pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: advancedpch@gmail.com

MAILING DATE: July 28, 2020

Ms. Georgetta Stotka
Co-Owner / President
Advanced Personal Care Home, Inc.
PO Box 5, 245 Center Street
Clarksville, Pennsylvania 15322

RE: Advanced Personal Care Home
Certificate #: 440480

Dear Ms. Stotka:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 19, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jody Garvey
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
6/24/20
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *ADVANCED PERSONAL CARE HOME* **License Number:** *44048*
Address: *245 CENTER STREET, PO BOX 5, CLARKSVILLE, PA 15322*
County: *GREENE* **Region:** *WESTERN*

Administrator

Name: *Georgette Stotka* **Phone:** *7243770662* **Email:** *ADVANCEDPCH@GMAIL.COM*

Legal Entity

Name: *ADVANCED PERSONAL CARE HOME INC*
Address: *PO BOX 5, 245 CENTER STREET, CLARKSVILLE, PA, 15322*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/01/1992* **Issued By:**

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *42* **Waking Staff:** *32*

Inspection

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

Inspection Dates and Department Representative

02/19/2020 - On-Site: Thomas Smith, Courtney Barry

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *39* **Residents Served:** *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *35*
Are 60 Years of Age or Older: *23*
Diagnosed with Mental Illness: *37*
Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *5*
Have Physical Disability: *0*

18 - Compliance With Laws

Regulations

2600.

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. If the carbon monoxide alarm operates by a battery, the battery must be labeled with the date of installation and replaced at least once annually or at such time as the carbon monoxide alarm signals a drained or failing battery, whichever is sooner.

At 11:07 a.m., the batteries in the carbon monoxide detector located outside of the 1st floor common bathroom were not dated.

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.)

By 4/16/20, the battery in the carbon monoxide detector located outside of the 1st floor common bathroom was replaced with a new battery and dated. 6/10/20

On 4/10/20, direct care staff were educated that anytime they replace any batteries they are to be dated. 6/10/20

Beginning 4/16/20, all batteries will be labeled with the date of installation and replaced at least once annually the month of the fire inspection and/or at such time as a the carbon monoxide alarm signals a drained or failing battery. 6/10

Legal Entity Representative

Georgetta Stotts	Administrator Georgetta Stotts	6-24-20
Signature	Printed Name and Title	Date

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

The above plan of correction is approved as of 6/10/20 (Date)

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

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented

☐ Not Implemented

65f - Training Topics

Regulations

2600.

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

1. Medication self-administration training.

Description of Violation

Direct care staff person A, hired 10/23/16, and direct care staff person B, hired 10/14/14, did not receive training in medication self-administration during the 1/1/19-12/31/19 annual staff training year.

Repeat Violation: 1/17/19

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.)

Staff member A will received training in medication self-administration by 6/26/20. Staff person B is no longer an employee. 6/10/20

By 6/26/20, the administrator or designated staff person will review all current staff training records to ensure all staff persons have completed the required trainings in accordance with §2600.65(f). These reviews will be discussed during the next quality management plan review and evaluation after 6/26/20. Documentation will be kept. 6/10/20

By 6/26/20, all staff responsible for staff training will be educated on §2600.65(f). 6/10/20

Legal Entity Representative

Georgette Stotke — Georgette Stotke Administrator 6-24-20

Signature — Printed Name and Title — Date

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☑ Implemented

☐ Not Implemented

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:

3. Resident rights.

Description of Violation

Direct care staff person A, hired 10/23/16, and direct care staff person B, hired 10/14/14, did not received training in resident rights during the 1/1/19-12/31/19 annual staff training year.

Plan of Correction (POC)

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

Staff person A received training in resident rights on 4/13/20. Staff person B is no longer an employee. 6/10/20

By 6/26/20, the administrator or designated staff person will review all current staff training records to ensure all staff persons have completed the required trainings in accordance with §2600.65(g). These reviews will be discussed during the next quality management plan review and evaluation after 6/26/20. Documentation will be kept. 6/10/20

By 6/26/20, all staff responsible for staff training will be educated on §2600.65(g). 6/10/20

Legal Entity Representative

Georgette Stotke — Georgette Stotke Administrator — 6-24-20

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☑ Implemented

☐ Not Implemented

85b - Infestation

Regulations

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 9/24/19, resident #2 was admitted to the hospital with bilateral foot redness and maggots on her feet. There were also maggots in the resident's shoes from putting them on directly after getting out of the shower creating moisture in the shoes.

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.)

By 4/16/20 resident #2 was asked to completely dry feet before putting on shoes to prevent future hygiene issues. 6/10/20

On 4/13/20, direct care staff were educated on personal hygiene. 6/10/20

Beginning 6/26/20, the administrator or designated staff persons will conduct weekly inspections of resident bedrooms for four weeks, then monthly inspections for one year to ensure there is no evidence of infestation of insects or rodents in the home. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotke — Georgette Stotke Administrator — 6-24-20

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89b - Hot Water Temperature

Regulations

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At 11:45 a.m., the hot water temperature in the 1st floor common bathroom sink was 130.1 degrees Fahrenheit and at 2:00 p.m., it was 130 degrees Fahrenheit.

Repeat Violation: 1/17/19

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.)

By 4/16/20, the hot water temperature was adjusted not to exceed 120 degrees Fahrenheit. 6/10/20

On 4/10/20, direct care staff were educated on safe water temperatures and the risk of unsafe water temperatures to residents. 6/10/20

Beginning on 6/26/20, the administrator or designated staff person will monitor the water temperature on a weekly basis to ensure the water temperature does not exceed 120°F. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotke — Georgette Stotke Administrator — 6-24-20

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92 - Windows

Regulations

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At 11:35 a.m., the was no screen in the window of resident bedroom #4.

Repeat Violation: 1/17/19

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.)

By 6/26/20, the administrator or designated staff person will install a screen in resident #4's window. 6/10/20

By 6/26/20, all staff responsible for maintenance and repairs in the home will be educated on §2600.92. 6/10/20
Documentation will be kept.

Beginning 6/26/20, the administrator or designated staff person will check the home weekly for four weeks, then at least monthly for one year to ensure all windows, including windows in doors, are in good repair. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotka	Georgette Stotka Administrator	6-24-20
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94b - Non-Skid Surface

Regulations

2600.

94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

The non-slip surface strips on the exterior wooden wheelchair ramp outside of the kitchen were approximately 10'-12' apart and not adequately placed to prevent slipping.

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.)

By 4/16/20, non skid/slip surface strips were placed on the exterior wooden wheelchair ramp outside of the kitchen. 6/10/20

By 6/26/20, all staff responsible for maintenance and repairs in the home will be educated on §2600.94(b). Documentation will be kept. 6/10/20

Beginning 6/26/20, the administrator or designated staff person will check all interior stairs, exterior steps and ramps weekly for four weeks, then at least monthly for one year to ensure the nonskid surfaces are in place and no hazards exist. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotke — Georgette Stotke Administrator — 6-24-20

Signature | Printed Name and Title | Date

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☐ Not Implemented

101r – Bedroom - shades/drapes/window covering

Regulations

2600.

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

Description of Violation

At 11:40 a.m., the blinds covering the window in resident bedroom #6 had approximately 4 broken slats creating a 4" X 6" hole.

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.)

By 4/16/20, the blind covering the window in bedroom #6 was replaced. 6/10/20

By 6/26/20, all staff will be educated on §2600.101(r). 6/10/20

Beginning 6/26/20, the administrator or designated staff person will check the home weekly for four weeks, then at least monthly for one year to ensure that any drapes, shades, curtains, blinds or shutters on bedrooms windows will be clean and in good repair, provide privacy and cover the entire window when drawn. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotka — Georgette Stotka — 6-24-20

Signature — Printed Name and Title — Date

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☑ Implemented

☐ Not Implemented

102i - Soap Dispenser

Regulations

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled bar of soap in the second floor common bathroom.

Repeat Violation: 1/17/19

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.)

By 6/26/20, the bar of soap in the second floor common bathroom will be disposed of. 6/10/20

By 6/26/20, all staff will be educated on §2600.102(i). 6/10/20

Beginning 6/26/20, the administrator or designated staff person will conduct weekly checks of each bathroom to ensure that a dispenser with soap is present and there are no unlabeled bars of soap. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotka — Georgette Stotka Administrator — 6-24-20

Signature — Printed Name and Title — Date

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☑ Implemented

☐ Not Implemented

121a - Unobstructed Egress

Regulations

2600.

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

Description of Violation

At 11:25 a.m., there was an approximately 12" X 12" crate and several other resident belongings blocking the egress route to the 2nd floor emergency exit door in resident bedroom #1. The emergency exit door was also unable to be opened with considerable force.

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.)

By 4/16/20, direct care staff removed all resident personal belongings from obstructing the 2nd floor emergency exit in bedroom #1, the door was fixed and residents were educated on the fire safety risks caused by obstructing doors. 6/10/20

On 4/10/20, direct care staff were educated on fire safety including unobstructed egresses in accordance with §2600.121(a). 6/10/20

Beginning 6/26/20, the administrator or designated staff person will conduct a weekly check of the home for four weeks, then at least monthly for one year to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. 6/10/20

Legal Entity Representative

Signature	Printed Name and Title	Date
Georgette Stotka	Georgette Stotka Administrator	6-24-20

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Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented
☐ Not Implemented

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

At 10:55 a.m., there was a can of Oatey Flowguard Gold CPVP Cement with a label indicating "highly flammable," located in the furnace room on top of a water heater.

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.)

By 4/16/20 the can of CPVP cement was removed from on top of the water heater in the furnace room. 6/10/20

On 4/10/20, direct care staff were educated on fire safety including combustible and flammable materials storage in accordance with §2600.125(a). 6/10/20

Beginning 6/26/20, the administrator or designated staff person will check the home weekly for four weeks, then at least monthly for one year to ensure combustible or flammable materials are not near heat sources. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgetta Stotka Georgetta Stotka 6-24-20
Signature Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented
☐ Not Implemented

131f - Fire Extinguisher Inspection

Regulations

2600.

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

Description of Violation

At 11:20 a.m., the kitchen fire extinguisher did not have a current inspection tag on it and the pin for the extinguisher had been removed.

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.)

By 4/16/20, the fire extinguisher was removed and replaced and all fire extinguishers were checked that pins were in place and tags were up to date. 6/10/20

By 6/26/20, all staff will be educated on §2600.131(f). 6/10/20

Beginning 6/26/20, the administrator or designated staff person will check the home weekly for four weeks, then at least monthly for one year to ensure all fire extinguishers have a current inspection tag and the pin is in place. Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotka — Georgette Stotka Administrator 6-24-20

Signature — Printed Name and Title — Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented

☐ Not Implemented

132b - Safety Inspection/Fire Drill

Regulations

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The homes most recent fire safety inspection and fire drill completed by a fire safety expert was completed on 4/16/19; however, the previous fire safety inspection and drill completed by a fire safety expert was completed on 2/21/18.

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.)

On 4/10/20, direct care staff were educated on fire safety by the administrator. The fire safety expert will conduct the annual fire safety training within 60 days of the date the Disaster Proclamation is lifted. 6/10/20

By 6/26/20, the administrator or designated staff person will develop and implement a process and procedure to ensure a fire drill is conducted by a fire safety expert annually. 6/10/20

By 6/26/20, all staff responsible for planning and coordinating the annual fire safety inspection and fire drill will be educated on §2600.132(b). Documentation will be kept. 6/10/20

Legal Entity Representative

Georgette Stotka Georgette Stotka Administrator 6-24-20

Signature | Printed Name and Title | Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented

☐ Not Implemented

141a 1-10 Medical Evaluation Information

Regulations

2600.

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

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

Description of Violation

Resident #1 was admitted on 6/28/19; however, the resident's initial medical evaluation form indicated 10/25/19 for the date the resident was evaluated.

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.)

By 6/26/20, the administrator or designated staff person will review medical evaluations for all newly admitted residents to ensure all new residents have an in-person medical evaluation completed within 60 days prior to admission or within 30 days after admission. 6/10/20

By 6/26/20, a new resident document tracking system will be developed and implemented to ensure compliance with §2600.141(a). 6/10/20

By 6/26/20, all staff persons involved with resident admissions will be educated regarding the tracking system. Documentation of training will be kept. 6/10/20

Legal Entity Representative

Georgette Stotka — Georgette Stotka — 6-24-20

Signature — Printed Name and Title — Date

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 6/10/20 (Date)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

144d - Smoking Outside

Regulations

2600.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

At 10:40 a.m., there were multiple cigarette butts and cigarette butt receptacles containing smoking cigarette butts located on the back porch of the home, which is not the home's designated smoking area.

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.)

By 4/16/20, the portable receptacles were removed from the personal care home, only the stationary cigarette receptacles remain in the designated smoking area and residents were reminded of the designated smoking areas and the home's policy for not smoking outside of the designated areas. 6/10/20

By 4/16/20, all staff were re-educated on the homes smoking area and safety rules. 6/10/20

Beginning 6/26/20, the administrator or designated staff person will conducted weekly checks of the smoking area and grounds for four weeks, then monthly for one year to ensure that the smoking policy and procedures are being followed. 6/10/20

Legal Entity Representative

Georgette Stotke — Georgette Stotke — 6-24-20
Signature — Printed Name and Title — Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented
☐ Not Implemented

224a - Preadmission Screen Form

Regulations

2600.

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

Description of Violation

Resident #1's preadmission screening form, dated 12/10/19, did not include a determination that the needs of the resident could be met by the services provided by the home.

Resident #3's preadmission screening form, dated 6/20/19, did not include a determination that the needs of the resident could be met by the services provided by the home.

Repeat Violation: 1/17/19

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.)

By 6/26/20, resident #1 and #3's preadmission screening forms will be updated to include a determination of whether the needs of the residents can be met by the services provided by the home. 6/10/20

By 6/26/20, all staff responsible for resident admissions will be educated on §2600.224(a). 6/10/20

Beginning 6/26/20, the administrator or designated staff person will review all preadmission screening forms for all newly admitted residents monthly to ensure the form is completed in accordance with §2600.224(a). 6/10/20

Legal Entity Representative

(cms)

Georgette Stotter — Georgette Stotter — 6-24-20

Signature — Printed Name and Title — Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented

☐ Not Implemented

225a - Assessment 15 Days

Regulations

2600.

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

Description of Violation

Resident #1 was admitted 12/12/19; however, the resident's initial assessment was not completed until 1/8/20.

Plan of Correction (POC)

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

By 6/26/20, the administrator or designated staff person will review resident assessments for all residents to ensure that assessments were completed timely. 6/10/20

By 6/26/20, all staff persons involved with the completion of assessments will be educated on §2600.225(a). Documentation will be kept. 6/10/20

Beginning 6/26/20, the administrator or designated staff person will review resident assessments for all newly admitted residents monthly to ensure the assessment was completed in accordance with 2600.225(a). 6/10/20

Legal Entity Representative

Georgette Stotka Georgette Stotka 6-24-20

Signature Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/22/20 (Date)

☑ Implemented

☐ Not Implemented