



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES



CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to MERCY LIFE CENTER CORPORATION

LEGAL ENTITY

To operate GARDEN VIEW MANOR

NAME OF FACILITY OR AGENCY

Located at 441 SWISSVALE AVENUE, PITTSBURGH, PA 15221

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

To provide Personal Care Homes

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 56
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: _____

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

55 Pa.Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from July 2, 2020 until July 2, 2021,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **440690**

Robert E. Robinson

ISSUING OFFICER

Jamie J. Buchenauer

Deputy Secretary

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

HS 628 – 6/20



Emailed: July 2, 2020

Mr. Craig Douglass
Chief Operating Officer
Mercy Life Center Corporation
Attn: Kimberly Munko
1200 Reedsdale Street
Pittsburgh, Pennsylvania 15233

RE: Garden View Manor
441 Swissvale Avenue
Pittsburgh, Pennsylvania 15221
Certificate #: 440690

Dear Mr. Douglass:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on December 17, 2020 and December 18, 2020, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Jamie L. Buchenauer". The signature is written in a cursive, flowing style.

Jamie L. Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosures
License
Licensing Inspection Summary

Violation Report

Facility Information

Name: GARDEN VIEW MANOR
Address: 441 SWISSVALE AVENUE, PITTSBURGH, PA 15221
County: ALLEGHENY Region: WESTERN

License Number: 44069

Administrator

Name: Carla McCoy Phone: 4123424602 Email: KMUNKO@PITTSBURGHMERCY.ORG

Legal Entity

Name: MERCY LIFE CENTER CORPORATION
Address: 1200 REEDSDALE STREET, ATTN: KIMBERLY MUNKO, PITTSBURGH, PA, 15233

Certificate(s) of Occupancy

Type: I-2 Date: 04/08/2010 Issued By: Labor and Industry

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 55 Waking Staff: 41

Inspection

Type: Full BHA Docket #: Notice: Unannounced
Reason: Renewal, Complaint, Provisional

Inspection Dates and Department Representative

12/17/2019 - On-Site: Laurie Garrigan, Jan Cutter, Desmond Grace
12/18/2019 - On-Site: Laurie Garrigan, Desmond Grace

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 56 Residents Served: 55

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 55 Are 60 Years of Age or Older: 28
Diagnosed with Mental Illness: 55 Diagnosed with Intellectual Disability: 7
Have Mobility Need: 0 Have Physical Disability: 7

3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 12/17/19 at 9:00 a.m. and 11:25 a.m., the home's current license, dated 8/8/2019- 2/8/2020, was not posted in a conspicuous and public place in the home.

Plan of Correction (POC)

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

This violation was not discussed at our exit interview. On 2/4/20 when the LIS was received the correct license dated 8/8/19 to 2/8/20 was in place. (see attached photo)

2/18/20-- continual monitoring began. The overnight staff verify that the license is present in the display case each night. Extra copies are in the Communication Log and ground floor office if needed. See attached overnight task assignment for Front Desk. Responsible Party: Overnight staff

2/26/20-- at the staff meeting, all staff were provided with education about regulation 2600.3.c and the purpose of tracking its presence in the case to ensure compliance. See attached sign in sheet. Responsible Party: PCHA

Beginning on 4/1/20 the Team Lead will complete an additional verification of the license presence in the display case. This will be documented on the QA and Regulatory Checklist and reviewed at our monthly Leadership meeting on the 3rd Monday of the month. Our 3/16/20 meeting was utilized for the implementation of emergency Covid-19 planning. The next meeting is on 4/20/20. Responsible Party: PCHA and Team Leads

Legal Entity Representative

Signature:  MA PCHA Printed Name and Title: Laurel Spigler, Program Supervisor Date: 3/30/20

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

The above plan of correction is approved as of 4/30/20 (Date) Plan of correction implementation status as of 4/30/20 (Date)

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

18 - Compliance With Laws

Regulations

2600.

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 9/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.

On 12/17/19, there were no carbon monoxide detectors present on the 1st and 2nd floors of the home where the residents reside and the alarms were not audible on those floors in accordance with The Care Facility Carbon Monoxide Standards Act. The home has a gas boiler.

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)

12/20/19-- After the walk through the home purchased and installed carbon monoxide detectors on the first and second floor. See attached photos. Responsible Party: Maintenance Supervisor

2/17/20— The Care Facility Carbon Monoxide Standard Act was reviewed by the PCHAs and housekeeping, maintenance, and kitchen supervisors by email. See attached email. Responsible Party: PCHA, Maintenance Supervisor, Housekeeping Supervisor, Kitchen Supervisor

2/27/20-- A face to face meeting took place to review Carbon Monoxide Standards Act, and to review expectations for continual monitoring, and to discuss the CMSA. Responsible Party: PCHA, Maintenance Supervisor, Housekeeping Supervisor

Beginning on 3/1/20 the continual monitoring process will begin. Housekeeping and maintenance will verify all detectors and report this to the PCHAs on a monthly basis. Verification is due to the PCHAs by the 30th of each month. See attached. Responsible Party: PCHA, Maintenance Supervisor and Staff

Legal Entity Representative


Signature  MARCHA

Laurel Spigler, Program Supervisor 3/30/20
Printed Name and Title Date

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(Date)

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(Date)

The above plan of correction was approved by 
(Initials)

Implemented
 Not Implemented

51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, hired 5/10/14, did not have a criminal background check completed.

Plan of Correction (POC)

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

On 2/17/20 staff member completed application for updated clearances, and subsequently the clearances have come back. See attached. Responsible Party: Staff person A, PCHA

4/1/20—for ongoing monitoring for all new transfers all clearance paperwork must be submitted to and reviewed by the PCHA prior to the staff's first day working at Garden View. There have been no transfers since the violation. Responsible Party: PCHA


4/17/20- PCHAs will review all existing transfer staff charts and coordinate with the HR department to review/obtain copies of clearances if a need is identified. Responsible Party: PCHA

4/30/20 or before- the home will have a phone conference with HR to ensure that HR recruiters and onboarding specialists are aware of Regulation 2600.51 and can assist with access to records in a timely manner. Responsible Party: PCHA

Legal Entity Representative

Signature:  MA PCHA Printed Name and Title: Laurel Spigler, Program Supervisor Date: 3/30/20

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 Implemented
 Not Implemented
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96a - First Aid Kit

Regulations

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 12/17/19 at 11:35 a.m., the first aid kit in the main entrance lobby did not include eye coverings or a breathing shield.

On 12/17/19 at 12:02 p.m., the first aid kit in the 1st floor medication room did not include adhesive tape, eye coverings and tweezers and the first aid kit in the 2nd floor medication room did not include adhesive tape, eye coverings and a breathing shield.

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 items were missing from the first aid kits because the kits had been used, and the items were not replaced which is our existing policy.

12/17/19—After being notified of the missing items during the inspection, the missing items were placed in the kit. The kits remain intact. See attached photos. Responsible Party: Direct Care Staff

Beginning the week of 2/24/20, and continuing forward a continuous monitoring process have been implemented. The first aid kits were added to the weekly room check form. On alternating weeks the daylight and evening staff will verify the contents of each kit, and replace any missing items, these forms will be submitted to the PCHAs for review. See attached recent checklists. Responsible Party: Direct Care Staff on Daylight/Evening

Beginning on 4/1/20 the Team Lead will complete a monthly check which will be reviewed by the PCHs during the monthly leadership meeting on the third Monday of each month. This will be placed on the Monthly Quality Assurance and Regulatory Checklist. Our March meeting (3/16/20) had to be utilized for planning and implementing urgent programmatic changes in response to Covid-19. Responsible Party: Team Lead and PCHA

Legal Entity Representative

Signature:  MA PCHA Printed Name and Title: Laurel Spizler, Program Supervisor Date: 3/30/20

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100a - Exterior - Free of Hazards

Regulations

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 12/17/19 at 10:55 a.m., an approximately 15- foot long black cable was laying on the cement pad directly outside the exit door from stairwell tower E, posing a potential tripping hazard to residents.

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.)

12/17/19- During the inspection maintenance staff moved the wire out of the egress, as it had been left behind by a telecommunications contractor. Responsible Party: Maintenance Staff

2/17/20- Maintenance staff cut and disposed of the wire after the contractor did not. Responsible Party: Maintenance Staff.

2/27/20- A meeting was held to discuss exterior and grounds issues and safety. It was decided that evening maintenance would round and check the grounds for safety Monday to Friday. They will address all identified issues and document any areas of concern. See attached daily checklist. Responsible Party: PCHA, Maintenance Supervisor, House Keeping supervisor, Evening Maintenance Staff (daily building rounds)

Ongoing monitoring will begin on 4/1/20 and will be reviewed at the monthly leadership team meeting scheduled on the 3rd Monday of the month. The March leadership meeting was utilized for Covid-19 planning. The next leadership meeting is 4/20/20, and monthly moving forward the PCHA and Team Leads will review any issues or areas of concern which have been identified to ensure ongoing safety and compliance. Responsible Party: PCHA, Team Lead, Maintenance and Housekeeping Staff (follow-up)

Legal Entity Representative

Signature  MA PCHA Printed Name and Title Laurel Spizler, Program Supervisor Date 3/30/20

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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

On 12/17/19 at 10:35 a.m., the toilet in the second floor common bathroom did not have a grab bar, handrail or assist bar.

Plan of Correction (POC)

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

This bathroom was not considered a resident bathroom because it is for staff use only, as a result one had not been installed.

2-11-20—A grab bar was installed in the bathroom. See attached photos. All other bathrooms were verified to have grab bars by maintenance staff. Responsible Party: Maintenance Staff

Beginning the week of 2/24/20 continual monitoring will occur during weekly room checks all bathrooms will be checked for functional grab bars and any damaged or missing bars will be replaced. If there are concerns identified, these will be documented on the Room Check form and submitted to maintenance for repair/replacement Responsible Party: Direct Care Staff on Daylight/Evening (verification) and Maintenance staff (repairs/replacements)

Legal Entity Representative

Signature:  MA PCHA Printed Name and Title: Laurel Spigler, Program Supervisor Date: 3/30/20

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121a - Unobstructed Egress

Regulations

2600.

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

Description of Violation

On 12/17/19 at 11:52 a.m., the emergency exit door in the basement boiler room required considerable force to open and obstructed the exit to the stairwell that lead to patio by the garden area.

Plan of Correction (POC)

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

2/10/20 PCHA requested the landlord evaluate the door for replacement. Responsible Party: PCHA

2/12/20 Landlord notified maintenance supervisor and residential manager that the door would need to be replaced, and would set up visit from contractor. Responsible Party: Maintenance supervisor

3/6/20 PCHA followed up with landlord regarding status of work, and projected date for the door to be replaced. Landlord notified us that the door needed to be special ordered, and PCHA requested a copy of proof of purchase/contract. This was not provided. Responsible Party: PCHA, Landlord, and Maintenance Supervisor

3/1/20- Until the door is replaced housekeeping and maintenance staff verify that the door is passable and that all egresses are clear Monday through Friday. See attached checklist. Responsible Party: Evening Maintenance Staff

3/30/20 Landlord notified PCHA that the door had been paid for on 3/10/20, but no ETA was available. He also advised all contracting for non-emergency issues is on hold due to Covid-19. The home continues to check Monday through Friday to ensure the egress is clear and the door does function. Responsible Party: Evening Maintenance Staff

Legal Entity Representative

Laurel Spigler, MA, PCHA
Signature

Laurel Spigler, Program Supervisor 3/30/20
Printed Name and Title Date

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(Date)

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(Date)

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

Implemented
 Not Implemented

127a - Portable Space Heaters

Regulations

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 12/17/19 at 10:30 a.m., there were two Best Comfort brand portable space heaters present on a shelf in the second floor storage room.

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.)

12/17/19—The space heaters were removed from the premise during the inspection. PCHAs met with the housekeeping supervisor and reviewed regulation 127.a. See attached photo of storage area. Responsible Party: PCHA, Housekeeping Supervisor, Maintenance Supervisor

2/27/20-- the PCHAs, Housekeeping and Maintenance supervisors discussed 127.a to ensure that there were not additional incidents of space heaters being brought into the building. Responsible Party: PCHA, Housekeeping Supervisor, Maintenance Supervisor

Legal Entity Representative

Signature  MA PCHA Printed Name and Title Laurel Spigler, Program Supervisor Date 3/30/20

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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

On multiple dates and times the homes drill records did not include the time it took to evacuate residents in am or pm to include the following: 8/25/19 at 10:30, 9/17/19 at 12:30, 10/31/19 at 11:10 and 11/28/19 at 10:30.

On multiple dates and times the home's fire drill records did not include the amount of time it took to evacuate residents in minutes and seconds to include the following: 4/30/19 at 3:00-only indicates 4 sec, 5/16/19 at 10:54-only indicates 4 sec, 9/17/19 at 12:30- only indicates 4 min and 11/28/19 at 10:30- only indicates 4 min.

On multiple dates and times the time to evacuate on the home's fire drill record was rounded to 4 minutes and 0 seconds to include the following: 9/17/19 at 12:30, 10/31/19 at 11:10 and 11/28/19 at 10:30.

On multiple dates and times the home's fire drill record did not not include the correct number of residents evacuated to include the following:

- * 2/18/19 at 11:00 a.m., the fire drill record indicates 51 residents present; however, only 5 residents evacuated
- * 3/18/19 at 12:31 p.m., the fire drill record indicates 52 residents present; however, only 3 residents evacuated
- * 4/30/19 at 3:00, the fire drill record indicates 52 residents present; however, only 3 residents evacuated
- * 8/25/19 at 10:30 the fire drill record indicates 52 residents present at the time of alarm sounding; however, 3 residents evacuated.
- * 9/17/19 at 12:30 the fire drill record indicates 49 residents present at the time of alarm sounding; however, 9 residents evacuated
- * 11/28/19 at 10:30 the fire drill record indicates 48 residents present at the time of alarm sounding; however, 8 residents evacuated.

The fire drill record indicates a fire drill was held on 10/31/19. However, multiple staff interviews indicted the actual fire drill was held on 10/15/19.

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.)

2/19/20 the home developed a new form to address identified issues with our fire drill record, the new form prompts staff to document all of the required information. February data was added to this form for continuity. See attached original form used in January, and updated form created the day of the February drill. Responsible Party: PCHA, Maintenance Supervisor

2/27/20- PCHA, Housekeeping supervisor, and maintenance supervisor (continues on page 11)

132c - Fire Drill Records (continued)

Legal Entity Representative


Signature  MA, PCHA

Printed Name and Title Laurel Spigler, Program Supervisor Date 3/30/20

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 Not Implemented

supervisor (director of facility management) reviewed the 2600.23 regulations on fire drill records and looked at past issues. Responsible Party: PCHA, Housekeeping supervisor, Maintenance Supervisor

3/1/20- the new form was implemented for tracking fire drills and documenting dire drills. See attached form. Responsible Party: Housekeeping Supervisor, Maintenance Supervisor

Beginning on 4/20/20 Monthly fire drill records will be reviewed at our monthly leadership meeting which is scheduled on the 3rd Monday of the month. The March leadership meeting was used for emergency Covid-19 planning. Responsible Party: PCHA, Team Lead

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

On 12/17/19 at 11:35 a.m., the first aid kit in the large van used to transport residents did not include eye coverings.

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 items were missing from the first aid kits because the kits had been used, and missing eye covers were not replaced which is our existing policy.

12/17/19—After being notified of the missing items during the inspection, the missing items were placed in the kit. The kits remain intact. See attached photo of the large van first aid kit. Responsible Party: Direct Care Staff

Beginning the week of 2/24/20, and continuing forward a continuous monitoring process have been implemented. The first aid kits were added to the weekly room check form. On alternating weeks the daylight and evening staff will verify the contents of each kit, and replace any missing items, these forms will be submitted to the PCHAs for review. The vans were both placed on the ground floor check-list to ensure they are not overlooked. See attached check lists. Responsible Party: Direct Care Staff on Daylight/Evening

Beginning on 4/1/20 the Team Lead will complete a monthly check which will be reviewed by the PCHs during the monthly leadership meeting on the third Monday of each month. This will be placed on the Monthly Quality Assurance and Regulatory Checklist. Our March meeting (3/16/20) had to be utilized for planning and implementing urgent programmatic changes in response to Covid-19. Responsible Party: Team Lead and PCHA

Legal Entity Representative


 MA, PCHA
Signature

Laurel Sprigler, Program Supervisor 3/30/20
Printed Name and Title Date

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(Date)

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(Date)

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(Initials)

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 Not Implemented

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

On 12/17/19, resident #2's Ketoconazole 2%- apply to affected area topically two times a day for 2 weeks, filled on 8/12/19, was still on the medication cart.

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 resident has been on and off of this medication for a significant period of time, and most recently on 1/6/20, after being discharged from the hospital, this medication was reinstated by Dr. Bunimovick a dermatologist. (see attached document: Page 13- Appointment Summary, Page 13- Current MAR)

Moving forward, two steps will be taken to prevent this from happening again. Beginning the week of 2/23/19 Garden View Nurses will pass medications 1 time per week in each medication room. During these medication passes the nurses will monitor the MARs and all medications and treatments for accuracy and timeliness. Special attention will be paid to medication expiration dates, time limited orders, and residents who have had recent medical appointments or lab work as needed.

Beginning in March overnight staff will verify all PRN, OTC, and Routine medications which are in the medication rooms against the MAR on a weekly basis. The purpose of this verification will be to ensure that all medication changes including dose changes, and discontinuation are managed appropriately. Medications which are found to be in the medication room, but are not on the MAR will be investigated in our WebConnect software and also in the resident's chart. If the correct information is available they will make the corrections to the MAR or remove the medication. All issues identified will be reported to the Garden View nursing and leadership team. This will be reviewed with all staff at the 2/26/20 staff meeting.

Legal Entity Representative

Laurel Spigler, MA PCHM
Signature

Laurel Spigler, Program Supervisor 2/18/20
Printed Name and Title Date

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4/30/20

(Date)

Plan of correction implementation status as of

5/29/20

(Date)

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(Initials)

Implemented

Not Implemented

183e - Storing Medications

Regulations

2600.

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

Description of Violation

Resident #1's prescribed Victoza 1.2 mg injection pen, was opened on 11/17/19 and expired on 12/17/19 according to the manufacturer's instructions. On 12/18/19, the expired medication was present in the medication cart and was administered to resident #1 during the 8:00 a.m. medication pass.

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.)

12/18/19, the expired Zictoza was removed from medication cart and replaced with a new pen. In addition, nursing staff verified that all injectables were current and not expired. Responsible Party: Nurse

Beginning 2/23/20 and moving forward, a new form was developed to show nurses verifying injectables on a weekly basis. Nurses will add information collected in previous medication cart audits to the new form. Responsible Party: Nurse

2/14/20-- stickers were ordered to assist with documenting expiration dates. See attached. Moving forward, once stickers arrive by 4/30/20, stickers will be placed on medications once opened to alert staff of the discard date for medication. This will be reviewed weekly by nurses. Responsible Party: RCA, Nurses, Team Lead, PCHA

2/26/20, Training occurred at monthly staff meeting. PCHA discussed the importance of documenting the date opened and checking expiration date on medications according to manufacturer's guidelines. Staff was reminded that you must discard a medication on the expiration date. See attached proof. Responsible Party: Staff-RCA, Nurses, Team Leads, PCHA's

Legal Entity Representative

 MA PCHA
Signature

Laurel Spigler, Program Supervisor 3/30/20
Printed Name and Title Date

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(Date) (Date)

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(Initials)

185a - Implement Storage Procedures

Regulations

2600.

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

Description of Violation

On 12/18/19, resident #1's glucometer was not calibrated to the current time.

Repeat Violation: 4/9/19

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.)

12/18/19 – All site glucometers had the times and dates verified. Responsible Party: Nurse

2/18/20- All site glucometers were verified again by the site nurse. From 2/18/20 to 3/1/20 nursing staff were to verify glucometers until overnight staff could be trained. Responsible Party: Nurse

2/26/20—PCHAs presented the new glucometer tracking form to all staff at the monthly staff meeting, and a follow-up communication was sent to staff. Staff who were not confident with programing glucometers were offered training. Responsible Party: PCHAs

3/2/20- Training sessions were offered to staff who requested it, staff were shown how to use various glucometer settings and how to complete the tracking. Responsible Party: Nurses, Residential Care Specialists

3/8/20- All glucometers were adjusted due to daylight saving time. Responsible Party: Overnight staff

Beginning on 3/2/20 for the purpose of ongoing monitoring the glucometers will be verified and the outcomes documented on our weekly glucometer verifications. This form will be completed each week, and reviewed at the monthly leadership meeting on the 3rd Monday of the month. See attached completed check lists. Responsible Party: Overnight staff, Team Leads, PCHAs

Legal Entity Representative


 MA PCHA
Signature

Laurel Spigler, Program Supervisor 3/30/20
Printed Name and Title Date

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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

On 12/17/19, multiple medications prescribed for resident #2 were present in the medication cart; however, they were not included on his December 2109 medication administration record (MAR) to include:

- * Lorazepam 0.5 mg- take 1 tablet by mouth as needed
- * Atropine 1% eye drop- apply one drop under tongue either side of tongue
- * Nystatin Cream 100000 units- apply topically to affected areas three times daily

Resident #3's December MAR does not include the strength of prescribed Atripla- take one tablet daily.

Plan of Correction (POC)

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

12/17/19- Resident #3 MAR was corrected by getting clarification on the dose, and making the edit. It appears this dosage was accidently deleted when the MAR was being updated. Responsible Party: Nurse

2/16/20-- To prevent this error from occurring the home will take the following steps to ensure no incorrect doses are left in the cart. If a resident is out of the building, their MARs will be coded as out of the building and flipped over. Resident medications to include PRNs, CAMs, and OTCs will be placed in an alternate storage area until the resident returns to the building and all orders are received and processed. In order to improve storage the program was approved to order new med carts in February. Responsible Party: Nurses, PCHA

(continues on page 17)

Legal Entity Representative

 MA PCHA
Signature

Laurel Spigler, Program Supervisor 3/30/20
Printed Name and Title Date

187a - Medication Record (continued)

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3/5/20 the home was notified that the cart order was only partially approved by the organization, and we are in process of researching additional storage options however this process is delayed due to Covid-19 and limited access to vendors. Responsible Party: PCHA

2/26/20- PCHA and nursing staff reviewed the importance of the 5-Rs and the steps to take to verify if a dose is missing from the MAR. Responsible Party: PHCA, Nurses

Beginning on 3/1/20 for the purpose of ongoing monitoring the Garden View Manor nursing staff will begin passing medications weekly, as a secondary check to our monthly cart audits. Responsible party: Nurses

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #4 was prescribed triamcinolone acetonide 55 mcg nasal spray- use 2 sprays in each nostril daily. However, this medication was not administered to the resident from 12/3/19 thru 12/17/19 because the medication was not available in the home.

Plan of Correction (POC)

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

Beginning on 12/31/19, after the resident continued to decline to pay for medication, a discontinue order was obtained from prescriber. See attached. Responsible Party: Nurse

Beginning on 1/23/20, PCHA, Senior Manager, Nurse met with pharmacy staff and discussed pharmacy assisting with options to help ensure all options are explored to assist residents in getting medications prescribed by exploring any discounts, coupons, helping prescriber explore a different medication covered by insurance. Responsible Party: Nurse, PCHA, Senior Manager

Beginning 2/1/20, Nurses will advocate to doctors to ensure medications are covered by insurance or OTC or see if samples are available to ensure the residents have access to medications prescribed/needed. In addition home will see if medications can be purchased in cheaper and/or in bulk at other places such as CVS, Sam's Club, and Wal-Mart etc. if resident still does not want to pay price given by pharmacy. If resident still does not want to pay after all options explored, home will reach out to doctor to see if prescriber wants to discontinue medication. Responsible Party: RCA, Nurses, Team Lead, PCHA, Physician

Legal Entity Representative


 MA PCHA
Signature

Laurel Spigler, Program Supervisor 3/30/20
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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 #2's assessment, dated 9/26/19, indicates he has a minimal problem with irritability, judgement, agitation and hallucinations. However, the support plan, dated 9/26/19, does not include the description, plan, frequency or responsible party to meet these service needs, these sections are 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.)

12/23/20—Resident #2 RASP was updated to include the missing information. See attached RASP pages.
Responsible Party: PCHA

2/26/20—All staff were reminded of the importance and purpose of coding, and were provided with an explanation of regulation 227.d. Responsible party: PCHA

Beginning on 4/1/20 the Team Leads and PCHA will divide RASPs for review and will discuss outcomes and concerns at the monthly leadership meeting, these will be reviewed at our monthly leadership meetings on the 3rd Monday of the month. This had originally been planned to start for the 3/16/20 leadership meeting, but this was delayed due to Covid-19 related planning. Responsible Party: PCHA, TL

Legal Entity Representative


 MA, PCHA
Signature

Lavel Spigler Program Supervisor 3/30/20
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227h - Support Plan Refuse Sign

Regulations

2600.

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

Description of Violation

The support plan for resident #1, dated 4/22/19, was not signed by the resident or noted by the home that the resident refused or was unable 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.)

On 4/22/19, upon Department request this plan was updated. It was noted that resident refused to sign plan. However, we did not note this on the form. This was home's fault as refusals are noted on forms.

Beginning on 12/23/19, the plan was updated and resident was asked to sign. Resident refused. Again, on 2/7/20, Resident was asked to sign to form and he refused. Refusals noted on form. Responsible Party: PCHA

On 2/26/20, at Monthly Staff Meeting, PCHAs discussed RASPs and importance of documentation with staff and notation of refusals. Staff was reminded to look through entire document and ensure all areas completed. Moving forward beginning 4/1/20, Team Leads will complete monthly quality assurance checks of charts to help address RASP, completions, and barriers. At Monthly Leadership meeting taking place 4/20/20 and moving forward the third Monday monthly, Team Leads and PCHA will address any compliance issues. Responsible Party: RCA, Team Lead, PCHA

Legal Entity Representative


 PCHA, MA
Signature

Laurel Spigler, Program Supervisor 3/30/20
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