



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES



CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to COUNTRYSIDE CONVALESCENT HOME LIMITED PARTNERSHIP

LEGAL ENTITY

To operate QUALITY LIFE SERVICES - MERCER

NAME OF FACILITY OR AGENCY

Located at 8221 LAMOR ROAD, MERCER, PA 16137

(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 36
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 36

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 7, 2020 until June 14, 2021,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **460500**

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



Email and Mailing DATE: July 14, 2020

Ms. Mary Susan Tack-Yurek
Chief Quality Officer / Co-Owner
Countryside Convalescent Home Ltd. Partnership
8221 Lamor Road
Mercer, Pennsylvania 16137

RE: Quality Life Services Mercer
Certificate #: 460500

Dear Ms. Tack-Yurek:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 28, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is a reduction from 100 to 36. The expiration date of the license remains unchanged.

Sincerely,

A handwritten signature in black ink that reads "Jamie L. Buchenauer". The signature is written in a cursive style with a large initial "J".

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

Enclosure
License

Since this is a reduction in the previous licensed capacity, you have the right to appeal this decision through a hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa.Code Part II, Chs. 31-35. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

RECEIVED

6/25/20

Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *QUALITY LIFE SERVICES - MERCER* License Number: *46050*
 Address: *8221 LAMOR ROAD,, MERCER, PA 16137*
 County: *MERCER* Region: *WESTERN*

Administrator

Name: *Claudia McIntyre* Phone: *7246625860* Email: *cjmcintyre@QUALITYLIFESERVICES.COM*

Legal Entity

Name: *COUNTRYSIDE CONVALESCENT HOME LIMITED PARTNERSHIP*
 Address: *8221 LAMOR ROAD, ATTN DIANNA JONES, MERCER, PA, 16137*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/04/2003* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *50* Waking Staff: *38*

Inspection

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

Inspection Dates and Department Representative

02/28/2020 - On-Site: Lori Gillette, Laurie Garrigan, Jan Cutter

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *37*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Lane* Capacity: *36* Residents Served: *11*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *37*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *13* Have Physical Disability: *0*

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 9:11 AM, 2 binders labeled "Daily Assignment" and "ADL record", were unlocked, unattended and accessible at the nurse's station and contained shower logs and a list of residents with wheelchairs, including residents #1, #2 and #3.

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.)

All Daily Assignment Binders and ADL Record binders are now kept in the locked medication room located off the PC nursing station. This was implemented at time of DHS inspection on 2-28-2020. This has been on-going. This was implemented by the PCNA.

See attachment: A
All staff education done: 6-24-2020 - see attached sign-in sheet.
Audit will be done weekly starting 6-24-2020 by PCNA/designee
Claudia McIntyre PCNA 6-23-2020

Legal Entity Representative

Claudia McIntyre

Signature

Claudia McIntyre PCNA 4-29-2020

Printed Name and Title

Date

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The above plan of correction is approved as of

6/30/20
(Date)

Plan of correction implementation status as of

6/30/20
(Date)

The above plan of correction was approved by

SE
(Initials)

Implemented
 Not Implemented

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

The resident-home contract, dated 8/1/18, for resident #4 was not signed by the resident.

The resident-home contract, dated 1/21/20, for resident #5 was not signed by the resident.

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.)

At time of survey on 2-28-2020 residents signed their contracts, See Attachments: B, C

Ongoing all contracts will be signed by the resident or indicate why resident is unable to sign. This is the responsibility of the PCHA/designee.

The PCHA will audit monthly all new admissions for resident signature this began 3-1-2020 and be in place for 3 months.

Audit Attached: D

All existing contracts will audited this will be completed by 7-1-2020

Claudia McIntyre PCHA 6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre PCHA 4-29-2020
Printed Name and Title Date

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- Not Implemented

82a - Poisonous Materials

Regulations

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At 10:40 AM, a plastic spray bottle containing an unlabeled, unidentified gold colored liquid was unlocked, unattended and accessible in a cabinet under the sink in the main dining 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.)

2-28-20 plastic spray bottle - unlabeled was removed and disposed of at time of DHS inspection 2-28-2020.

All poisonous materials will be stored in their original, labeled containers and shall be kept locked and inaccessible to residents.

The Director of House Keeping/maintenance was educated on this regulation upon hire and monitors all areas for compliance. See attached: E

All staff education provided 6-23-2020. Audit (weekly) will be performed weekly for 4 weeks starting 6-23-20.

Claudia McIntyre, PCHA 6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCHA 4-29-2020
Printed Name and Title Date

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 Not Implemented

88a - Surfaces

Regulations

2600.

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

Description of Violation

The ceiling is in disrepair in the following locations:

- * Bedroom #35 - ceiling is bubbled and paint is loose in an area approximately 1.5' x 3", above the door
- * Storage room #201- paint is bubbled in an area approximately 2' x 2', above the sink
- * Secured Dementia Care Unit (SDCU) dining room - paint is peeling and missing in an area approximately 1.5' x 1.5', above the kitchen cabinets and refrigerator

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.)

Bedroom #35 above door repairs completed See Attached: ①

Storage Room #201 above sink repairs completed See Attached: ②

The area of the roof that has caused the penetration, peeling and missing paint in the SDCU has been approved by the CEO of Quality Life Services to be replaced. After roof is replaced, the ceiling in this area will be repaired and painted. Roofing companies are being contacted for price quotes so this work can begin ASAP, 6-24-20 Roof replaced,

③ Ceiling fixed - see attached, Education done, Audit to be done by Maintenance Director weekly for 1 month beginning 6-23-20
Claudia McIntyre PEHA 6-24-20
Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PEHA 5-7-2020
Printed Name and Title Date

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Implemented
 Not Implemented

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103f - Refrigerator/Freezer Temps

Regulations

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 11:26 AM the temperature in the SDCU refrigerator was 48 degrees Fahrenheit and at 1:59 PM it was 34 degrees Fahrenheit.

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 temperature in the SDCU refrigerator was immediately adjusted on 2-28-2020 at time of DHS Survey. It was observed @ 1:59 pm that the adjustment made was effective. Maintenance is notified to make adjustment. The temperature of refrigerators are monitored and documented daily by the dietary staff. If adjustments are required they are made, then rechecked for effectiveness. This is also done by the dietary staff. These daily temps are logged on the Refrigerator Temperature logs and reviewed weekly by the Certified Dietary Manager for compliance. See Attached: F, G All staff education done 4-23-20 All ^{staff} audit remain in place as previously submitted. This audit will be done for 3 months, done daily.

Claudia McIntyre PCHA 4-24-2020

Legal Entity Representative

Claudia McIntyre

Signature

Claudia McIntyre PCHA 4-29-2020

Printed Name and Title

Date

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(Initials)

Implemented

Not Implemented

125b - Combustible Restrictions

Regulations

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

At 10:15 AM, a red metal gas can containing approximately 2 gallons of gasoline was unlocked, unattended, and accessible to residents at the exterior of the home near the basement exit.

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.)

2-28-2020 during DHS Annual Survey this gas can was removed from exterior of the home near basement exit.

A Craftsman storage cabinet was purchased by home for the purpose of storing gas can. This cabinet is located on exterior of building by exit to maintenance shop. This cabinet has a lock on it. 6-23-2020

See Attached: H, I

upon Assisted Living License inspection on 4-23-2020 it was verified by inspector that gas can was removed from exterior of the home near basement exit.

6-23-20 All staff education done, weekly audit by Maintenance Director will be performed for 4 weeks.

Claudia McIntyre PCHA 6-23-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre PCHA 4-29-2020
Printed Name and Title Date

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Implemented
 Not Implemented

QUALITY LIFE SERVICES - MERCER

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

The medication addendum on resident #2's annual medical evaluation, dated 3/5/19, indicates "see attached list"; however, no list is attached.

Repeat Violation: 12/21/2018

Plan of Correction (POC)

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

All DME's will be reviewed by PCCHA / designee to ensure all sections are properly completed. This will be done upon admission annually and significant change. The medication summary dated 3-5-19 was attached to DME. The PCCHA will audit DME's monthly to ensure compliance. This will begin 5-1-2020. This audit will be in place for 3 months. The medication list was attached to resident #2's DME. see 6/30/20. This will be done by PCCHA.

See Attached; (J) 6-23-20 This audit will be done (initial) by 7-1-20 and will remain in place for 3 months. This audit also serves as a tracker. See Attached; (K) C. McIntyre PCCHA 6-23-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre PCCHA 4-29-2020
Printed Name and Title Date

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

162c - Menu Posted

Regulations

2600.

162.c. Menu, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu was only posted through 2/29/20.

Plan of Correction (POC)

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

This was corrected at time of DHS survey 2-28-2020.
A audit was created 2-28-2020 and will be done weekly, this began on 2-28-2020, by PCHA.
See Attached: L

This audit will be completed for 3 months by the PCHA.
All staff education done 4-23-20

Claudia McIntyre PCHA
6-24-2020

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre
Printed Name and Title

4-29-2020
Date

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(Date)

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6/30/20
(Date)

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SE
(Initials)

Implemented
 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

The medication cart contained Aleve Naproxen Sodium capsules 220mg for resident #1, however, she has no current prescription for this medication and her February 2020 Medication Administration Record (MAR) indicates she is allergic to this medication.

Repeat Violation: 12/21/18

Plan of Correction (POC)

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

2-28-2020 at time of DHS Annual Survey this medication (Aleve) was removed from the medication cart, explanation was provided to resident #1 on rationale.

Upon receiving the 2-28-2020 Violation Report, a whole house medication audit is scheduled to begin Monday 5-11-2020 by LPN/PCA and Quality Pharmacy consulting RPH. Staff (PCAs/medTechs) will be educated on all violations received concerning medications and document that they understand the education. This education will be in employee training files. See Attached (M) This will be completed by 7-1-2020. A weekly medication audit will be done by PCAs/medTechs for 3 months to ensure compliance, see Attached (N) 6-23-20 Staff educated completed, error 6-24-20 (M) Claudia McIntyre RW - 6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCA 5-6-2020
Printed Name and Title Date

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SE (Initials)

Implemented
 Not Implemented

184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #1 is prescribed Humalog/100ML - administer per sliding scale subcutaneously 1 time a day; however, the medication did not contain a pharmacy label.

Resident #4 is prescribed Novalog/100ML - administer per sliding scale subcutaneously 4 times a day; however, the pharmacy label did not contain the sliding scale.

Resident #4 is prescribed Venlafaxine HCL ER Capsule Extended Release 24 Hour, 37.5mg - give 2 capsules by mouth in the morning; however, the pharmacy label indicates - Venlafaxine HCL ER 75mg - take 1 capsule in the morning.

Repeat Violation: 12/21/2018

Plan of Correction (POC)

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

2-28-2020 at time of DHS Annual Survey these violations were corrected for resident #1 by returning insulin back to original container with a pharmacy label on it. Resident #4 insulin was returned to container (original) with a pharmacy label and a change of direction sticker placed on bag. Resident #4 medication was corrected by placing a change of direction sticker on the medication card. On 5-6-2020 per the DHS violation report the medication order was update with correction on eMAR. A whole house medication audit is scheduled to begin Monday 5-11-2020 by LPN/PCHA and Quality Pharmacy consulting RPH, Staff PCHA's/med techs. They will be educated on all violations received concerning medications and document that they understand the education. kept in Training file see Attached. A weekly medication audit will be done by PCHA's/med Tech for 3 months to ensure compliance. See Attached. This education will be completed by 7-1-2020.

Legal Entity Representative

Claudia McIntyre PCHA 6-24-20

Claudia McIntyre
Signature

CLAUDIA McIntyre, PCHA 5-6-2020
Printed Name and Title Date

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(Date)

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(Date)

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(Initials)

- Implemented
 Not Implemented

185a - Implement Storage Procedures

Regulations

2600.

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

Description of Violation

Resident #1 is prescribed Lantus Solostar 100 units/ML - administer 57 units subcutaneously at bedtime, and Humalog/100ML - administer per sliding scale subcutaneously 1 time a day; however, these medications do not indicate the date opened.

Resident #3's glucometer is not calibrated to the current date and time.

Resident #4 is prescribed Lantus Solostar 100 units/ ML - administer 10 units subcutaneously at bedtime, and Novalog/100ML - administer 7 units subcutaneously 1 time a day; however, these medications do not indicate the date opened.

Resident #4's glucometer is not calibrated to the current 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.)

2-28-2020 at time of DHS Annual Survey date, opened labels were placed on residents #1 and residents #4 insulin. Resident #3 and resident #4's glucometer were calibrated to correct date and time. 4-29-2020 Upon receiving the 2-28-2020 violation report, a whole house medication audit is scheduled to begin 5-11-2020 by LPN/PCA and Quality Pharmacy Consulting RPH. Staff (PCA's/med Techs) will be educated on all violations received concerning medications and document that they understand the education. See Attached. A weekly medication audit will be done by PCA's/med Techs for 3 months to ensure compliance. See Attached. (R) This education will be completed by 7-1-20

Claudia McIntyre PCA
6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre PCA
Printed Name and Title
5-6-2020
Date

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

6/30/20
(Date)

Plan of correction implementation status as of _____
(Date)

Implemented
 Not Implemented

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

SE
(Initials)

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.

Description of Violation

Resident #1 is prescribed Furosemide tablet 20 mg - take 20 mg by mouth one time a day; however, her February 2020 MAR indicates - Furosemide tablet 40 mg - take 20 mg by mouth 1 time a day.

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.)

4-29-2020 upon receiving the 2-28-2020 Violation Report, resident #1 Furosemide order was verified and put in eMAR to reflect correct MD order. A whole house medication audit is scheduled to begin Monday 5-11-2020 by LPN/PCA and Quality Pharmacy consulting RPH. Staff will then be educated on all violations received concerning medications and document that they understand the education. This education will be in employee training files See Attached: (S) This education will be completed by 7-1-2020 A weekly medication Audit will be done by PCAs/Med Techs for 3 months to ensure compliance. See Attached: (T) Claudia McIntyre PCA 6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCA 5-6-2020
Printed Name and Title Date

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(Date)

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(Initials)

- Implemented
- Not Implemented

225a - Assessment 15 Days

Regulations

2600.

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

Description of Violation

Resident #1's initial medical evaluation, dated 8/28/19, indicates a diagnosis of Essential Hypertension, Chronic Kidney Disease Stage 3, Obesity, Lumbar Spinal Stenosis, Insomnia, Primary Generalized Osteoarthritis, Fatty Replacement of the Pancreas, GERD, Frequent Falls, Mild Aortic Stenosis, and Moderate Mitral and Mild to Moderate Tricuspid Resurge. However, her initial assessment, dated 9/17/19, does not include these diagnoses.

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.)

4-29-2020 RASP was updated to include all diagnosis as indicated on 8-28-19 initial medical evaluation. This was done by PCHA. See attached: U

Ongoing all DME's RASP's will be reviewed by PCHA for completion and accuracy on initial, annual and significant change department paperwork.

See Pre-Screen/DME/RASP Tracking Audit Tool

See attached: V

This whole house PC audit will be completed by 7-1-2020 by PCHA/designee

Claudia McIntyre PCHA
6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre PCHA
Printed Name and Title Date

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Implemented
 Not Implemented

225c - Additional Assessment

Regulations

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

Description of Violation

Resident #4's most recent assessment was completed on 7/9/18.

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.)

This RASP was done on 2-28-2020 as corrective action on this violation noted on the Annual DHS survey on 2-28-2020. See Attached: W
Ongoing it is the responsibility of the PCHA/designee to review all RASPs for accurate, timely completion. This is ongoing to ensure this violation will not reoccur. The attached Audit tool will be used. See Attached: X

This audit will be completed by 7-1-2020 Claudia McIntyre, PCHA
4-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCHA 4-29-2020
Printed Name and Title Date

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(Date)

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(Date)

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

Implemented
 Not Implemented

231b - Medical Evaluation

Regulations

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the SDCU on 1/3/19; however, her medical evaluation was completed on 7/9/18, with no indication of the need for the resident to be served in a secured dementia care unit.

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 2-28-2020 a new DME was completed noting need for secured memory unit.
See Attached: Y

PCHA / designee will review. Pre-Screens/DME's/RASPs for accurate, timely completion. This is on-going to ensure this violation will not reoccur.
See Attached: Z

This audit will be completed by 7-1-2020 *Claudia McIntyre PCHA*
6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCHA 4-29-2020
Printed Name and Title Date

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The above plan of correction is approved as of 6/30/20
(Date)

Plan of correction implementation status as of 6/30/20
(Date)

- Implemented
- Not Implemented

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

231c - Preadmission Screening

Regulations

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the SDCU on 1/3/19; however, no written cognitive preadmission screening was 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 2-28-2020 a new Preadmission Screening was completed to reflect need for a secured dementia care unit. See attached: AA

PCHA/designee will review Pre-Screen's/DME's/RASP's for accurate, timely completion, This is on-going to ensure this violation will not reoccur.

See Attached: BB

This audit will be completed by 7-1-2020

Claudia McIntyre PCHA
6-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCHA 4-29-2020
Printed Name and Title Date

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The above plan of correction is approved as of 6/30/20 (Date)

Plan of correction implementation status as of 6/30/20 (Date)

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

Implemented
 Not Implemented

231f - Assessed Annually

Regulations

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident #4 was admitted to the SDCU on 1/3/19; however, she has not been assessed for the need for an SDCU.

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 RASP was done on 2-28-2020 as corrective action on this violation noted on the Annual DHS survey on 2-28-2020. See attached; CC

Ongoing it is the responsibility of the PCHA / designee to review all RASPs for accurate, timely completion.

This is on-going to ensure this violation will not re-occur. The attached Audit tool will be used.

See Attached; DD

This audit will be completed by 7-1-2020

Claudia McIntyre PCHA
10-24-20

Legal Entity Representative

Claudia McIntyre
Signature

Claudia McIntyre, PCHA 4-29-2022
Printed Name and Title Date

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The above plan of correction is approved as of 6/30/20
(Date)

Plan of correction implementation status as of 6/30/20
(Date)

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

Implemented
 Not Implemented

233a - Lock Approval

Regulations

2600.

233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locking system used on the exit doors from the SDCU.

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.)

At the time of DHS survey 2-28-2020, this letter to meet this regulation was not located. After the survey this letter was located.

See Attached: EE

An inspection by Richardson Inspection services (a local building authority inspector) was completed 6-18-2020. See Attached All staff education was done 6-23-2020. Audit will be done weekly for 4 weeks by Maintenance Director to ensure compliance.

Claudia McIntyre PCHA
6-24-20

Legal Entity Representative

Claudia McIntyre

Signature

Claudia McIntyre, PCHA 4-29-2020

Printed Name and Title

Date

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The above plan of correction is approved as of

6/30/20
(Date)

Plan of correction implementation status as of

6/30/20
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

SE
(Initials)