pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: karhav@yahoo.com

MAILING DATE: July 9, 2020

Ms. Karen Haverilla
Administrator
Haverilla Personal Care Home, Inc.
775 Stonetown Road
Rossiter, Pennsylvania 15772

RE: Haverilla Personal Care Home
Certificate #: 427930

Dear Ms. Haverilla:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 6, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jason Williams
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *HAVERILLA PERSONAL CARE HOME* **License Number:** *42793*
Address: *775 STONETOWN ROAD, ROSSITER, PA 15772*
County: *INDIANA* **Region:** *WESTERN*

Administrator

Name: *Kelli Haverilla* **Phone:** *8149383399* **Email:** *KARHAV@YAHOO.COM*

Legal Entity

Name: *HAVERILLA PERSONAL CARE HOME INC*
Address: *775 STONETOWN ROAD, ROSSITER, PA, 15772*

Certificate(s) of Occupancy

Type: *Other* **Date:** *07/28/1977* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *48* **Waking Staff:** *36*

Inspection

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

Inspection Dates and Department Representative

03/06/2020 - On-Site: Belinda Graziano, Tom Smith

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served:** *24*

Secured Dementia Care Unit

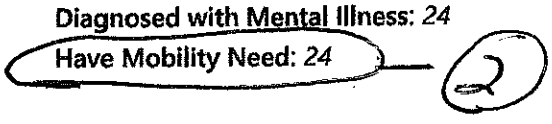
In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *21*
Diagnosed with Mental Illness: *24*
Have Mobility Need: *24*
Are 60 Years of Age or Older: *14*
Diagnosed with Intellectual Disability: *1*
Have Physical Disability: *0*



17 - Record Confidentiality

MAY 0 1 2020

Regulations

2600.

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

Description of Violation

At approximately 9:00 a.m., multiple documents with resident information were unlocked, unattended, and accessible on the bulletin board near the emergency exit in the back storage room to include:

Resident #1's outpatient referral with date of birth and diagnoses

Resident #2's outpatient orders with date of birth and medical tests ordered

Plan of Correction (POC)

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

Resident #1's referral and resident # 2's orders were removed from the bulletin board in the staff room immediately during the inspection on 3-6-20 by the administrator (Kelli). The papers were put into a new folder and placed in the locked file cabinet. This was to correct the violation.
In order to prevent this violation in the future, the new folder has been labeled "lab orders, Dr appointments, etc" and is being kept inside the locked med cart where it will be reviewed each weekday morning by Kelli for upcoming appointments, etc.
Picture Included

Legal Entity Representative

Karen Haverilla — Signature

Karen Haverilla, administrator — Printed Name and Title

4/20/20 — Date

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

The above plan of correction is approved as of 7/2/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

18 - Compliance With Laws

Regulations

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Care Facility Carbon Monoxide Alarms Standards Act of June 23, 2016 requires that a carbon monoxide detector be installed in close proximity of, but not less than 15 feet from any fossil fuel-burning device or appliance. The home did not have a carbon monoxide detector installed for the laundry room's natural gas hot water tank. In addition, the carbon monoxide detector was approximately 6 feet from the wall mounted natural gas heater in the bedroom #1 in building 45. Also, the carbon monoxide detector was approximately 8 feet from the wall mounted natural gas heater in bedroom #2 in building 45.

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.)

A carbon monoxide detector was installed in the laundry room on 3-7-20 at a distance of 15 feet from the natural gas hot water tank. On the same date, the carbon monoxide detector in bedroom 1 building 45 was moved to a distance of 15 feet from the wall mounted natural gas heater. And likewise, in bedroom 2 building 45, the carbon monoxide detector was moved to 15 feet from the wall mounted natural gas heater. This was completed by the owner to correct these violations.
In order to prevent this violation in the future, the administrators together reviewed the "Care Facility Carbon Monoxide Alarms Standards Act - Enactment Act of June 23, 2016". We are aware of it's requirements for any future needs.
Pictures Included

Legal Entity Representative

Karen Haverilla
Signature

Karen Haverilla, administrator
Printed Name and Title

4/20/20
Date

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☑ Implemented
☐ Not Implemented

65i - Training Record

Regulations

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff interviews indicate that annual fire safety training was completed for staff persons A, B, and C on 3/1/2019; however, the home record of direct care staff training does not include documentation of this training.

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.)

Upon reviewing this on 3/7/20/ by administrators (Kelli and Karen), we discovered that the training, Fire Safety, was mis titled as Emergency Medical Plan. To correct this violation we made a new, correct sign in sheet and had the staff that attended sign. It is enclosed along with the incorrect sheet. Also enclosed is the paper from Fire Chief, Shelley Pisano that was with the fire drill records, to show she was there and participated in the training as well.
To prevent this violation in the future, I will be sure to review all training materials each month after the training date to be sure it was completed and properly recorded and documented.

Legal Entity Representative

Karen Haverilla — Signature

Karen Haverilla, administrator — Printed Name and Title

4/20/20 — Date

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☐ Not Implemented

84 - Heat Sources

Regulations

2600.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from comin in contact with the heat source.

Description of Violation

There was no protective guard to prevent residents from coming in contact with the open flame natural gas wall heater in the storage room in the back of the kitchen. The heater had an approximate 10-inch by 2-inch opening exposing a flame and was located in the direct path of an emergency exit from the home.

Plan of Correction (POC)

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

On 3/11/20 a maintenance man was hired to install a more protective guard over the wall mounted natural gas heater in the staff room off of the kitchen to correct this violation.
To prevent this violation in the future, if a wall mounted gas heater needs to be installed or replaced, a protective guard will be added at that time.
Picture Included

Legal Entity Representative

Karen Haverilla

Signature

Karen Haverilla, administrator

Printed Name and Title

4/20/20

Date

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Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 11:20 a.m., there were approximately 20 cigar and cigarette butts in the gravel driveway in front of the side porch of the home.

Repeat Violation: 3/12/2019

Plan of Correction (POC)

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

The cigar and cigarette butts in the gravel driveway in front of the side porch of the home were immediately cleaned up during the inspection on 3/6/20 by staff to correct this violation. All residents who smoke were reminded by owner of our smoking policy which states that our only designated smoking area is on the covered cement patio off the rec room.
To prevent this violation of butts, all staff has been instructed, by owner, to watch out for any resident disobeying this policy and to direct them to the designated area to smoke. Also, another larger No Smoking sign has been hung on the side entrance for a reminder.
Policy Included
Picture Included

Legal Entity Representative

Karen Haverilla

Signature

Karen Haverilla, administrator — Printed Name and Title

4/20/20 — Date

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☐ Not Implemented

86b - Bathroom

Regulations

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The common bathroom located between the dining room and foyer of the home does not have an operable ventilation fan or an operable outside window.

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 3/11/20 the maintenance man also installed a new ventilation fan in the bathroom located between the dining room and the foyer to correct this violation.
To prevent this violation, the owner has made sure all bathrooms are in compliance with this regulation, and will be sure that existing fans remain in good working order in the future.
Pictures Included

Legal Entity Representative

Karen Haverilla

Signature

Karen Haverilla, administrator — Printed Name and Title

4/20/20 — Date

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☑ Implemented
☐ Not Implemented

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

A section of the concrete floor in the foyer measuring approximately 1 inch by 2 feet was uneven with the rest of the floor posing a tripping hazard.

Repeat Violation: 3/12/2019

Plan of Correction (POC)

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

The uneven section of the concrete floor in the foyer was patched and evened out with cement on 3/7/20 by owner to correct this violation.
To prevent a repeat violation, the owner has committed to a bi annual inspection of the floors, walls, ceiling, windows, doors, and other to be sure they are up to standard. This will be done in March and September and a chart will be kept in his fire drill folder as a reminder.
Pictures Included

Legal Entity Representative

Signature Karen Haverilla

Karen Haverilla , administrator — Printed Name and Title

4/21/20 — Date

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Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

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

There were no screens in either operable window in bedroom #5.

Plan of Correction (POC)

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

To correct this violation, the window screens were retrieved from storage and put back into the windows on 4/1/20 by staff .
Staff has been instructed by administrator to keep the screens in the windows year round to prevent this violation from recurring.
Pictures Included

Legal Entity Representative

Karen Haverilla — Signature

Karen Haverilla, administrator — Printed Name and Title

4/21/20 — Date

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Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

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

Resident #3 does not have an operable bedside lamp.

Resident #4 does not have an operable bedside lamp. The lamp was approximately 5 and 1/2 feet away and could not be accessed from the bed.

Repeat Violation: 3/12/2019

Plan of Correction (POC)

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

Resident #3's bedside lamp was replaced by owner immediately during inspection on 3/6/20 to correct this violation. Resident #4's lamp remains on the table that was not easily accessible to him, but a stick on type light was placed by his bed side on 3/6/20/, by owner, to correct this violation. daily JW 7/2/20
To prevent this violation in the future, staff has been instructed by administrator to add lamp checks during room cleaning to be sure they are all in operable condition and near bedside.
Pictures Included

Staff were educated on this regulation and the schedule of checks on 6/22/20. JW 7/2/20

Legal Entity Representative

Karen Haverilla
Signature

Karen Haverilla, administrator — Printed Name and Title
4/21/20 — Date

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

☑ Implemented
☐ Not Implemented

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

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Resident #5's most recent annual medical evaluation was completed on 10/25/2018.

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.)

The Monday following inspection, 3/10/20, while going through the folders and other papers to reorganize, resident #5's current medical evaluation, dated 8/21/19, was found by administrator, who knew it had to have been completed for his income. This corrected this violation as it was somehow overlooked.
To prevent this violation, administrators will try to keep more organized during inspections.
Copy Included

Legal Entity Representative

Karen Haverilla — Signature

Karen Haverilla, administrator — Printed Name and Title

4/21/20 — Date

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Plan of correction implementation status as of 7/2/20 (Date)

- [x] Implemented
- [ ] Not Implemented

144c1 - Smoking Area Guidelines

Regulations

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home permits smoking on the side porch; however, there was no receptacle in this 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.)

Actually, smoking is not permitted on the side porch, as noted on page 6, violation to regulation 85a, sanitary conditions. Residents had been smoking there, without permission, through the winter. The POC on page 6 addresses this violation also. All residents who smoke were reminded, by owner, of our smoking policy which states our only designated smoking area is the covered cement patio off the rec room. All staff has been instructed by the owner to watch for any resident disobeying this policy and direct them to the designated area to smoke, which has receptacles. Also a new, larger No Smoking sign has been hung on side porch to remind residents of the policy. Policy and picture included with page 6.

Legal Entity Representative

Karen Haverilla — Signature

Karen Haverilla, administrator — Printed Name and Title

4/21/20 — Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

183b - Meds and Syringes Locked

Regulations

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At approximately 9:00 a.m., a bottle of Cyanocobalamin 1000 mcg for resident #6 was unlocked, unattended, and accessible on the mantle in the kitchen.

Repeat Violation: 3/12/2019

Plan of Correction (POC)

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

The bottle of Cyanocobalamin 1000 mcg for resident #6 was immediately removed from the mantle and placed into the locked med cart during inspection, by administrator, to correct this violation.
To prevent this violation, when a refill order needs called in, the info will be written down, called in, then destroyed. The empty, or near empty, bottle will remain in the locked cart until the new arrives, then discarded.

Staff received education on this regulation and frequency of checks on 6/22/20. JW 7/2/20

Legal Entity Representative

Kara Haverilla
Signature

Karen Haverilla, administrator
Printed Name and Title

4/21/20
Date

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Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

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 #7's glucometer was not calibrated to the correct time. At 3:50 p.m., the glucometer indicated 8:42 p.m.

In addition, on multiple dates and times, resident #7's glucometer reading did not match the resident's March 2020 medication administration record (MAR) as follows:

3/1/2020 at 8:00 a.m., glucometer reading was 143, MAR indicated 134

3/1/2020 at 12:00 p.m., glucometer reading was 332, MAR indicated 322

3/2/2020 at 8:00 a.m., glucometer reading was 110, MAR indicated 111

3/2/2020 at 5:00p.m., no reading on glucometer, MAR indicated 150

3/4/2020 at 12:00 p.m., glucometer reading was 238, MAR indicated 249

3/4/2020 at 5:00p.m., no reading on glucometer, MAR indicated 200

3/6/2020 at 8:00 a.m., glucometer reading was 230, MAR indicated 239

3/6/2020 at 5:00 p.m., glucometer reading was 427, MAR indicated 424

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.)

Residents #7's glucometer was reset to the correct time on 3/9/20 by a visiting nurse to correct the violation. All incidents above involved 2 staff, who were questioned about this by administrators.Together we tried to determine reasons, including the nearly 5 hour time discrepancy and that the resident, at times, refuses his tests and/ or insulin. To prevent this violation, I reviewed proper procedures with all staff on 3/10/20. All readings will be checked weekly, on Fridays, by administrator.

Legal Entity Representative

Karen Haverilla
Signature

Karen Haverilla, administrator
Printed Name and Title

4//22/20
Date

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Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

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 #8 is prescribed Almacone-2 Liquid, give 30 ML 30 minutes after eating; however, on the following dates and times the resident refused the medication:

3/1/2020 at 8 a.m., 12 p.m., 5 p.m., 8 p.m.

3/2/2020 at 8 a.m., 12 p.m., 5 p.m., 8 p.m.

3/3/2020 at 8 a.m., 12 p.m., 5 p.m., 8 p.m.

3/4/2020 at 8 a.m., 12 p.m., 5 p.m., 8 p.m.

3/5/2020 at 8 a.m., 12 p.m., 5 p.m., 8 p.m.

3/6/2020 at 8 a.m., 12 p.m.

The refusals were not reported to the prescriber.

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.)

The prescriber was called immediately on 3/6/20, during the inspection, by administrator who left a message with the receptionist for the doctor concerning resident #8's refusal of Almacone 2 Liquid. The doctor sent a note with instructions on refusals, saying the home should document refusals daily on the MAR and then let him know when he does his monthly rounds. He also discontinued resident #8's Almacone Liquid on 3/30/20. To prevent a similar violation in the future, any refusal will be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber.
Copies Included

Legal Entity Representative

Karen Haverilla

Signature

Karen Haverilla, administrator — Printed Name and Title

4/22/20 — Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented

☐ Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #7 is prescribed Admelog Solostar 100 unit, inject subcutaneously per daily: 140-180 = 1 unit; 181-200 = 2 units; 201-240= 3 units; 241-280= 4 units; 281-320= 6 units; 321-360= 8 units; 351-400 = 10 units; 400-450 = 12 units; >451 = 14 units call MD.

However, on 3/1/2020, at 8:00 a.m., resident #7's glucometer reading was 143 and should have received 1 unit, but was administered no units.

Also, on 3/4/2020, at 12:00 p.m., resident #7's glucometer reading was 238 and should have received 3 units, but was administered 4 units.

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.)

This violation relates back to page 14, 185a. The dosages given were correct for the readings recorded in the MAR, but did not match the reading shown on the glucometer. Again, we were unable, with total certainty, to know why. To prevent a similar violation, actions taken on the former violation (185a, pg14 of this report) will be used. This includes a review of proper procedures from testing to documentation to determining dosage, with all staff on 3/10/20 by administrator/ med trainer. The MAR will be checked for correct dosage and matching readings with the glucometer to ensure correct dosage weekly, on Fridays, by administrator.
Copy of training is with page 14.

Legal Entity Representative

Signature

Karen Haverilla, administrator
Printed Name and Title

4/22/20
Date

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The above plan of correction was approved by (initials)

Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #5's current assessment was completed on 12/30/2019. However, the resident's previous assessment was completed on 1/2/2018.

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.)

After looking through Resident #5's folder throughly on 3/10/20 by administrators, it is determined that the assessment that was due by 1/2/19 was somehow not completed.
To prevent this or a similar violation in the future, the administrator has developed a checklist to be dated when a required form is completed. It will be used for all resident and will ensure annual assessments, as well as other other required forms, are completed when due.
Copy of checklist form included

See page 17a of 17

Legal Entity Representative

Karen Haverilla — Signature

Karen Haverilla, administrator — Printed Name and Title

4/22/20 — Date

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Plan of correction implementation status as of 7/2/20 (Date)

☑ Implemented
☐ Not Implemented

Addition to page 17. Regulation 225(c)

All Resident Assessments will be checked on a monthly basis to make sure they are all current as well as accurate. This monthly check up will be completed by Kelli Haverilla or by her assignee.