 17 of 29
A

12-23-19 ep.

185a - Implement Storage Procedures

Regulations

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2's PRN tylenol and lotrimin cream was not available at the time of the inspection. NOT IMPLEMENTED *OP*

Resident #3's PRN hydrocortisone cream was not available at the time of the inspection. NOT IMPLEMENTED *OP*

The homes narcotic policy is to count the narcotics at the end of each shift and sign the weekly controlled inventory book. On the following days the book was not signed that the narcotic count was completed: incoming 2nd shift and outgoing 2nd shift on 10/27/19, incoming 2nd shift and outgoing 2nd shift on 11/4/19.

Repeat Violation: 11/8/18

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

Legal Entity Representative

Micheline Panopoulos

Micheline Panopoulos
Signature

Executive Director
Printed Name and Title
12/13/2019
Date

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The above plan of correction is approved as of *12-18-19*
(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented

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

Not Implemented

185a:

~~Randal Evans~~, recommended by PALA as a certified Med-Tech Trainer will provide all med-tech staff training from 8am-3:30pm on January 17, 2020 to retrain and to recertify my current med-techs

The Home is working on a contractual agreement with ~~Danville~~ Pharmacy (Current in-house pharmacy is ~~PrimeCare~~, will provide 30-day notice of change to all Residents (POA) for a seamless transition of services for a projected date of February 1, 2020

Additional Changes:

PRN Management of Medications, overnight Med-Tech staff are performing the audits and passing the information to day shift staff to re-order, Wellness Director and Administrator will oversee and review in 90 days

Controlled Substances:

11/20/2019-11/21/2019: Retrained and reinforced the narcotic count and signature requirement. Med-Tech staff are to report immediately to the Wellness Director and the Wellness Director will report to the Administrator any discrepancies. Since this training the home to this date has not had any incidents to report

Michelene Giannopoulos
Michelene Giannopoulos
Administrator
December 13, 2019

P. 18/24
AV

12-23-19 Cp

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:

6. Dose.

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 & 4's PRN ativan is listed on the MAR but is not a current order.

Resident #2's omeprazole, levothyroxine, donepezil, mirtazapine, atorvastatin, olanzapine and amonium lactate cream do not have a diagnosis or purpose listed on the MAR.

Resident #2's marobid does not include the dose.

Resident #5's prednisone and immodium do not have a diagnosis or purpose listed on the MAR.

Repeat Violation: 11/8/18

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

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos

Executive Director
Printed Name and Title

12/13/2019
Date

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(Date)

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(Date)

Fully Implemented

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

Not Implemented

187a

November 20-21, 2019 retrained staff

Med-Tech's third shift doing audit of MAR's

Since November 21, 2019 to present date no reportable errors

Certified Med-Tech Trainer ~~Randall Evans~~ will be retaining all med-techs on January 17, 2020

Michelene Giana
Michelene Giana
Administrative
Dec 13, 2019

p. 19_A of 24

12-23-19

Ⓚ

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2's ammonium lactate cream twice daily was initialed as administered on the MAR on 11/7/19 at 8am but was not administered yet.

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

Legal Entity Representative

Micheline Giannacopoulos

Micheline Giannacopoulos
Signature

Executive Director
Printed Name and Title

12/13/2019
Date

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(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented

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

Not Implemented

187b

Immediate Action: Med-Techs were retrained on proper documentation on MARs

All Med-Techs were trained on November 20-21, 2019 on proper documentation techniques, training will be repeated on January 17, 2020

Wellness Director is making periodic checks during med

Michelene GIANC...
Michelle
Administat
Dec 13, 2019.

P. 20A of 24

12-23-19 Q

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #4 has an order for metoprolol 25mg twice daily 1/2 tablet, hold for heart rate less than 60 or systolic blood pressure less than 100. On the following dates the heart rate was less then 60 and the medication was administered when it should have been held. 11/5/19 8am HR 48, 11/5/19 8pm 56. and 11/4/19 8pm HR 57.

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

Legal Entity Representative

Micheline Gianacopoulos
Signature

Micheline Gianacopoulos

Executive Director
Printed Name and Title
12/13/2019
Date

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(Date)

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(Date)

Fully Implemented

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

Not Implemented

187d

It's imperative that Following all the physicians orders for all the Residents must be performed daily

Wellness Director must ensure all the physicians orders are clearly understood by all med-techs

The Med-Techs will be trained on all new orders on all shifts as well as changes in orders

Daily training will occur based on acuity of Residents

187 d

Physician must be notified of all refusals

Internal incident report by med tech, med-techs will notify the physician and the family and the wellness director oversees

Micheline Cianaciputo
Micheline Cianaciputo
Adminstrator
Dec 19, 2019.

P. 21 of 24

12-23-19 Q

231b - Medical Evaluation

Regulations

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

The (D.M.E.) for resident #6 dated 12/16/18, did not indicate the resident's need to reside in the home's secure dementia unit.

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

Legal Entity Representative

Michdene G. Annacopoulos

Signature *Michdene G. Annacopoulos* Printed Name and Title *Executive Director* Date *12/13/2019*

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The above plan of correction is approved as of 12-18-19 (Date) Plan of correction implementation status as of 12-23-19 (Date)

Fully Implemented

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

231b

Immediate Action: Resident #6 no longer resides in the home, was in SNF then passed away

Audit of all SCDU DMEs was performed to assure residents need for secure dementia unit was established


DME will be obtained upon admission to the homes SCDU, change in condition, and annually

DMEs were scheduled on a calendar for yearly updates

Retrained staff on required elements of change of condition

Wellness Director updates and Administrator reviews before being placed in the record

Q & A monthly audits are scheduled


Michelle A. Gannon
Administrator
Dec 13, 2019
P. 231b
24.

12-23-19 QP.

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

The resident records, who reside in the home's secured dementia unit - #6, #7 & #8 did not include that the resident and the resident's designated person have not objected to the resident's admission to the secured dementia unit.

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.

Legal Entity Representative

Micheline Granapoulis

Micheline Granapoulis
Signature

Executive Director.
Printed Name and Title

12/13/2019
Date

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(Date)

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(Date)

Fully Implemented

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

Not Implemented

231 e

Resident #6 no longer resides in the home, Resident # 7 & Resident #8 POA signed no objection statement to reside in SCDU/ Pine House

Staff retrained on Nov 21, 2019 on the procedure for admission of all Residents to the Pine House (all must be treated as a brand new admission with all the required documentation completed for a new admission, including a Resident Agreement for admission to SCDU which includes the regulation of a no objection statement

Upon Admission to Pine House/ SCDU all new admission paperwork will be audited by the Administrator prior to being filed in the record

Wellness Director and Lead Med Techs will assist the process of completing the necessary documents (pre-admission screen, DME, RASP, Resident agreement with no objection statement included, physicians order with DX of Dementia)

Michèle Cianacopulos
Michèle Cianacopulos
Administrator

Dec 13, 2019

P. 23A of 24

12-23-19 *CP*

233c - Key-Locking Devices

Regulations

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The key pad, at the exterior emergency exit and from the home's secured dementia courtyard, did not include the code to gain access into the building.

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.

Legal Entity Representative

Micheline Canacopoulos
Signature

Micheline Canacopoulos

Executive Director
Printed Name and Title

12/13/2019
Date

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(Date)

Plan of correction implementation status as of *12-23-19*
(Date)

Fully Implemented

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

Not Implemented

233.c

Immediate action: Code was placed within view near the keypad to allow access to building.

Maintenance Director will inspect all keypads weekly to assure proper code is present, will update and replace as needed.

Maintenance Director will report to Administrator the results of the inspection.

Micheline Granac-paul
Micheline Granac
Administratr.

Dec 13, 2019

P. 24 of 24.

12-23-19

Violation Report

Facility Information

Name: OAKWOOD TERRACE

License Number: 22661

Address: 400 GLEASON DRIVE, MOOSIC, PA 18507

County: LACKAWANNA

Region: NORTHEAST

Administrator

Name: Micheline Gianacopoulos

Phone: 5704513171

Email: mgianacopoulos@pstgroupllc.com

Legal Entity

Name: PREMIER OAKWOOD TERRACE OPERATING LLC

Address: 245 PARK AVENUE, 39TH FLOOR, NEW YORK, NY, 10167

Certificate(s) of Occupancy

Type: C-2 LP

Date:

Issued By:

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 42

Waking Staff: 32

Inspection

Type: Partial

BHA Docket #:

Notice: Unannounced

Reason: Interim, POC Verification

Inspection Dates and Department Representative

12/23/2019 - On-Site: Ryan Yankow, Gerald Dumas

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 58

Residents Served: 35

Secured Dementia Care Unit

In Home: Yes

Area: Pine

Capacity: 13

Residents Served: 6

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 35

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 7

Have Physical Disability: 0

103g - Storing Food

Regulations

2600.

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

Description of Violation

2 clear packs of chocolate and oatmeal cookies where located in the cabinet of the homes memory care unit. The cookies were not sealed.

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.

Legal Entity Representative

Michelene Canacejar
Signature

Michelene Canacejar, J.A. Vary
Printed Name and Title

8/20/20
Date

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(Date)

Plan of correction implementation status as of *1-20-20*
(Date)

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

Implemented
 Not Implemented


p. 2 of 6

103 g: Immediate Action

The cookies were placed in a secure Ziploc plastic bag and dated. The home will always have a box of Ziploc bags in the SCDU, Pine Unit. The RA on duty will assure all snacks are securely stored and dated at change of shift.

The Wellness Director will monitor daily during morning rounds and the Charge Med-Tech will assure at change of shift ongoing compliance

Michelle Camacho
Administrator
January 8, 2020

1-13-2020 

185a - Implement Storage Procedures

Regulations

2600

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1's PRN Blistex lip ointment was not available at the time of the inspection.

Repeat Violation: 11/8/18

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.

Legal Entity Representative


Micheline Cianciopolo
Signature

Micheline Cianciopolo *January 8*
Printed Name and Title Date
2020

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(Date)

Plan of correction implementation status as of 1-13-2020
(Date)

The above plan of correction was approved by 
(Initials)

Fully Implemented
 Not Implemented

p. 3 of 6

185a: Immediate Action

The Wellness Director received order to D/C Blistex

A Review of orders and medication was conducted to assure all medications were present

Wellness Director will obtain clarification orders as needed

Third shift checks new orders and all new orders are monitored monthly for changeover

Michelle Granados
Administrator
January 8, 2020

1-13-2020 *CP*

186c - Change in Medications

Regulations

2600:

186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

Description of Violation

Direct care staff member A took a verbal order from the doctor on 12/22/19 for Resident #3's insulin coverage. Direct care staff member A is not a licensed professional able to take verbal orders in accordance with regulations of the Department of State.

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.

Legal Entity Representative

Micheline Cianacopoulos
Signature

Micheline Cianacopoulos
Printed Name and Title
Date *8/2020*

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The above plan of correction is approved as of 1-13-2020 (Date) Plan of correction implementation status as of 1-13-2020 (Date)

The above plan of correction was approved by: *[Signature]* (Initials) Implemented Not Implemented

p.4 of 6

186c: Immediate Action

Med-Techs were in-serviced that when the Wellness Director , who is a LPN, is not in the facility the directive is to ask the prescriber to fax a written order to the facility, or to call the order into the pharmacy, or to have the Wellness Director call the physician

The Wellness Director will check for accuracy

Third shift Med-Techs will audit new orders

Michelle Gianacopoli
Administrator
January 8, 2020

1-13-2020 *EP*

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:

- 5. Dose.

Description of Violation

Resident #1 has an order for coumadin take 2 4mg tablets to equal 8mgs on Monday, Thursday and Friday. The MAR notes Coumadin take 1 8mg tablet on Monday, Thursday and Friday.

Repeat Violation 11/8/19

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.)

See attached.

Legal Entity Representative

Michelle Garacopoulos
Signature

Michelle Garacopoulos
Printed Name and Title
Administrator

8
Date
2020

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(Date)

Plan of correction implementation status as of *1-13-2020*
(Date)

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

- Fully Implemented
- Not Implemented

P 5 of 6

Immediate Action:

MAR was rewritten to match the order

All Coumadin Orders on MAR's were audited and clarification orders were obtained as needed

Wellness Director will audit daily and when the Wellness Director is not in the building, the 3rd shift Med-Tech will audit

Michelle Gianopoulos
Administrator
January 8, 2020

1-13-20-20

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2's metoprolol 25mg was initialed as administered on the MAR on 12/15/19 at 8am but the medication was held due to parameters.

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.

Legal Entity Representative

Signature

Printed Name and Title

Date

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(Date)

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(Date)

- Fully Implemented
- Not Implemented

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

P 6 of 6

Immediate Action:

After investigation the Med-Tech was using the notation "MNG" for Med Not Given, all Med-Techs were in-serviced on correct method of documentation. (Initial in Box and circle, then on the back of the paper MAR, state why not given)

Med- techs were re-trained on the correct method of documentation of medications not given, as well as for refusals, or for medications held for parameters.

Michelle Gianopoulos
Administrator

January 8, 2020

1-13-2020