



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES



CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **KEVIN & ROMONA DONAHUE**

LEGAL ENTITY

To operate **DONAHUE'S PERSONAL CARE I**

NAME OF FACILITY OR AGENCY

Located at **1610 HYBLA STREET, PITTSBURGH, PA 15212**

(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 **17**

(MAXIMUM CAPACITY)

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

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 23, 2020** until **July 23, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **430340**

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



Emailing Date: July 23, 2020

Mr. Kevin Donahue
Administrator
Kevin & Romona Donahue
1143 Lapish Road
Pittsburgh, Pennsylvania 15212

RE: Donahue's Personal Care I
1610 Hybla Street
Pittsburgh, Pennsylvania 15212
Certificate #: 430340

Dear Mr. Donahue:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on January 28, 2020 and March 30, 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 style with a large initial "J".

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

Enclosures
License
Licensing Inspection Summary

Violation Report

Facility Information

Name: DONAHUE'S PERSONAL CARE I
Address: 1610 HYBLA STREET,, PITTSBURGH, PA 15212
County: ALLEGHENY Region: WESTERN

License Number: 43034

Administrator

Name: Kevin Donahue Phone: 4127616421 Email: DONAHUESPC@GMAIL.COM

Legal Entity

Name: KEVIN & ROMONA DONAHUE
Address: 1143 LAPISH ROAD, PITTSBURGH, PA, 15212

Certificate(s) of Occupancy

Type: C-2 LP Date: 10/26/1985 Issued By: City of Pittsburgh

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 16 Waking Staff: 12

Inspection

Type: Full Reason: Provisional BHA Docket #: Notice: Unannounced

Inspection Dates and Department Representative

01/28/2020 - On-Site: Barbara Barone, Courtney Barry

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 17 Residents Served: 16

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 5 Are 60 Years of Age or Older: 9
Diagnosed with Mental Illness: 10 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 0 Have Physical Disability: 0

64c - Annual Training

Regulations

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, completed 0 hours of Department-approved training in the 1/1/19 - 1/31/19 training year.

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.)

Legal Entity Representative

See page 2a of 18


Signature 

Printed Name and Title *Ketan Donahue* Date *3/3/20*

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

The above plan of correction is approved as of *3/19/20*
(Date)

Plan of correction implementation status as of *6/10/20*
(Date)

The above plan of correction was approved by 
(Initials)

Implemented
 Not Implemented

2600.64c

It is important that Donahue's Personal Care Administrator shall have at least 24 hours of annual training relating to job duties.

The problem occurred due the Administrator's presumption that the home would no longer be licensed to operate.

On March 2, 2020, The Administrator completed 12 hours of department approved training. See attachment A 1-12

On March 2, 2020, The Administrator registered and paid for 15 hours of Administrator training through the Butler Community College professional certifications program. The first class, "Care for Residents with Dementia" is scheduled for March 20, 2020. The second class, "Care for Residents with Mental Illness" is scheduled for April 3, 2020. See attachment A - 13

Following the aforementioned classes, the Administrator will have completed 27 hours of Administrator training for the 2019 calendar year.

Due to the Corona Virus, PCH Administrator classes at the Butler County Community College (BC3) are canceled for now and are being moved to online classrooms. The BC3 program admin believes the online classes will be ready by April 3, 2020. See attachment U1 & U2.

The Administrator of Donahue's Personal Care will fax/email documentation of such by May 31, 2020.

Going forward, the Administrator will continue to meet the annual training requirements as expected. The Administrator will complete a minimum of 24 hours of Administrator training by year end for the 2020 calendar year. The target date for the first 12 hours for 2020 will be completed at BC3 by October 15, 2020. The additional 12 hours of Administrator training for 2020 will be completed by December 10, 2020. All 24 hours of Administrator training will be completed in the next fall semester at BC3 campus.

The Administrator is responsible to ensure all required training hours are completed with in the training calendar year. The Administrator is responsible to save/copy certificates for Administrator's file for future viewing purposes.



85a - Sanitary Conditions

Regulations

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

Description of Violation

There is a hole in the basement floor, approximately 2 1/2' x 2 1/2' x 5" with 4" of standing water, directly in front of an exit door with no latch or door handle, held shut from the outside by a brick leaning against the door, creating a mold hazard and blocking outside egress.

The underside of the bathmat in the shower of the 2nd floor common bathroom has a black mold-like substance around multiple suction cups.

There is a used, wet washcloth in the shower next to a bottle of shampoo in the 2nd floor common bathroom.

The lid on the kitchen trash can is covered in dried debris.

The ceiling fan in the kitchen is covered in a thick layer of dust.

There are approximately 50 cigarette butts on the ground along the uncovered portion of the smoking deck.

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.)

Legal Entity Representative



Signature

Printed Name and Title *Karin Donahue* Date *3/3/20*

See page 3a of 18

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

The above plan of correction is approved as of *3/19/20*
(Date)

Plan of correction implementation status as of *6/10/20*
(Date)

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

Implemented
 Not Implemented

2600.85a

Donahue's Personal Care understands the importance of maintaining sanitary conditions.

The Administrator had taken immediate action to remedy the items discussed in Regulation 85.a.

The Administrator identified the source of the run off water collecting by the back-basement door. The Administrator learned that slope of downspout extender was allowing water to roll back towards the back-basement door. On February 26, the Administrator dug out a trench to allow the run off water to flow outward away from the home in the downspout extender. The area is dry and no longer collecting water. See attachment B - Figure 1

On January 28, 2020 (same day), the Administrator removed and discarded the bath matt. On January 30, 2020, the Administrator purchased and installed a new bath matt. See attachment B - Figure 2

On January 28, 2020 (same day), the Administrator removed the washcloth and placed in the dirty laundry area.

On February 27, 2020, the Administrator spoke to all the residents and informed them of the "do's and dont's" of what can and cannot be left in the bathroom areas. Each resident was advised to ensure towels and washcloths are placed for laundry after each use. See attachment S1 & S2

On February 27, 2020, the Administrator purchased a new kitchen trash container and discarded the old one. See attachment C - Figure 3

On February 27, 2020, the Administrator personally disassembled cleaned and sanitized the blades and light globe of the kitchen ceiling fan and then reassembled. See attachment D - Figure 1 & 2

On February 27, 2020, the Administrator spoke to all residents who use tobacco and advised to place cigarette butts in the approved cigarette extinguisher receptacles. Residents were understanding and seem to be complying with the Administrators request.

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report and the items mentioned above. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

Documentation shall be kept for Department review.

 3/19/20

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

There are 12 full black trash bags, 1 full white trash bag, multiple cardboard boxes and an empty peanut butter jar without a lid, lying on the ground by the full trash cans near the side deck.

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.)

Legal Entity Representative

See page 4a of 18

[Handwritten Signature]

Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

Implemented
 Not Implemented

01/28/2020

2600.85e

Donahue Personal Care values the importance that trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

The problem occurred due to a basement cleaning project. During this time there was more than twice as much trash going out for pick up which caused trash bags to not have a spot inside the bin. The bin itself has reached its useful life and was in need of replacement.

The site survey was on Tuesday January 28, 2020. The homes collection day is every Wednesday. The trash by the trash bin by the back deck along with all of the other trash from the basement cleaning project was taken down to the curb that night (same day) for pick up. The area was cleaned up and remains in compliance. See attachment E Figure 2

Attached is an invoice from our refuse vendor indicating the extra charge for extra items to be picked up. Such requests by the Administrator must be made approximately 5 days in advance. See attachment F

Extra trash that cannot be fit into a regular covered trash bin for weekly pick-up is a rarity and will continued to need to be monitored and coordinated by the Administrator on a case by case basis. All of the trash placed curbside was picked up next day by the refuse company except for a bathroom sink top. See attachment G Figure 1 & 2

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

It is the staff's responsibility daily to report any all issues with trash debris around the premise.

It is the Administrator's responsibility daily to ensure any/all debris is cleaned up, collected and discarded in an orderly fashion. Beginning February 29, 2020, the Administrator has added building grounds (trash area) to the building bi-weekly check list. See attachment H

Documentation shall be kept for Department review.

 3/19/20

87 - Lighting

Regulations

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

There is no light bulb in the the exterior light fixture by the emergency exit from bedroom #5.

Plan of Correction (POC)

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

Legal Entity Representative

See page 5a of 18

[Handwritten Signature]
Signature

Kerri Donahue
Printed Name and Title

3/3/20
Date

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

The above plan of correction is approved as of 3/19/20
(Date)

Plan of correction implementation status as of 6/10/20
(Date)

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

Implemented
 Not Implemented

2600.87

Donahue Personal Care understands that the home's hallways, interior stairs, outside doorways, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure residents, including those with vision impairments can safely move through the home and safely evacuate.

The problem was the light bulbs to the automatic sensor light were missing completely. The Administrator believes a resident unscrewed the light bulbs for some strange reason or for use in bedroom lamps. However, the Administrator and or staff should have caught this and remedied immediately.

On January 28, 2020, (same day) the Administrator retrieved and installed two new lightbulbs. See attachment E Figure 1

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

The Administrator will continue to monitor this and ensure adequate lighting is always operational. The Administrator added check 2nd floor emergency lights to the bi-weekly building check list to ensure compliance is maintained. Check lists are completed on or around the 10th and 25th of each month.

Documentation shall be kept for Department review.

It is the Administrator's responsibility to check and remedy any issues that may arise. Building check lists will be hung in the dining area for immediate viewing purposes.

3/19/20

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

There is a hole in the basement floor, approximately 2 1/2' x 2 1/2' x 5" with 4" of standing water, directly in front of an exit door with no latch or door handle, held shut from the outside by a brick leaning against the door, creating a mold hazard and blocking outside egress.

A section of wall tile, approximately 12" x 1", is deteriorated where it meets the kitchen sink, exposing the wall framing.

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.)

Legal Entity Representative

See page 6a of 18

Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

Implemented
 Not Implemented

2600.88a

Donahue Personal Care strives to maintain floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

The Administrator identified the source of the run-off water collecting by the back-basement door. The Administrator learned that slope of downspout extender was allowing water to roll back towards the back-basement door. On February 26, the Administrator dug out a trench to allow the run-off water to flow outward away from the home in the downspout extender. The area is dry and no longer collecting water. See attachment B Figure 4

On February 27, 2020, the Administrator repaired the section of deteriorating tile where it meets the kitchen sink and re-caulked all the way around the kitchen sink. See attachment D Figure 4

This matter is repaired and should continue to maintain compliance with no further issues.

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes. See attachment H

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

1 side of the 2nd floor foyer smoke detector is detached from and hangs down from the ceiling approximately 2", exposing a wire.

There are no drawer pulls on the top drawer of resident #1's dresser in bedroom #3.

The legs of the toileting chair in the 1st floor common bathroom near bedroom #3 are deteriorating, leaving a layer of rust on the front rim of the toilet bowl.

The seat cushion on the chair next to the fireplace in bedroom #6 is covered in dried debris.

The under-cabinet light above the kitchen sink is not operable.

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.)

Legal Entity Representative

Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

See page 7a of 18

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

The above plan of correction is approved as of

3/19/20

(Date)

Plan of correction implementation status as of

6/10/20

(Date)

The above plan of correction was approved by

(Initials)

Implemented

Not Implemented

2600.95

Donahue Personal Care believes furniture and equipment must be in good repair and free of hazards.

The problem occurred to the smoke detector due to a newer smoke detector being installed in the same area. The smoke detector found to be hanging was an older one no longer in use. It should have been removed when the new one was installed. See attachment C Figure 1 & 2

The problem occurred to the dresser drawer handle because it is a single drawer made with two handles. The top handle braking did not limit the resident's ability to easily open and close the top dresser drawer. On February 27, 2020, the administrator installed two new knobs in place of the missing handle. See attachment I Figure 2 & 3

The problem occurred to toileting chair support bar was due to its age. The toileting chair was in need of total replacement. On, February 28, 2020, the Administrator purchased and installed a new toileting chair to go over the porcelain toilet. See attachment J Figure 2 & 3

The seat cushion on the chair next to the fireplace in bedroom 6 was cleaned and sanitized. The under-cabinet light was replaced with a new under cabinet light due to its age. See attachment K Figure 1 & 2

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

Staff were reeducated regarding the requirements of this regulation on 2/27/20.

 3/19/20

Kevin Donahue, Administrator



Date 3/3/2020

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

Green moss is covering the top of the handrails on the side deck near the trash cans, posing a slip/fall hazard.

There are multiple full black trash bags, 3 broken plastic laundry baskets, a 5 gallon container of paint and other trash sitting on the sidewalk in front of the home, posing a trip hazard.

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.)

Legal Entity Representative

See page 8a of 18



Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

- Implemented
- Not Implemented

2600.100a

Donahue Personal Care understands the importance that the exterior of the building and the building grounds or yard must be in good repair and free of hazards.

The green moss on the handrails occurred due the over hanging trees. On February 28, the Administrator purchased moss, mold and algae remover. See attachment L Figure 1,2 & 3

On February 27, 2020, the Administrator sprayed all affected areas. The moss is now completely removed. The hand rails will need to be re-painted once the weather warms. This project is scheduled for the second week of April 2020.

The problem occurred due to a basement cleaning project. During this time there was more than twice as much trash going out for pick-up which caused trash bags to not have a spot inside the bin. The bin itself has reached its useful life and was in need of replacement.

The site survey was on Tuesday January 28, 2020. The homes collection day is every Wednesday. The trash by the trash bin by the back deck along with all of the other trash from the basement cleaning project was taken down to the curb that night (same day) for pick up. The area was cleaned up and remains in compliance. See attachment G Figure 3

Attached is an invoice from our refuse vendor indicating the extra charge for extra items to be picked up. Such requests by the Administrator must be made approximately 5 days in advance. See attachment F

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks on the 10th and 15th of each month to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

101j1 - Mattress Fire Retardant

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

There are multiple tears in resident #1's mattress. The largest tear is approximately 3' x 1". Resident #1 resides in bedroom #3.

There is a tear approximately 1/2" x 1/2" on the middle left side near the top of resident #2's mattress. Resident #2 resides in bedroom #6.

There are 3 long tears on the top of resident #3's mattress, each approximately 3' x 1/4" - 1/2". Resident #3 resides in bedroom #6.

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.)

Legal Entity Representative

See page 9a of 18

[Handwritten Signature]

Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

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

The above plan of correction is approved as of

3/19/20

(Date)

Plan of correction implementation status as of

6/10/20

(Date)

The above plan of correction was approved by

SE

(Initials)

Implemented

Not Implemented

Donahue Personal Care

2600.101j

Donahue Personal Care works hard to ensure each resident has a bed with a solid foundation and a mattress that is in good repair, clean and supports the resident.

The problem occurred due to mattress rubbing against metal bed frames.

On February 6, 2020, the Administrator had taken action by purchasing new replacement mattresses.

See attachment M Figure 1,2 & 3

The mattresses that were found to have tears were replaced and discarded for trash.

The Administrator is continuing to work with medical equipment suppliers to ensure mattresses are replaced in a timelier manner.

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes. See attachment H

Kevin Donahue, Administrator



Revised Date 3/19/2020

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #4 does not have access to a source of light that can be turned on/off at bedside. Resident #4 resides in bedroom #7.

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.)

Legal Entity Representative

See page 10a of 18

Kevin Donahue

Signature

Kevin Donahue

Printed Name and Title

3/3/20
Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

Implemented
 Not Implemented

2600.101j.7

Donahue Personal Care believes it to be very important that each resident shall have and operable lamp or other source of lighting that can be turned on at bedside.

The problem occurred due to the resident moving the bedside lamp further down the dresser and out of arms reach. The staff failed to catch and correct the problem in a timely fashion.

On January 28, 2020 (same day) the Administrator moved the lamp back into the correct position, ensured the lamp was plugged in and operational. Compliance was then immediately met same day of site survey. See attachment N Figure 4

On February 27, 2020, the Administrator spoke to all the residents and informed them of the "do's and dont's" of what can and cannot be left in the bathroom areas. Each resident was advised to ensure towels and washcloths are placed for laundry after each use. See attachment S1 & S2

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

The Administrator spoke to all residents in the home about the "Room Rules" posted on each resident bedroom door. The Administrator reminded residents that furniture is not permitted to be moved without staff permission and that lamps are not unplugged for the intended use of other electronic devices. The residents were understanding and seemed to willing to comply.

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

Kevin Donahue, Administrator



Revised Date 3/19/2020

101o - Walls, Floors, Ceilings

Regulations

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

Multiple dark sections of debris are on the ceiling light panel in bedroom #5, blocking the light. In addition, 2 ceiling tiles adjacent to the light are stained brown and contain a substance that appears to be mold.

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.)

Legal Entity Representative

See page 11a of 18

[Handwritten Signature]

Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

- Implemented
- Not Implemented

2600.101.o.

Donahue Personal Care work hard to ensure the bedrooms have walls, floors and ceilings that are finished and in good repair.

The problem occurred due to the age of the light covering and lack of staff cleaning activities for this item.

On February 28, 2020, the Administrator purchased a new clear plastic light covering and two new drop-ceiling tile panels. The replacements items were installed eliminating the problem. See attachment N Figure 1 & 2

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes. See attachment H

102e - Privacy - Doors/Partitions

Regulations

2600.

102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

There is no lock on the door of the 1st floor common bathroom, near bedroom #3, and no other means to provide privacy while in use.

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.)

Legal Entity Representative

See page 12a of 18

[Handwritten Signature]

Signature

Kevin Donahue

Printed Name and Title

3/3/20
Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

- Implemented
- Not Implemented

2600.102.e

Donahue Personal Care strives to ensure privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

The problem occurred due to the "eye hook" lock becoming worn and inoperable. The bathroom door continued to provide privacy; however, the locking mechanism was in need of repair.

On January 29, 2020, the Administrator drilled a new hole and installed a new locking mechanism to ensure privacy standards are met. See attachment I Figure 2

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

It is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home.

Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

102k - No Common Towel

Regulations

2600.

102.k. Use of a common towel is prohibited.

Description of Violation

There was an unlabeled, multi-colored towel hanging on the shower grab bar to the left of the toilet in the 2nd floor common bathroom.

Repeat Violation: 9/27/2018

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.)

Legal Entity Representative

See page 13a of 18

[Handwritten Signature]

Signature

Kevin Donahue

Printed Name and Title

3/3/20

Date

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

The above plan of correction is approved as of

3/19/20

(Date)

Plan of correction implementation status as of

6/10/20

(Date)

The above plan of correction was approved by

SE

(Initials)

Implemented

Not Implemented

Donahue Personal Care

Certificate 430341

2600.102k

Donahue Personal Care understands the importance that the use of a common towel is prohibited.

The problem occurred due to certain residents using the towel to place on floor for exiting the shower.

On January 28, 2020 (same day), the Administrator removed the towel and placed near laundry area for cleaning.

On February 27, 2020, the Administrator spoke to all the residents and informed them of the "do's and dont's" of what can and cannot be left in the bathroom areas. Each resident was advised to ensure towels and washcloths are placed for laundry after each use. See attachment S1 & S2

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

It is the staff's responsibility to identify and correct daily during bathroom cleaning rounds. The staff shall continue to work with residents who have a hard time understanding why this is important.

Going forward, it is the staff's responsibility daily to correct as they become aware of them in the home.

The Administrator has developed a building checklist and will performed bi-weekly building checks on the 10th and 25th of each month to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

Kevin Donahue, Administrator



Revised Date 3/19/2020

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

There is a hole in the basement floor, approximately 2 1/2' x 2 1/2' x 5" with 4" of standing water, directly in front of an exit door with no latch or door handle, held shut from the outside by a brick leaning against the door, creating a mold hazard and blocking outside egress.

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.)

Legal Entity Representative



Signature

Kevin Donahue

Printed Name and Title

See page 14a of 18

3/3/20
Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

Implemented
 Not Implemented

2600.121a

Donahue Personal Care understands the importance that stairways, hallways, doors and passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

The problem occurred due to debris being left behind by the walk-out basement door during the basement cleaning project.

On January 29, 2020, the Administrator removed the debris to ensure the walk-out basement door was operational and able to open with ease. See attachment B Figure 4

On January 29, 2020, the Administrator installed a latch on the walk-out basement door. See attachment N Figure 3

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks on the 10th and 15th of each month to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

131f - Fire Extinguisher Inspection

Regulations

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The kitchen fire extinguisher has no tag to indicate the date it was inspected by a fire safety expert.

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.)

Legal Entity Representative


Signature

Kevin Donahue
Printed Name and Title

See page 15a of 18

3/3/20
Date

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

The above plan of correction is approved as of 3/19/20
(Date)

Plan of correction implementation status as of 6/10/20
(Date)

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

Implemented
 Not Implemented

2600.131f

Donahue Personal Care strive to work with vendors to ensure fire extinguishers shall be inspected and approved annually by a fire safety expert. And that the date of the inspection shall be on the extinguisher.

The problem occurred due to the fire extinguisher vendor missing or incorrectly replacing the fire extinguisher located in the kitchen without properly tagging the date of inspection. The problem continued to occur from staff oversight by not checking the vendor's work.

On February 23, 2020, the Administrator contacted the fire extinguisher vendor to report the problem. On February 28, 2020, the vendor came to the home and inspected/replaced and tagged the fire extinguisher located in the kitchen. See attachment O & O-1

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

The Administrator will be present for future annual fire extinguisher inspections and ensure all work is completed timely and accurately by the fire extinguisher vendor. The next fire extinguisher inspection is due in June 2020.

Kevin Donahue, Administrator



Revised Date 3/19/2020

133.1 - Exit Signs

Regulations

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

There is no exit sign above or nearby the basement door leading outside the building.

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.)

Legal Entity Representative

See page 16a of 18

Kevin Donahue
Signature

Kevin Donahue
Printed Name and Title

3/3/20
Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

Implemented
 Not Implemented

2600.133.1

Donahue Personal Care works hard to ensure the doors exiting the building are bearing the word "EXIT" in plain legible letters shall be placed at all exits.

The problem occurred because an exit sign was not present on the walk-out basement door.

On January 28, 2020, the administrator purchased and installed on the door a glow in the dark exit sign. See attachment B Figure 3

Going forward, it is the staff's responsibility daily to report needed repairs/replacements as they become aware of them in the home. Once reported, it is the Administrator's responsibility to ensure the repairs/replacements are coordinated and followed through. The Administrator has developed a building checklist and will perform bi-weekly building checks to ensure compliance is maintained. Completed building checklists will be hung on a hook for viewing purposes at any time.

Staff were reeducated regarding the requirements of this regulation on 2/27/20.

 3/19/20

Kevin Donahue, Administrator



Date 3/3/2020

190b - Insulin Injections

Regulations

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person B's most current diabetes and insulin training was completed 6/5/18; however, she administered insulin to resident #1 on multiple dates to include: 1/4/20 at 8:00 am, 11:30 am, 4:30 am and 8:00 pm and on 1/26/20 at 8:00 am, 11:30 am, 4:30 am and 8:00 pm.

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.)

Legal Entity Representative

See page 17a of 18

[Handwritten Signature]
Signature

Kevin Donahue
Printed Name and Title

3/3/20
Date

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

The above plan of correction is approved as of

3/19/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

- Implemented
- Not Implemented

The above plan of correction was approved by

se
(Initials)

2600.190.b

Donahue Personal Care works hard to ensure a staff person is permitted to administer insulin injections following the successful completion of a department approved medications administration course that includes the passing of a written performance based competency test within the past two years, as well as successful completion of a department approved diabetes patient education program within the past 12 months.

The problem occurred due to the homes policy to ensure diabetes certification training is held bi-annually. Historically, this has always been a planned bi-annual training for all regular staff and part of the initial orientation training program for all new employees.

On January 28, 2020 (same day) the Administrator reached out Excela Health and Diabetes Center to schedule diabetes training certification. The trainer from Excela Health replied that training is scheduled for March 6, 2020 at 1:00 p.m. See attachment P, P 1-3

The training was held and completed on March 6, 2020. Michele Axelson with Excela health conducted a 2-hour training session on "The basics of Diabetes and Insulin Administration." See attachment T1 - T4

On February 27, 2020, the Administration held a 2-hour training session with the staff to discuss the violation report. The staff was educated regarding the violations cited during the January 28, 2020 site inspection. All staff understand the importance of maintain compliance daily. See attachment R1

Going forward, it is the Administrator's responsibility to ensure staff training certificates are current and up to date. The Administrator has added to google calendar to call and schedule annual diabetes training certification annually in the month of February each year. The cost of the training is excessive and the Administrator hopes the DHS could arrange a free or more affordable diabetes training certification training program in the future.

Kevin Donahue, Administrator



Revised Date 3/19/2020

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 #5's initial assessment, dated 5/22/2019, does not include the diagnosis of chronic paranoid schizophrenia as listed on her initial medical evaluation, dated 5/20/2019.

Plan of Correction (POC)

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

Legal Entity Representative

See page 18a of 18

[Handwritten Signature]
Signature

Kevin Donahue
Printed Name and Title

3/3/20
Date

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

The above plan of correction is approved as of 3/19/20
(Date)

Plan of correction implementation status as of 6/10/20
(Date)

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

Implemented
 Not Implemented

2600.225a

Donahue Personal Care understands the importance of a resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The Administrator of designee or a human service agency may complete the initial assessment.

The problem occurred due the oversight of the Administrator during admission and assessment.

On February 27, 2020, the Administrator sat with the resident to re-evaluate assessment and to ensure pertinent diagnosis information is corrected/added. The Administrator made the addition and initialed off of the edit. See attachment Q & Q 1.

The Administrator is responsible to ensure all assessment information is entered as needed and accurately. The Administrator will continue to work to ensure all assessments are completed in its entirety.

On January 29 and 30, 2020, the Administrator performed a quality review of all resident assessments to ensure all residents have the appropriate diagnosis listed in support plans and assessments. During this time all resident assessments were completed and verified.

Going forward, assessments and support plans are and will continue to be the Administrator's responsibility. The Administrator has added an extra level of coverage by assigning the Administrator Designee the task of reviewing completed assessments for accuracy and completeness.

at least monthly.
Documentation shall be kept
for Department review.

Staff were reeducated regarding the requirements of this regulation on 2/27/20.

 6/10/20

 6/10/20

Violation Report

Facility Information

Name: DONAHUE'S PERSONAL CARE I
Address: 1610 HYBLA STREET, PITTSBURGH, PA 15212
County: ALLEGHENY Region: WESTERN

License Number: 43034

Administrator

Name: Kevin Donahue Phone: 4127616421 Email: DONAHUESPC@GMAIL.COM

Legal Entity

Name: KEVIN & ROMONA DONAHUE
Address: 1143 LAPISH ROAD, PITTSBURGH, PA, 15212

Certificate(s) of Occupancy

Type: C-2 LP Date: Issued By:

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 16 Waking Staff: 12

Inspection

Type: Partial Reason: Complaint, Monitoring BHA Docket #: Notice: Unannounced

Inspection Dates and Department Representative

03/20/2020 - On-Site: Joe Eveses, Mike Marini

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 17 Residents Served: 16

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 5 Are 60 Years of Age or Older: 8
Diagnosed with Mental Illness: 10 Diagnosed with Intellectual Disability: 7
Have Mobility Need: 0 Have Physical Disability: 0

85d - Trash Receptacles

Regulations

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:15 AM, the kitchen trash can was uncovered and full of trash. The lid was on the floor next to the can.

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.)

Legal Entity Representative

See page 2a of 4

[Handwritten Signature]

Signature

Kevin Donahue

Printed Name and Title

5/2/20

Date

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

The above plan of correction is approved as of

6/10/20
(Date)

Plan of correction implementation status as of

6/10/20
(Date)

The above plan of correction was approved by

SE
(Initials)

- Implemented
- Not Implemented

Donahue's Personal Care I

Certificate #430431

2600.85 d

Donahue's Personal Care and staff work to ensure trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

The problem occurred due to a resident entering the kitchen area to discard breakfast items and to place plate and silverware in the sink. The resident simply neglected to ensure the lid to the kitchen trash can was put back on top of the can. An additional contributing factor is the staff person was in the dining area and not in the kitchen area and was unaware the lid to the trash receptacle was placed beside it and not back in the proper place. This problem was not noticed until after an inspector pointed it out to the staff person.

On March 20, 2020, the administrator picked the trash receptacle lid off from the side of the trash can and placed back on top in its proper place.

On March 21, 2020, the administrator posted two labels/signs by the trash can and above the trash can to remind all residents and staff that the lid to the trash can must be on at all times. See attachment A

Next, the administrator provided technical assistance to the staff that all trash cans in the kitchen and bathrooms must have a lid on covering the trash receptacle at all times. Last the administrator spoke to the residents and reminded them that since everyone has free access to the kitchen area that it is important that we make a group effort to ensure the trash can lid is always back on top after each use since the staff cannot be all places all the time. The administrator asked the residents politely that we continue to work as a group effort to ensure compliance is maintained.

Going forward, it is the staff's responsibility to ensure the trash can lid is on at all times during their shift. It is also the staff's responsibility daily to identify residents who are not putting the lid back on properly and to positively encourage the resident to try and remember. The staff is responsible to report any other issues and problems regarding the kitchen and trash receptacles to the administrator.

The administrator has added the kitchen trash can lid to the building check list and will inspect and record findings twice a month during the unannounced bi-weekly building check. The administrator is looking into possibly purchasing a trash receptacle that has an attached lid with an auto-close feature.

Documentation of building checks shall be kept for Department review.

 6/10/20

Kevin Donahue


Admin

05/02/2020

KD/db05022020

88a - Surfaces

Regulations

2600.

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

Description of Violation

A 12" x 12" kitchen floor tile is missing in front of the door exiting to the back deck.

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.)

Legal Entity Representative

See page 3a of 4


Signature

Kevin Donahue
Printed Name and Title

5/2/20
Date

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

The above plan of correction is approved as of 6/10/20
(Date)

Plan of correction implementation status as of 6/10/20
(Date)

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

- Implemented
- Not Implemented

Donahue's Personal Care I

Certificate #430431

2600.88 a

Donahue's Personal Care understands the importance that floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

The missing floor tile problem occurred due to salt and weather-related conditions. The location of the missing tile is situated in front of the door to the back-deck area. The constant resident traffic caused the floor tile to become loose and chipped.

On March 20, 2020 (same day) the home administrator immediately posted a caution sign to alert residents to be careful due to the missing floor tile when entering and exiting the home from the deck area. Following the posting, the administrator chipped away, cleaned and removed the entire area to prep for replacement tiles.

On March 21, 2020, the administrator arrived at the home with replacement tiles and supplies to correct the problem. New floor tiles were glued down eliminating the problem. See Attachment A

Following the repair, the administrator educated the staff to immediately post a caution sign for resident safety for all future like matters. The administrator spoke to the residents to remind them that they can at anytime call the administrator to report any problems and/or to request any type of repair.

Going forward, the staff is responsible daily to report building issues and other possible issues requiring repair/replacement. The administrator is responsible to complete the repair/replacement or to contact a contractor and oversee the work to ensure repairs are completed correctly in a work like manner.

he administrator will monitor bi weekly and documentation will be kept for Department review.

 6/10/20

Kevin Donahue


Admin

05/02/2020

KD/db05022020

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

From approximately 9:05 AM to 9:20 AM agents of the Department observed direct care staff A administering medications to multiple residents. However, direct care staff A did not document these administrations, to include administration of medication to resident #1, in the resident's medication administration record until 9:47 AM.

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.)

Legal Entity Representative

[Handwritten Signature]
Signature

Kevin Donahue, Admin
Printed Name and Title

5/2/20
Date

See page 4a of 4

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

The above plan of correction is approved as of *6/10/20*
(Date)

Plan of correction implementation status as of *6/10/20*
(Date)

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

Implemented
 Not Implemented

2600.187 b

Donahue's Personal Care believes it to be imperative to ensure medications shall be recorded at the time of administration.

The problem occurred because resident #1 was the last resident to wake and come out for breakfast. Later, staff person A was not positive if in fact she did record the administration in the MAR at the time it was given. Staff person A, advised that she later went to check the MAR to ensure it was recorded and was reviewing the MAR of other residents for accuracy as well as she was sitting at the table.

Upon the exit interview, the inspector indicated to staff person A that it appeared she was marking the MAR book. Staff person A's response that she was not marking and was simply reviewing the MAR's.

On March 20, 2020, the administrator spoke to staff person A immediately following the exit interview. The administrator advised there should never be a need to review the MAR book in the amount of time that she did after a scheduled medication administration. The administrator also advised that all medications are initialed following each administration just as staff person A was trained to do. Staff person A now understand that any MAR review for accuracy should be performed immediately following the administration of the last resident and not 45 minutes later.

On May 1, 2020, the administrator called in staff members for a brief educational meeting to review and discuss the 15 steps of the medication administration process. During this training the administrator discussed the "5 Rights" and gave special emphasis to steps 6,7,8 and 12 to the staff of the proper medication administration process. See attachment B1, B2, B3, B4

On May 1, 2020, the Administrator advised there will be an additional team supervised medication observation on May 14, 2020 and then later each staff person will have 2 unannounced medication administrations observed prior to May 30, 2020. The administrator will record the findings and save documentation in employees file for future viewing purposes. The administrator will take immediate and necessary action to staff for unfavorable matters relating to proper med pass protocol.

It is the staff's responsibility daily to ensure all steps of the medication administration process are adhered to as trained. The staff is responsible to follow all training protocols for med passes daily.

The administrator designee/practicum observer is responsible for performing med audits weekly, med pass observations as scheduled and to report any issues/problems that may arise to the administrator.

Documentation of med audits and med pass observations will be kept for Department review. The administrator is responsible to oversee the medication administration process and schedule training as needed for areas of staff improvement.

Kevin Donahue


Admin

05/02/2020

KD/db05022020

SE
6/10/20