



pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: bmcquaide@integracare.com

MAILING DATE: May 4, 2020

Ms. Loriann Putzier
President/CEO
Tithonus Mt. Lebanon LP
C/O Integracare Group
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: The Pines of Mt. Lebanon
1537 Washington Road
Pittsburgh, Pennsylvania 15228
Certificate #: 443610

Dear Ms. Putzier:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 4, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Jon B. Kimberland".

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *THE PINES OF MT. LEBANON*
Address: *1537 WASHINGTON ROAD,, PITTSBURGH, PA 15228*
County: *ALLEGHENY* Region: *WESTERN*

License Number: *43361*

Administrator

Name: *Belinda McQuaide* Phone: *4123414400* Email: *bmcquaide@INTEGRACARE.COM*

Legal Entity

Name: *TITHONUS MT. LEBANON LP*
Address: *6600 BROOKTREE COURT SUITE 1000, C/O INTEGRACARE CORP, WEXFORD, PA, 15090*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/06/1989* Issued By: *Dept of L&I*
Type: *Other* Date: *11/23/2010* Issued By: *Mt. Lebanon*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *53* Waking Staff: *40*

Inspection

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

Inspection Dates and Department Representative

03/04/2020 - On-Site: Scott Klein, Belinda Graziano, Vicki Siegert

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* Residents Served: *37*

Secured Dementia Care Unit

In Home: *Yes* Area: *Life Stories* Capacity: *18* Residents Served: *4*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *37*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *16* Have Physical Disability: *2*

17 - Record Confidentiality

Regulations

2600.

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

Description of Violation

At approximately 9:25 a.m. there was a black plastic wall bin to the left of the bulletin board in the main lobby holding white binder labeled "Personal Care Home Regulations and Community Survey History" which was unlocked, unattended, and accessible containing several license inspection summaries that have confidential information to include:

- * Behind page 3 of the inspection summary dated 2/26/19, a list with resident names and a chart indicating activities that each resident participates in including religious services for resident #1, resident #2, and resident #3.
- * Behind page 4 of the inspection summary dated 3/26/19, a fax form dated 04/01/19 to Dr. Daroski to "d/c Tessalon 200mg ÷ cap 3 times daily as needed for cough" for resident #4.
- * Behind page 4 of the inspection summary dated 3/26/19, a fax form dated 4/18/19 to Dr. Daroski for "Amoxicillin 500mg four capsules (2GM) prior to (1 hour) dental procedure/treatment for infection prophylaxis" for resident #5.
- * Behind page 4 of the inspection summary dated 3/26/19, a prescription label for resident #6 from Johnson's Pharmaceutical Services indicating – refer to SSI calc for coverage 4x daily as follows: < 70 call MD and protocol 141-180 – 2u Diabetes 21 Humalog 100/ml Kwipen
- * Behind page 8 of the inspection summary dated 3/26/19, 2 incidents for resident #6 reporting incorrect glucose documentation.

At approximately 4:50 p.m. the top drawer of an unlocked credenza under the bulletin board in the home's main lobby contained a red binder entitled "Emergency Management Plan" that was unlocked, unattended, and accessible which includes a tab labeled "Resident Roster" that contains multiple pages of resident information to include:

- * A list dated 2/28/2020 that include resident first and last names, room number, and phone number.
- * A list of residents with mobility needs to includes resident #7, resident #8, resident #1, and resident #9. The list also indicates that all residents in memory care are considered mobility needs and names the 4 residents of the secured dementia care unit to include resident #10.
- * A list of "DNR" to include resident #1, resident #9, and resident #11.
- * A list of "Diabetics" to include resident #8, resident #12, resident #5, and resident #13.
- * A list of residents on "Oxygen" to include resident #14, and resident #15.

17 - Record Confidentiality (continued)

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 Pages 3A and 3B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Belinda McQuaide, Executive Operations Officer 3/23/20

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 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

BM
(Initials)

PLAN OF CORRECTION 17

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 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.

2. Violation Interpretative Statement:

At approximately 9:25 a.m. there was a black plastic wall bin to the left of the bulletin board in the main lobby holding white binder labeled "Personal Care Home Regulations and Community Survey History" which was unlocked, unattended, and accessible containing several license inspection summaries that have confidential information to include:

- * Behind page 3 of the inspection summary dated 2/26/19, a list with resident names and a chart indicating activities that each resident participates in including religious services for resident #1, resident #2, and resident #3.
- * Behind page 4 of the inspection summary dated 3/26/19, a fax form dated 04/01/19 to Dr. Daroski to "d/c Tessalon 200mg 3 times daily as needed for cough" for resident #4.
- * Behind page 4 of the inspection summary dated 3/26/19, a fax form dated 4/18/19 to Dr. Daroski for "Amoxicillin 500mg four capsules (2GM) prior to (1 hour) dental procedure/treatment for infection prophylaxis" for resident #5.
- * Behind page 4 of the inspection summary dated 3/26/19, a prescription label for resident #6 from Johnson's Pharmaceutical Services indicating - refer to SSI calc for coverage 4x daily as follows: < 70 call MD and protocol 141-180- 2u Diabetes 21 Humalog 100/ml Kwipen
- * Behind page 8 of the inspection summary dated 3/26/19, 2 incidents for resident #6 reporting incorrect glucose documentation.

At approximately 4:50 p.m. the top drawer of an unlocked credenza under the bulletin board in the home's main lobby contained a red binder entitled "Emergency Management Plan" that was unlocked, unattended, and accessible which includes a tab labeled "Resident Roster" that contains multiple pages of resident information to include:

- * A list dated 2/28/2020 that include resident first and last names, room number, and phone number.
- * A list of residents with mobility needs to include resident #7, resident #8, resident #1, and resident #9. The list also indicates that all residents in memory care are considered mobility needs and names the 4 residents of the secured dementia care unit to include resident #10.
- * A list of "DNR" to include resident #1, resident #9, and resident #11.
- * A list of "Diabetics" to include resident #8, resident #12, resident #5, and resident #13.
- * A-list of residents on "Oxygen" to include resident #14, and resident #15.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



PLAN OF CORRECTION 17

Review the benefit of the Regulation, per RCG:

Protects resident privacy and ensures that homes comply with other applicable laws.

4. Description of the Repair of the Immediate Problem:

IMMEDIATELY DONE: Both the Personal Care Home Regulations and Community Survey History binder and the Emergency Management Plan binder have been redacted so as to not to disclose any personal information or identifying markers of the residents. All direct resident information was immediately removed from the Personal Care Home Regulations and Community Survey History Binder and all POC detail pulled. "New" redacted survey results were printed and included within the binder. All resident information included within the Emergency Management Plan binder was pulled and, in its place, a page disclosing the required information (residents, status, etc) could be found in the Emergency Management Plan Binder that is locked/ secured in the copy room. This has already been done to address the confidentiality concerns of both of these binders.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure compliance with 2600.17 (primarily monitoring).

6. Detail Action Steps/System Developed to prevent future occurrence:

Ongoing Monitoring

Staffing education (training sign-in on 3/15/2020 included in this POC) to review regulation 2600.17 and the importance of ALL staff taking ownership of ensuring privacy of residents is protected.

7. Designated position responsible and specify target date for correction.

The executive operations officer or designee will perform a weekly sweep of the community to identify any potential concerns related to regulation 2600.17. Checklist attached.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



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

At approximately 9:25 a.m. the influenza awareness poster is not posted in a public and conspicuous place in the home in accordance with the Influenza Awareness Act, enacted in July 2016, which requires that each facility shall ensure that the that the required influenza information is posted in a public place in the facility.

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 Page 4A of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

EF
(Initials)

Implemented
 Not Implemented

PLAN OF CORRECTION 18

Community Name: Pines of Mt Lebanon
License Number: 43361
Date of Visit: March 4, 2020
Date of Submission: March 23, 2020

1. Violation Review: 2600.17.

A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2. Violation Interpretative Statement:

At approximately 9:25 a.m. the influenza awareness poster is not posted in a public and conspicuous place in the home in accordance with the Influenza Awareness Act, enacted in July 2016, which requires that each facility shall ensure that the required influenza information is posted in a public place in the facility.

3. Review the benefit of the Regulation, per RCG:

Ensures compliance with other applicable health, safety, and wellness requirements not incorporated by Chapter 2600.

4. Description of the Repair of the Immediate Problem:

Scott Klein emailed me the poster as well as the location that it could be found on the Department of Health's website, for future reference. I printed the poster and immediately put up in 2 conspicuous locations around the community – first and foremost at the front entrance.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure compliance with 2600

6. Detail Action Steps/System Developed to prevent future occurrence:


Ongoing Monitoring

Assessment and verification that the Flu posters are both up and in good condition has been added to the monthly verification checklist for EOO or designee. Checklist attached.

7. Designated position responsible and specify target date for correction.

The executive operations officer or designee will have the primary responsibility for checking the status of the flu poster monthly and printing and putting up the flu poster when tattered. Both the Director of Wellness and Administrative Services Director will serve as reminders to ensure the process is not overlooked again.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

25b - Contract Signatures

Regulations

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #9's contract addendum, dated 11/27/19, was not signed by resident, nor did it indicate that resident was unable or unwilling 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 Pages 5A and 5B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

CP
(Initials)

PLAN OF CORRECTION 25.b

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.25.b.

The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

2. Violation Interpretative Statement:

Resident #9's contract addendum, dated 11/27/19, was not signed by resident nor did it indicate that resident was unwilling or unable to sign.

3. Review the benefit of the Regulation, per RCG:

Signing the contract constitutes a pledge by both parties to abide by the specified terms.

4. Description of the Repair of the Immediate Problem:

The addendum was both reviewed with and signed by Resident #9. His designated person had already signed.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure compliance with 2600.25.b.

6. Detail Action Steps/ System Developed to prevent future occurrence:

Teaching/Training


Both the Marketer and the Administrative Service Director required additional training on the necessity of both resident participation and signature (signifying a meeting of the minds) or the acknowledgment of refusal or inability to sign. Training complete: April 1, 2020.

Ongoing Monitoring

Review of all current contracts and addendums for accuracy, completeness and compliance with 2600.25.b has been completed on April 7, 2020.

Authorized Signature: Belinda McQuaide

Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 25.b

7. Designated position responsible and specify target date for correction.

The executive operations officer took responsibility for the education and training with the Marketer and Administrative Services Director which is completed.

Review of all current contracts and addendums for completeness has been performed by the Administrative Services Director.

Quarterly Auditing will be performed by the Administrative Services Director. Auditing will be documented, and documentation will be retained for reference. Target date: ongoing quarterly.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



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

The record of training for direct care staff person A does not include the date, source, content, and length of training for medication self-administration during the 2019 training year [1/1/19 to 12/31/19].

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 pages 6A and 6B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

BM
(initials)

- Implemented
- Not Implemented

PLAN OF CORRECTION 65.i.

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 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.

2. Violation Interpretative Statement:

The record of training for direct care staff person A does not include the date, source, content, and length of training for medication self-administration during the 2019 training year (1/ 1/19 to 12/ 31/19).

3. Review the benefit of the Regulation, per RCG:

Allows the administrator to track each staff person's training progress throughout the year and provides evidence of successful training completion.

4. Description of the Repair of the Immediate Problem:

Our previous training/education platform for calendar year 2019 was bought out by another company. In the process, we were unable to access our documents of completed courses for our staff members. We have since been able to rectify that but our self-administration training, because it was a company created training course that was uploaded into our training platform, was not able to be retrieved. We have rectified this for 2020 and included our self-administration training course in the first quarter to have accurate documentation on all current staff as having completed this education.

5. Determine/ document the Root Cause of the Violation:


Lack of process to ensure compliance with 2600.65.i.

6. Detail Action Steps/ System Developed to prevent future occurrence:

Ongoing Monitoring

Administrative Services Director now prints monthly logs of completed courses for all staff members. This is to ensure that even while we may have issues with the platform technology in the future, we are still able to validate course work and completion for our team members.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 


PLAN OF CORRECTION 65.i.

7. Designated position responsible and specify target date for correction.

Employee was retrained on the self administration course. Documentation attached.

Monthly coursework completion by employee will be printed and logged by the Administrative Services Director. All documentation will be retained for reference. Target date: ongoing monthly.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

85e - Trash Outside Home

Regulations

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 11:05 a.m. at the main entrance to the home, there is a square trash receptacle that is not covered, has an open rectangular area on each of the four sides, and is approximately one quarter full with trash.

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 Page 7A of 20

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

JP
(Initials)

- Implemented
- Not Implemented

PLAN OF CORRECTION 85.e.

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.85.e.

Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

2. Violation Interpretative Statement:

At approximately 11:05 a.m. at the main entrance to the home, there is a square trash receptacle that is not covered, has an open rectangular area on each of the four sides, and is approximately one quarter full with trash.

3. Review the benefit of the Regulation, per RCG:

Rodent or insect infestation in exterior trash containers raises the risk that the interior of the home will become infested. Additionally, secured trash containers are less likely to attract wild animals.

4. Description of the Repair of the Immediate Problem:

New trash receptacles that are within compliance (covered/no "open" areas on the sides) were ordered and have been placed at the entrance of community.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure compliance with 2600.85.e.


6. Detail Action Steps/ System Developed to prevent future occurrence:

Ongoing Monitoring

Safety and Maintenance Engineer will monitor trash receptacles to ensure their compliance with 2600.85.e.

Ongoing monthly checks to ensure compliance with 2600.85.e. Checklist attached.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

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 in resident #1's room #224, does not have telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and the personal care complaint hotline posted on or by 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 Pages 8A and 8B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

CP
(Initials)

PLAN OF CORRECTION 91

Community Name: Pines of Mt Lebanon
License Number: 43361
Date of Visit: March 4, 2020
Date of Submission: March 23, 2020

1. Violation Review: 2600.91

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.

2. Violation Interpretative Statement:

The telephone in resident #1's room #224, does not have telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and the personal care complaint hot line posted on or by the telephone.

3. Review the benefit of the Regulation, per RCG:

Due to most Residents having a telephone in their apartment, the emergency phone list is kept by each telephone should the Resident have an emergency in which they need to call local emergency authorities such as the hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline.

4. Description of the Repair of the Immediate Problem:

An audit was completed by the Director of Environmental Services on March 5, 2020 to ensure that all telephones in Resident apartments had an emergency phone list available. The emergency phone list for resident #1 was immediately replaced on March 5, 2020, by the Director of Environmental Services.

5. Determine/ document the Root Cause of the Violation:

The Housekeeping department does monthly apartment checks to ensure the emergency phone lists are present by each telephone in all Resident apartments. The checks are done when the Housekeeping Assistants do their weekly apartment cleanings. We learned that the Resident discarded the emergency phone list which was present by the phone during February's audit but was missing during the survey on March 5th.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



6. Detail Action Steps/ System Developed to prevent future occurrence:

Changing practice? No change in practice needed for this violation - corrective measures only and continued Resident education.

Teaching or Training? The Resident was re-educated on March 5, 2020, by the Director of Environmental Services about the importance of the emergency phone lists being present and/or near the telephones, in the apartments, should an emergency occur.

On-going Monitoring? The Housekeeping Department will continue to monitor the emergency phone lists on their check sheets weekly during weekly housekeeping cleaning services. Should an emergency phone list be missing, the Housekeeping Assistant will provide education to the Resident regarding this regulation. Please see attached check sheet that the housekeeping department uses when tracking these audits.

7. Designated position responsible and specify target date for correction.

The Housekeeping Department is responsible for ensuring that each Resident apartment has an emergency phone list present by each phone. This will be monitored weekly and tracked on the check sheet that is already implemented. The emergency phone list was immediately replaced on March 5, 2020, by the Director of Environmental Services for resident #1.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

95 - Furniture and Equipment

Regulations

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At approximately 2:55 p.m. in resident #1's room #224, the enabler attached to the resident's bed frame has a cover that begins approximately halfway down the enabler loop which exposes an opening measuring approximately 12 inches wide by 8 inches high creating a risk of entanglement for resident #1.

At approximately 12:15 p.m. in resident #17's room #248, the enabler strapped under the resident's mattress has a cover that is torn and pushed to the bottom of the enabler loop which exposes an opening measuring approximately 10 inches wide by 9 inches high creating a risk of entanglement for resident #17.

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 Pages 9A and 9B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

CP
(Initials)

PLAN OF CORRECTION 95

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.95

Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

2. Violation Interpretative Statement:

At approximately 2:55 p.m. in resident #1's room #224, the enabler attached to the resident's bed frame has a cover that begins approximately halfway down the enabler loop which exposes an opening measuring approximately 12 inches wide by 8 inches high creating a risk of entanglement for resident #1.

At approximately 12:15 p.m. in resident #1's room #248, the enabler strapped under the resident's mattress has a cover that is torn and pushed to the bottom of the enabler loop which exposes an opening measuring approximately 10 inches wide by 9 inches high creating a risk of entanglement for resident #17.

3. Review the benefit of the Regulation, per RCG:

Furniture and equipment that is clean, free of hazards, and in good repair helps to maintain sanitary conditions in the home and minimize the risk that residents will suffer an injury while using the furniture or equipment.

4. Description of the Repair of the Immediate Problem:

New mesh coverings were purchased and attached to both enablers to mitigate the potential risk for the residents to get caught in the openings.

5. Determine/ document the Root Cause of the Violation:

Needed a more routine auditing process to ensure equipment is in good repair.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



PLAN OF CORRECTION 95

6. Detail Action Steps/ System Developed to prevent future occurrence:

Changing practice? Added enabler assessments to our EOO or designee weekly review checklist.

Teaching or Training? Resident wellness associates (aides) needed re-educated on the importance of assessing and escalating issues/concerns identified during room assessment audits so that we can address concerns before they become problematic.

On-going Monitoring? The EOO or designee will assess all enablers in the community weekly for condition and safety. Checklist attached.

7. Designated position responsible and specify target date for correction.

The EOO or designee will audit rooms with enablers for identification of concerns that need addressed weekly. This has already started and will be ongoing. See attached.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

Regulations

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

At approximately 12:23 p.m. in resident #17's private bathroom in room #248, there is no grab bar, hand rail, or assist bar at the toilet.

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 Pages 10A and 10B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Belinda McQuaide, Executive Operations Officer 3/23/20

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 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

EP
(Initials)

PLAN OF CORRECTION 102.d.1

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.102.d.1

Toilet and bath areas must have grab bars, handrails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

2. Violation Interpretative Statement:

At approximately 12:23 p.m. in resident #17's private bathroom in room #248, there is no grab bar, handrail, or assist bar at the toilet.

3. Review the benefit of the Regulation, per RCG:

Grab bars, handrails, or assist bars prevent injurious falls and allow residents to engage in self-care if desired.

4. Description of the Repair of the Immediate Problem:


Grab bars have been purchased and installed in resident #17's bathroom.

Determine/ document the Root Cause of the Violation:

5.

Needed a more routine auditing process to ensure equipment is in good repair.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 102.d.1

6. Detail Action Steps/ System Developed to prevent future occurrence:

The EOO or designee will assess all grab bars in the community weekly for condition and to ensure they are tightened enough. Checklist attached.

7. Designated position responsible and specify target date for correction.

The EOO or designee will audit rooms with grab bars for identification of concerns that need addressed weekly. This has already started and will be ongoing. See attached.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

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

The home conducted a fire drill on 2/28/2020 at "5:00." However, the fire drill record does not indicate whether the drill was conducted at 5:00 a.m. or 5:00 p.m.

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 Pages 11A and 11B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide
Signature

Belinda McQuaide, Executive Operations Officer 3/23/20
Printed Name and Title Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

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

Implemented
 Not Implemented

PLAN OF CORRECTION 132.c.

Community Name: Pines of Mt Lebanon
License Number: 43361
Date of Visit: March 4, 2020
Date of Submission: March 23, 2020

1. Violation Review: 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

2. Violation Interpretative Statement:

The home conducted a fire drill on 2/28/2020 at "5:00." However, the fire drill record does not indicate whether the drill was conducted at 5:00 a.m. or 5:00 p.m.

3. Review the benefit of the Regulation, per RCG:

Recording fire drill information helps homes ensure compliance with all of the regulations relating to fire drills, and to identify and correct problems with evacuation.

4. Description of the Repair of the Immediate Problem:

The log was appropriately updated to reflect AM as the sign in sheet and fire drill report out detailed the 5 AM drill time.

5. Determine/ document the Root Cause of the Violation:


Needing the time clearly identified on all forms and logs.

6. Detail Action Steps/ System Developed to prevent future occurrence:

Changing practice? No change in practice required. Reeducation of importance of the qualifier of AM or PM to determine which shift obtained the fire drill experience.

Ongoing? Safety and Maintenance Engineer will assess log forms monthly to ensure appropriate designation of time is logged.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 132.c.

7. Designated position responsible and specify target date for correction.

The Safety and Maintenance Engineer will audit all fire drill log forms monthly to ensure the appropriate qualifier has been identified for time. This has already started and will be ongoing. Appropriately updated forms are attached.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



141b1 - Annual Medical Evaluation

Regulations

2600.

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

Description of Violation

Resident #1 had an annual medical evaluation completed on 6/13/19. However, resident #1's the previous medical evaluation was completed on 5/17/18.

Resident #8's had an annual medical evaluation completed on 6/13/19. However, resident #8's previous medical evaluation was completed on 5/17/18.

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 Pages 12A and 12B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

JB
(Initials)

PLAN OF CORRECTION 141.b.1

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.141. b.1. A resident shall have a medical evaluation: At least annually.

2. Violation Interpretative Statement:

Resident #1's annual medical evaluation is dated 6/13/19. However, resident #1's previous medical evaluation was completed on 5/17/18.

Resident #8's had a medical evaluation completed 6/13/19. However, resident #8's previous medical evaluation was completed on 5/17/18.

3. Review the benefit of the Regulation, per RCG:

Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans and ensures that resident's needs will be met.

4. Description of the Repair of the Immediate Problem:

Both residents currently have appropriate medical evaluations within the required timeframe.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure compliance with 2600.141.b.1

6. Detail Action Steps/ System Developed to prevent future occurrence:

a. Teaching or Training


The LPN Charge Nurse will receive training in the requirement. Documentation of training will be maintained. Target date is 04/01/2020.

b. On-going Monitoring

To establish the extent of compliance, all DME's have been audited for completeness and for the condition identified on the visit relating to 2600.141.b.1. and this audit was completed on March 24, 2020. Any discrepancies will be documented, and those which are correctable, will be corrected.

Director of Wellness will review Annual DME's and DME's for new admissions and change of condition daily during the business week. The Executive Operations Officer will set a daily tickler to verify that any DME's newly introduced to the community are complete, and compliant with 2600,141.b.1.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 141.b.1

7. Designated position responsible and specify target date for correction.

The Director of Wellness performed an audit of the existing resident medical records to assess for compliance of reg. 141.b.1 and all appropriate updates have been made and the audit is complete.

The Director of Wellness will monitor the DME's of new admissions, annual renewals, and significant changes for compliance, daily as needed based on circumstance.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

171b5 - First Aid Kit

Regulations

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

At approximately 12:30 p.m. the first aid kit in the home's bus, which is used to transport residents to doctor's visits and activities, does not contain antiseptic.

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 Pages 13A and 13B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Belinda McQuaide, Executive Operations Officer 3/23/20

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 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

[Signature]
(Initials)

PLAN OF CORRECTION 171.b.5.

Page 13A of 21

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.171.b.5.

The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

2. Violation Interpretative Statement:

At approximately 12:30 p.m. the first aid kit in the home's bus, which is used to transport residents to doctor's visits and activities, does not contain antiseptic.

3. Review the benefit of the Regulation, per RCG:

Ensures that essential items for basic emergency medical care are present in case of an emergency.

4. Description of the Repair of the Immediate Problem:

Antiseptic was purchased and placed in the first aid kit in the transportation van.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure that once an item was utilized, it would be replaced.

6. Detail Action Steps/ System Developed to prevent future occurrence:

Changing practice? Utilization log of items in the first aid kit to ensure prompt ordering and replacing of necessary items.

Ongoing? Activities Director uses the log to place weekly orders to ensure prompt replacement of utilized items. Monthly auditing of first aid kit against a checklist to double check that all required items are present.

Authorized Signature: Belinda McQuaide Date: 3/23/2020


4/24/2020



7. Designated position responsible and specify target date for correction.

The Activities Director has primary oversight of the management of first aid kit supplies and the replacement of utilized items. Monthly audits of kits will ensure all appropriate items are present. This has already started and will be ongoing.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The home maintained a blister pack of Buspirone HCL 5 MG Tablet – Take one tablet by mouth twice daily as needed for anxiety for resident #10. However, there is no current physician’s order for of Buspirone HCL 5 MG Tablets for resident #10.

The home maintained a blister pack of Acetaminophen 325 MG tablet – Take two tablets (650mg) by mouth every six hours as needed for mild pain/fever for resident #10. However, there is no current physician’s order for Acetaminophen 325 mg tablets for resident #10.

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 Pages 14A and 14B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

EM
(Initials)

PLAN OF CORRECTION 183.d

Community Name: The Pines of Mt. Lebanon
License Number: 43361
Date of Visit: March 4, 2020
Date of Submission: March 23, 2020

1. **Violation Review:** 2600.183.d

Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

2. **Violation Interpretative Statement:**

The home maintained a blister pack of Buspirone HCL 5 MG Tablet - Take one tablet by mouth twice daily as needed for anxiety for resident #10. However, there is no current physician's order for of Buspirone HCL 5 MG Tablets for resident #10.

3. **Review the benefit of the Regulation, per RCG:**

The benefit of this regulation is to make sure homes have a system in place to remove discontinued medications from the medication carts. The regulation is to also ensure that Residents do not receive a medication that no longer has an active order from a physician and to also ensure that unnecessary medications are being stored in the medication carts.


4. **Description of the Repair of the Immediate Problem:**

The discontinued medication for Resident #10 were immediately removed from the medication carts during the annual inspection.

5. **Determine/ document the Root Cause of the Violation:**

The root cause of the violation is due to systems not being followed, as well as oversight, to ensure discontinued medications are removed by the medication assistants. A monthly audit of random medication carts should occur to ensure that all medications are current, discontinued medications are removed from the carts, medication labels are matching the physician's order and medication administration records, labels are available on all necessary medications, and medications are available to the Residents. By doing an additional monthly random audit on the carts, we will be able to see patterns, ensure systems are in place as educated, and hold medication assistants accountable for not following policies/ procedures.


Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 183.d

6. Detail Action Steps/ System Developed to prevent future occurrence:
 - a. **Changing practice?** In addition to the medication assistants, the Resident Wellness Director will now be responsible for doing random monthly medication cart audits, as an oversight to the medication assistants. This will help ensure the task is being completed by adding an oversight process. This will also be in support of the Executive Operating Officer if needed. Should a cart be out of compliance while conducting an audit, both the Resident Wellness Director and Executive Operating Officer will do a full medication cart audit as well as hold medication assistants accountable should non-compliance be found.
 - b. **Teaching or Training?** Medication assistants and charge personnel will be re-educated on this regulation on March 27th, 2020 (during departmental mtg) by the Resident Wellness Director. Medication assistants reeducation will ensure that all orders match the label, that the appropriate label is being used moving forward, and discontinued medications are removed from the cart s. The Resident Wellness Director will instruct the medication assistants to notify her when one of these concerns occur to track inconsistencies and to hold medication assistants accountable for not following through our processes and systems. The Resident Wellness Director will also educate the mediation assistants on the oversight process.
 - c. **On-going Monitoring?** A complete medication cart audit was conducted on March 12, 2020, to ensure that discontinued medications were removed, correct labels are being used, and labels were present on all necessary medications. The Resident Wellness Director will oversee the process by doing random medication cart audits each month to ensure compliance is met. If patterns and non-compliance are found, both the Wellness Director and Executive Operating Office with do a full medication cart audit and will correct any issues that arise during that time. Medication assistants will also be held accountable for not following through with our processes/systems that are already in place.
7. Designated position responsible and specify target date for correction. The medication assistants with oversight by the Resident Wellness Director and Executive Operating Office, if needed moving forward and ongoing .
 - a. **Teaching or Training?** Resident Wellness Director and Executive Operating Officer reviewed this regulation together on March 5, 2020.
 - b. **On-going Monitoring?** For oversight, the Wellness Director will audit the carts monthly to identify any non-compliance with this regulation and to address and escalate.
2. Designated position responsible and specify target date for correction. Resident Wellness Director and Executive Operating Officer on March 5, 2020, moving forward and ongoing.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

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 #8's medication administration record indicates a blood sugar reading of 200 on 3/3/2020 at approximately 5:00 p.m. However, the resident's glucometer has no reading on that date at that time.

Resident #8's medication administration record indicates a blood sugar reading of 236 on 3/2/2020 at approximately 8:00 p.m. However, the resident's glucometer has no reading on that date at that time.

Resident #8's medication administration record indicates a blood sugar reading of 399 on 2/29/2020 at approximately 5:00 p.m. However, the resident's glucometer had a reading of 431 on that date and time.

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 Pages 15A and 15B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Belinda McQuaide, Executive Operations Officer 3/23/20

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 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

JP
(Initials)

Implemented
 Not Implemented

PLAN OF CORRECTION 185.a

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 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.

2. Violation Interpretative Statement:

Resident #8's medication administration record indicates a blood sugar reading of 200 on 3/03/2020 at approx. 5:00 PM. However, the resident's glucometer has no reading on that date at that time.

Resident #8's medication administration record indicates that a blood sugar reading of 236 on 3/03/2020 at approx. 8:00 PM. However, the glucometer has no reading on that date at that time.

Resident #8's medication administration record indicates a blood sugar reading of 399 on 2/29/2020 at approx. 5:00 PM. However, the resident's glucometer had a reading of 431 on that date and time.

3. Review the benefit of the Regulation, per RCG:

Reduces the risk that medications and medical equipment will be misplaced, lost or misused.

4. Description of the Repair of the Immediate Problem:

Monthly glucometer verification forms initiated and kept in medication charts to ensure proper administration and tracking.

5. Determine/ document the Root Cause of the Violation:

Lack of process to ensure compliance with 2600.185.a. (primarily verification).

6. Detail Action Steps/ System Developed to prevent future occurrence:


a. Teaching or Training

Director of Wellness provided education on the required use of the glucometer verification forms. Documentation of training attached.

b. On-going Monitoring

To establish the extent of compliance, glucometer verification forms have been implemented to ensure compliance with regulation 2600.185.a. Any discrepancies will be documented and corrected.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 185.a

7. Designated position responsible and specify target date for correction.

Director of Wellness provided education on the required use of the glucometer verification forms.
Documentation of training attached.

To establish the extent of compliance, glucometer verification forms have been implemented to ensure compliance with regulation 2600.185.a. Any discrepancies will be documented and corrected.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



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:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident#10 is ordered Arthritis Pain 650mg – Take two tablets (1300MG) by mouth twice daily as needed for pain. However, the medication is not listed on the resident's medication administration record.

Resident#10 is ordered Menthol-Zinc Oxide 0.45% - 20% - Apply topically to excoriated buttocks every shift. However, on 2/2/2020 between 3 p.m. and 11 p.m. and on 2/15/2020 between 12 a.m. and 7 a.m. the home did not document the administration of the Menthol-Zinc Oxide 0.45% - 20%.

Resident #1 is ordered Inzo Barrier Cream – Apply topically to buttocks every shift. However, the home did not document administration of Inzo Barrier Cream on several dates to include, 2/1/2020, 2/6/2020, and 2/11/2020 from 12:00 a.m. to 7:00 a.m. on all three dates.

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 Pages 16A and 16B of 21

SEE ATTACHED

PLAN OF CORRECTION 187.a.

Page 16A of 21

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.187.a.

A medication record shall be kept to include the following for each resident for whom medications are administered:

- a. Resident's name
- b. Drug allergies
- c. Name of medication
- d. Strength
- e. Dosage form
- f. Dose
- g. Route of administration
- h. Frequency of administration
- i. Administration times
- J Duration of therapy, if applicable
- K Diagnosis or purpose for the medication, including PRN
- L Date and time of medication administration
- m. Name and initials of the staff person administering the medication

2. Violation Interpretative Statement:

Resident#10 is ordered Arthritis Pain 650mg - Take two tablets (1300MG) by mouth twice daily as needed for pain. However, the medication is not listed on the resident's medication administration record.

Resident# 10 is ordered Menthol- Zinc Oxide 0.45% - 20% - Apply topically to excoriated buttocks every shift. However, on 2/2/2020 between 3 p.m. and 11 p.m. and on 2/15/2020 between 12 a.m. and 7 a.m. the home did not document the administration of the Menthol-Zinc Oxide 0.45% - 20%.

Resident #1 is ordered Inzo Barrier Cream - Apply topically to buttocks every shift. However, the home did not document administration of Inzo Barrier Cream on several dates to include, 2/1/2020, 2/6/2020, and 2/11/2020 from 12:00 a.m. to 7:00 a.m. on all three dates

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020



3. Review the benefit of the Regulation, per RCG:

The benefit of this regulation is to ensure that prescribed medications are reflected on the medication administration record (MAR) so that the needs of the Residents are met. The regulation ensures that the Residents receive the medication per physician's orders.

4. Description of the Repair of the Immediate Problem:

For Resident #10, orders were sent to pharmacy for profiling on March 6, 2020 so that the medication would present on the MAR. Also, for Resident #10, audit of all standing orders were completed and all orders were obtained.

5. Determine/ document the Root Cause of the Violation:

Resident #10 readily had available the medication as prescribed by the physician. However, the order was not profiled on Quick MAR for the medication assistants to administer.

6. Detail Action Steps/System Developed to prevent future occurrence:

Teaching or Training? Training in reference to this regulation will be conducted by the Director of Wellness during the March 2020 monthly meeting. All Medication Assistants will be retrained at this time. Importance of logging medications when given to ensure resident is receiving timely and appropriate care. Verification will be sent to the Department of Human Services once the training is completed.

Ongoing Monitoring? Director of Resident Care Services and/or designee will do random checks of 10% of Residents monthly to ensure all medications are listed on the Resident Medication Administration Record (MAR).

7. Designated position responsible and specify target date for correction.

The Director of Wellness and/or designee will complete an audit on all Residents by May 1, 2020 to verify that all medications are profiled in Quick MAR for medication administration.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

187a - Medication Record (continued)

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide

Printed Name and Title

4/24/2020

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

BM
(Initials)

- 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 #1 is ordered Clopidogrel 75mg Tablet -- Take one tablet by mouth once daily. However, on 3/1/2020 at approximately 8:00 a.m., the home did not administer the resident's Clopidogrel 75mg tablet, the pill was still in the blister pack on 3/4/2020.

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 Page 18A of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Belinda McQuaide, Executive Operations Officer 3/23/20

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 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

BM
(Initials)

- Implemented
- Not Implemented

PLAN OF CORRECTION 187.d.

Page 18A of 21

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.187.d.

The home shall follow the directions of the prescriber.

2. Violation Interpretative Statement:

Resident #1 is ordered Clopidogrel 75mg Tablet - Take one tablet by mouth once daily. However, on 3/1/2020 at approximately 8.00 a.m., the home did not administer the resident's Clopidogrel 75mg tablet, the pill was still in the blister pack on 3/4/2020.

3. Review the benefit of the Regulation, per RCG:

Ensures that residents receive medications and treatments as ordered by a physician.

4. Description of the Repair of the Immediate Problem:

Assessed and evaluated that resident had not missed any of medication deliveries per se - he refused to take and it was not documented appropriately. No additional issues with resident taking medications noted.

Determine/ document the Root Cause of the Violation:

5.


Not documenting and notifying appropriate parties that the resident refused medication.

6. Detail Action Steps/System Developed to prevent future occurrence:

Teaching or Training? Training in reference to this regulation has been conducted by the Director of Wellness during the March 27, 2020 monthly meeting. All Medication Assistants have been retrained. Importance of documenting medication refusal and physician notification was discussed.

Developed refusal form attached.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

225c - Additional Assessment

Regulations

2600.

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

- 1. Annually.

Description of Violation

Resident #9's annual assessment, dated 12/11/2019, was not updated to include the medical diagnoses of dementia, toxic metabolic encephalopathy, GERD, agitation, or BPH as indicated on medical evaluation dated 12/12/19.

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 Pages 19A and 19B of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

BM
(Initials)

- Implemented
- Not Implemented

PLAN OF CORRECTION 225.c

Community Name: Pines of Mt. Lebanon
License Number: 43361
Date of Visit: March 4, 2020
Date of Submission: March 23, 2020

1. Violation Review: 2600.225c

The Resident shall have additional assessments as follows:
Annually

2. Violation Interpretative Statement:

Resident #9's annual assessment, dated 12/11/ 2019, was not updated to include the medical diagnoses of dementia , toxic metabolic encephalopathy, GERO, agitation, or BPH as indicated on medical evaluation dated 12/12/19.

3. Review the benefit of the Regulation, per RCG:

The benefit of this regulation is to ensure the Resident Assessment Support Plan carries over all necessary information reflected on the medical evaluation , which includes medication administration , allergies, safety around poisonous items, dietary needs, diagnoses, appropriate program for the Resident, list of medications, positioning if needed, and mobility needs. The medical evaluation is the first step in creating a Resident Assessment Support Plan in which the information on both forms match.

4. Description of the Repair of the Immediate Problem:

Resident #9's missing diagnoses were immediately added to the Resident Assessment Support Plan during the DHS annual inspection on March 4, 2020.


5. Determine/ document the Root Cause of the Violation:

The root cause of the violation was due to missing diagnosis that should have been carried over from the medical evaluation. A system to ensure that all necessary information carried over to the support plan was not in place.

6. Detail Action Steps/ System Developed to prevent future occurrence:

- a. **Changing practice?** The Resident Wellness Director is responsible for completing the Resident Assessment Support Plan on all Residents. It is her responsibility to ensure that all necessary information is carried over to create thorough Resident Assessment Support Plans that reflects the needs of each Resident. Moving forward, before the Resident Wellness Director gives the Resident Assessment Support Plans to the Unit Clerk for signature, the Resident Wellness Director will give the Executive Operating Officer the document to ensure that all necessary diagnoses are present and reflect the diagnoses as stated on the medical evaluation.


Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

PLAN OF CORRECTION 225.c

In addition to all current support plans have been reviewed and appropriately updated (this is completed) the Executive Operating Office will provide the second set of eyes that all are checked and appropriately reflect residents' needs.

Authorized Signature: Belinda McQuaide Date: 3/23/2020

4/24/2020 

227d - Support Plan Medical/Dental

Regulations

2600.

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

Description of Violation

Resident #11's annual support plan, dated 3/1/19, did not include a plan to meet the service need or frequency for multiple areas of the support plan to include: managing health care, securing health care, doing laundry, shopping, securing and using transportation, managing finances, making and keeping appointments, writing correspondence, obtaining seasonal clothing, supervision, medication management, all diagnoses indicated in the medical, dental, dietary and sensory needs section as well as all diagnoses indicated in the mental health, behavioral health, and cognitive function needs section. These areas of the support plan were left blank.

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 Page 20A of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

CP
(Initials)

- Implemented
- Not Implemented

PLAN OF CORRECTION 227.d

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600227.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.

2.. Violation Interpretative Statement:

Resident #11 's annual support plan, dated 3/1/19, did not include a plan to meet the service need or frequency for multiple areas of the support plan to include: managing health care, securing health care, doing laundry, shopping, securing and using transportation, managing finances, making and keeping appointments, writing correspondence, obtaining seasonal clothing, supervision, medication management, all diagnoses indicated in the medical, dental, dietary and sensory needs section as well as all diagnoses indicated in the mental health, behavioral health, and cognitive function needs section. These areas of the support plan were left blank.

3. Review the benefit of the Regulation, per RCG:

Ensures that each resident's needs are met as those needs change, and that accountability for meeting those needs is firmly established.

4. Description of the Repair of the Immediate Problem:

On March 5, 2020, we updated Resident #11's annual support plan to be more detailed in our descriptives and account for each of the categories. Resident #11 is our most independent and "non-needy" resident we have, but that doesn't negate the need to explain expectations in the support plan.

5. Determine/ document the Root Cause of the Violation:

Underappreciation for the fact that while resident #11 is our most autonomous, we still need to detail explicitly who is responsible for what. Even if that means resident #11 is doing for herself, that needs to be spelled out in the support plan.

6. Detail Action Steps/ System Developed to prevent future occurrence:

On-going Monitoring

All support plans have been audited for completeness and detail. Completed: April 3, 2020.

Director of Wellness to audit moving forward 5 support plans quarterly to determine level of detail.

Any identified issues will be addressed immediately. Ongoing target.

Authorized Signature: Belinda McQuaide

Date: 3/23/2020

4/24/2020



234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #10, admitted to the secured dementia care unit on 8/21/19, did not have a support plan developed, implemented, and documented in the resident's record until 8/27/19.

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 Page 21A of 21

SEE ATTACHED

Legal Entity Representative

Belinda McQuaide

Signature

Belinda McQuaide, Executive Operations Officer 3/23/20

Printed Name and Title

Date

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

The above plan of correction is approved as of 4/24/2020
(Date)

Plan of correction implementation status as of 4/24/2020
(Date)

The above plan of correction was approved by

EP
(Initials)

- Implemented
- Not Implemented

PLAN OF CORRECTION 234.a

Community Name: Pines of Mt Lebanon

License Number: 43361

Date of Visit: March 4, 2020

Date of Submission: March 23, 2020

1. Violation Review: 2600.234a

Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

2. Violation Interpretative Statement:

Resident #10, admitted to the secured dementia care unit on 8/21/19, did not have a support plan developed, implemented, and documented in the resident's record until 8/27/19.

3. Review the benefit of the Regulation, per RCG:

Ensures that there is a plan to serve residents with challenging behaviors as soon as possible.

4. Description of the Repair of the Immediate Problem:

Resident has an appropriate support plan at this time.

5. Determine/ document the Root Cause of the Violation:

Our electronic records that house the support plans do not provide a support plan complete date, giving the appearance that it wasn't 'complete' until the signing of the document (resident/staff member).

6. Detail Action Steps/ System Developed to prevent future occurrence:

On-going Monitoring

A support plan complete date has been added to allow for validating turn around time compliance, especially as it pertains to the 72 hr window for secured dementia residents.

Authorized Signature: _____

Belinda McQuaide

Date: 3/23/2020

4/24/2020

