pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: jwiney@nippenosevalleyvillage.com
MAILING DATE: June 12, 2020

Mr. Chris A. Lorson
Owner
Nippenose Valley Village, Inc.
7190 South Route 44 Highway
Williamsport, Pennsylvania 17701

RE: Nippenose Valley Village
License #: 226700

Dear Mr. Lorson;

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 12, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *NIPPENOSE VALLEY VILLAGE* License Number: *22670*
Address: *7190 SOUTH STATE ROUTE 44 HWY,, WILLIAMSPORT, PA 17701*
County: *LYCOMING* Region: *NORTHEAST*

Administrator

Name: *Jasmyn Winey* Phone: *5707452400* Email: *JWINEY@NIPPENOSEVALLEYVILLAGE.COM*

Legal Entity

Name: *NIPPENOSE VALLEY VILLAGE INC*
Address: *7190 SOUTH STATE ROUTE 44 HWY, WILLIAMSPORT, PA, 17701*

Certificate(s) of Occupancy

Type: *I-1* Date: *10/16/2015* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *41* Waking Staff: *31*

Inspection

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

Inspection Dates and Department Representative

03/12/2020 - On-Site: Ryan Yankowy, Amy Deluca

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *59* Residents Served: *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *32*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *9*
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 home did not have a carbon monoxide monitor installed 15 feet away from the gas fired kitchen stove located in the home's kitchen as required by The Care Facility Carbon Monoxide Standards Act.

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.)

As the home has passed our opening and previous licensing inspections, we were unaware that we were in violationof this regulation and The Care Facility Carbon Monoxide Standards Act.

After the licensing inspection where this was brought to our attention, the Administrator reviewed The Care Facility Carbon Monoxide Standards Act and had the Maintenance Director order a battery powered Carbon Monoxide Alarm from a local hardware store where we have an account.

The Maintenance Director measured out and installed the Carbon Monoxide Alarm 15 feet away from the gas fired stove in our kitchen. A picture has been provided as proof of this installation.

The Maintenance Director will replace the battery and test the alarms every year in January, when he replaces the other Carbon Monoxide Detecor batteries and tests the alarms that are located in the facility. He will record this on the same log as the other CO2 dectectors. The Administrator reviews the logs every February to ensure compliance.

If the Maintenance Director ever finds that this alarm is not in working condition, it will be replaced immediately.

Legal Entity Representative

Signature | Jasmyn Winey, Administrator 4/27/20 (Printed Name and Title / Date)

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

The above plan of correction is approved as of 4-28-2020 (Date)

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

Plan of correction implementation status as of 4-28-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

29a SOPb1- Hospice Care: Doctor Certification

Regulations

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

Resident #1, who receives hospice care due to being in an actively dying status, was not evacuated during the fire drill conducted on 2/28/20 at 10:41. The home did not have written certification from a physician stating the information required in this regulation. Instead, the written document was signed by a registered nurse.

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 home acknowledges that it misunderstood the regulations and thought the written documentation needed to be from the hospice company in general.

Immediately after our inspection, the Administrator requested this documentation from the doctor associated with the hospice company. Unfortunately, the home did not receive this documentation back before the resident passed away. A fire drill was not held in March prior to the resident passing away.

The Administrator clarified these regulations with all of the hospice agencies that it currently works with, and will provide a copy of these regulations for any new hospice agencies.

Going forward, should the home support a resident on hospice who is determined to be actively dying the Administrator will obtain this documentation from the hospice company's physician immediately, or work with the hospice agency to find appropriate placement for the individual, as the home will not evacuate an individual who actively dying during a fire drill.

Legal Entity Representative

Signature

Jasmyn Winey, Administrator — Printed Name and Title

4/27/20 — Date

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

The above plan of correction is approved as of 4-28-2020 (Date)

Plan of correction implementation status as of 4-28-2020 (Date)

● Implemented
☐ Not Implemented

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

29a SOPb10 - Hospice Care: Resident Assessment and Support Plan

Regulations

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

10. The resident's assessment and support plan are to be kept current and specify the requirements of this section as it relates to the specific resident.

Description of Violation

Resident #1 is in an actively dying state. The home simulated an emergency evacuation during the fire drill conducted on 2/28/20 rather than evacuate the resident. The home did not include this information on the resident's most recent RASP dated 2/3/20.

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.)

The home understands the importance of this regulation, however they were unaware that this specific information needed to be included in the resident's RASP, as the individual's RASP indicated that the individual was on Hospice. Staff had also been notified that the resident was determined by the Hospice Agencey to be actively dying and should not be evacuated during a drill and trained on how to simulate an evacuation for Resident #1. As we did not have the proper documentation, which was found during the licensing inspection, and because the resident passed away before we were able to obtain proper documentation, we did not update the RASP.

Going forward any changes in a resident, including changes after a hospice admission, will be included on the RASPS.

Legal Entity Representative

Signature	Printed Name and Title	Date
[signature]	Jasmyn Wiley, Administrator	4/27/20

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

The above plan of correction is approved as of 4-28-2020 (Date)

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

Plan of correction implementation status as of 4-28-2020 (Date)

● Implemented

☐ Not Implemented

29a SOPb11 - Hospice Care: Records

Regulations

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

11. Documentation of compliance with this section is to be kept in the fire drill record, as well as in the resident's record. The documentation is to include the following:
    i. A copy of the Department of Health license for the hospice agency.
    ii. Written certification by the physician as specified in paragraph (1).
    iii. Written informed consent as specified in paragraph (2).

Description of Violation

Resident #1 was not evacuated during the fire drill conducted 2/28/20. The home implemented procedures to simulate an evacuation of the resident due to the resident's active dying status. The home did not have the physician's certification form, the family's consent, or the hospice agency's license stored with the fire drill documents as required.

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 home acknowledges that this regulation was overlooked and the copies of this documentation werenot stored along with the fire drill documents.

Immediately after the licensing inspection, the Administrator included the family's consent, and the hospice agency's license in with the fire drill records and tried to obtain the physician's certification, as we only had one from a nurse. The resident passed away prior to receiving this documentation and prior to the next fire drill.

Going forward should the home support anyone on hospice who is actively dying, the Administrator will store copies of this documentation along with the fire drill documents.

Legal Entity Representative

Signature

Jasmyn Wiley, Administrator — Printed Name and Title

4/27/20 — Date

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

The above plan of correction is approved as of 4-28-2020 (Date)

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

Plan of correction implementation status as of 4-28-2020 (Date)

- [x] 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.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Ancillary staff member A hired 12/9/16 did not receive training in resident rights, The Older Adults Protective Services Act and falls and accident prevention in 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 home understands this regulation and schedules regular trainings for all staff members. After the licensing inspection the Administrator reviewed records as to why the ancillary staff person did not receive their annual training and she discovered that the staff person had been out on medical leave in December when this annual training occured.

The Administrator conducted this training with the ancillary employee the following week. Documentation of this training is provided.

Going forward, the Administrator will review training records on the first Monday of every month to ensure that staff have not missed any training.

Legal Entity Representative

Signature

Josmyn Wiley, Administrator 4/27/20

Printed Name and Title Date

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

The above plan of correction is approved as of 4-28-2020 (Date)

Plan of correction implementation status as of 4-28-2020 (Date)

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

● Implemented

☐ Not Implemented

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

There were no required emergency numbers posted on or near the phone that was in resident room #47.

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 home understands this licensing regulation. We have laminated Emergency Telephone cards that we post at every phone in every room.

After the licensing inspection, the Administrator took in a new card of Emergency Telephone Numbers to post by the residents phone and found the one that had been posted on the Residents phone table mixed in with her mail which is on a file on the table.

The Administrator explained to the resident the importance of keeping this card posted by her phone.

The Administrator will conduct monthly room checks during her monthly chats with the residents to make sure this documentation is posted by every resident's phone. If this documentation is missing it will be replaced immediately.

Legal Entity Representative

Signature

Jasmyn Wiley, Administrator — Printed Name and Title

4/27/20 — Date

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

The above plan of correction is approved as of 4-28-2020 (Date)

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

Plan of correction implementation status as of 4-28-2020 (Date)

● Implemented

☐ Not Implemented

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 homes notice to the fire department does not indicate the total capacity of the home. The letter also notes the home serves 7 residents with mobility needs however the home currently has 9 residents that require assistance in the event of 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.)

The home acknowledges the discrepancy in it's letter to the fire department and upon investigation found that it had failed to update the fire department of two residents who had recently declined. The home had been updating the fire department each time they had a new admission or a resident had a change in status that would affect evacuations.

During the licensing inspection, the inspector explained to the Administrator how to write a letter to the fire department indicating our license capacity and the types of residents we serve so that we do not have to update them every time we have a new admission or a resident's evacuation ability and status change. The Administrator sent this letter to the fire department the following week. A copy of the letter is attached.

The Administrator will send an updated letter to the fire department yearly.

Legal Entity Representative

Signature | Jasmyn Wiley Administrator | 4/27/20

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 4-28-2020 (Date)

Plan of correction implementation status as of 4-28-2020 (Date)

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

● Implemented
☐ Not Implemented

132c - Fire Drill Records

Regulations

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

A fire drill was conducted on 2/28/20 in which resident #1 was not evacuated due to being in an active dying status. The home did not record this information on the fire drill log

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 home understands this regulation and completes the fire drill log as indicated above. As the home had simulated this evacuation, the Administrator did not realize that she had to indicate on the log that the individual was not evacuated.

Going forward, should the home service an individual on hospice who has been determined to be actively dying and they have proper documentation to not evacuate them in a drill, this information will be documented on the fire drill log by the Administrator.

Legal Entity Representative

Signature | Jasmyn Wiley, Administrator | 4/27/20
Printed Name and Title | Date

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

The above plan of correction is approved as of 4-28-2020 (Date)

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

Plan of correction implementation status as of 4-28-2020 (Date)

● Implemented
☐ Not Implemented

132g - Fire Drills Days/Times

Regulations

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills conducted from 3/19 - 11/19 have all been conducted at the end or near the end of the month.

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 home would like to contest this violation. The home does it's best to hold the drills on different days of the week and different times. Occasionally, other tasks and emergencies prevent that from happening.

The home feels that "at or near the end of the month" is a subjective statement as you do not want to have overlapping fire drills. Upon reviewing the logs the Administrator believes the different days of the week, different dates, and different times should be sufficient for this regulation.The fire drill log is attached.

This regulation is withdrawn with a serious word of caution. The best preparation for a fire is practice for the unexpected. If staff and residents expect or believe a fire drill is likely at the end of the month, the home is undermining the best opportunity for surprise and "expect the unexpected". The more variety and break in routine the home can introduce into fire drills, the more likely residents and staff are to successfully survive a true emergency. 4-28-2020 ag

WITHDRAWN

Legal Entity Representative

Signature | Jasmyn Wiley, Administrator (Printed Name and Title) | 4/27/20 (Date)

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

The above plan of correction is approved as of _____ (Date)

Plan of correction implementation status as of _____ (Date)

☐ Implemented
☐ Not Implemented

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

WITHDRAWN

184b - Resident's Meds Labeled

Regulations

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #2's Vitamin E did not have the residents name on the bottle.

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 home acknowledges this medication error. The bottle had just come in and the Medication Technician on duty aknowledged the error when discussed.

After the licensing inspection, all OTCs and CAMs were reviewed in the medication carts and no other errors were found.

The Administrator and Director of Nursing met with all of the medication technicians to review this violation. During this meeting it was discussed that at the beginning of all shifts, Medication Technicians should check all OTCs and CAMS to make sure the proper documentation is listed.

The Director of Nursing will review the cart every Monday afternoon and the Administrator will review the cart on the first Tuesday of every month.

Legal Entity Representative

Signature | Jasmyn Wacey, Administrator | 4/27/20
Printed Name and Title | Date

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

The above plan of correction is approved as of 4-28-2020 (Date)

Plan of correction implementation status as of 4-28-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

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 #3 was admitted to the home on 7/15/2019. The pre-admission screening form was completed on 4/11/19, more than 30 days prior to admission.

Plan of Correction (POC)

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

The home aknowledged this oversight in paperwork. The resident was initially scheduled to move to the home in April, but decided to delay her admission due to personal reasons. This is not a normal circumstance for us.

Due to this oversight, the Administrator has implemented a new policy for the Admissions department that all preadmission screenings must be conducted no more than one week prior to the scheduled move in of the home. If a resident's admission becomes delayed, a new pre-admission screening must be completed.

Legal Entity Representative

Signature | Jasmyn Wiley, Administrator (Printed Name and Title) | 4/27/20 (Date)

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

The above plan of correction is approved as of 4-28-2020 (Date)

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

Plan of correction implementation status as of 4-28-2020 (Date)

- [x] Implemented
- [ ] Not Implemented