pennsylvania
DEPARTMENT OF HUMAN SERVICES

October 16, 2020

Mr. Michael J, Laffey
Attorney
Laffey 7 Associates, P.C.
415 Chartiers Avenue
Carnegie, Pennsylvania 15106

RE: Victoria Manor
100 Rose Court
Oakdale, Pennsylvania 15071

Dear Mr. Laffey:

This is to acknowledge receipt of your request to appeal the Department's decision to issue a Second Provisional license for Victoria Manor Personal Care Home. Your request has been forwarded to the Department of Human Services, Bureau of Hearings and Appeals. You will be contacted regarding the date and time of the hearing.

Sincerely,

Jeanne Parisi
Director

cc: Eugene Cuccarese (West), Office of General Counsel

Laffey & Associates, P.C.

ATTORNEYS AT LAW

415 Chartiers Avenue
Carnegie, PA 15106

800-827-8276
412-429-7079
Fax: 412-429-7078
mlaffey@subrogation.com

Michael J. Laffey ESQ.

August 28, 2020

Sent Via Facsimile and Priority FedEx
717-783-5662

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120

Re: Victoria Manor Personal Care Home
100 Rose Court
Oakdale, PA 15071
Certificate #: 446422

Dear Mr. Patel:

Please be advised that I represent Victoria Manor Personal Care Home regarding the August 21, 2020 decision to issue a second provisional license to Victoria Manor Personal Care Home, Certificate #: 446422. Please consider this an official request for an Appeal of the Pennsylvania Dept. of Human Services (DHS) decision to issue a second provisional license and a request for a hearing before the Bureau of Hearing and Appeals.

As your staff is aware, all of the violations specified on the LIS have been corrected and plans of correction were submitted to the DHS. Victoria Manor administrator, Tracy Ronigh, has provided responses appropriately and timely to all of the DHS' concerns. We request an Appeal of this decision to issue a second provisional license and are hopeful that a full license will be issued shortly.

Please advise me of the date or process for the Appeal Hearing so that I may provide documentary proof for the hearing officer to review as part of the Appeal. If you have any comments or questions please do not hesitate to contact me directly.

Sincerely,

Michael J. Laffey
Attorney for Victoria Manor

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LAFFEY HEALTH CARE SERVICES LLC**
LEGAL ENTITY

To operate **VICTORIA MANOR PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **100 ROSE COURT, OAKDALE, PA 15071**
(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 **38**
(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 **August 21, 2020** until **February 21, 2021**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **446422**

Robert E. Robinson
ISSUING OFFICER

Jamie L. 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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: August 21, 2020

Ms. Kathleen Krise
Administrator
Laffey Healthcare Services, LLC
801 Elm Spring Road
Pittsburgh, Pennsylvania 15243

RE: Victoria Manor Personal Care Home
100 Rose Court
Oakdale, Pennsylvania 15071
Certificate #: 446422

Dear Ms. Krise:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 2, 2019; October 3, 2019; December 30, 2019 and March 10, 2020, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 446421 dated September 13, 2019 to March 13, 2020, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from August 21, 2020 to February 21, 2021.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	X	Fine Per resident Per day	=	Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
81b	II	38		$5		$190	5 calendar days from mailing date of this letter
89b	II	38		$5		$190	5 calendar days from mailing date of this letter
141a	III	38		$3		$114	15 calendar days from mailing date of this letter
183b	III	38		$3		$114	15 calendar days from mailing date of this letter
225a	III	38		$3		$114	15 calendar days from mailing date of this letter

Fines were assessed for 2600.65.e, 65.f, 65.g, and 141.b.1 but have been removed due to a temporary suspension of these regulations as of March 29, 2020.

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, 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.

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Inspection Summary

Violation Report

Facility Information

Name: *VICTORIA MANOR PERSONAL CARE HOME* **License Number**: *44642*
Address: *100 ROSE COURT,, OAKDALE, PA 15071*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: *Kathleen Krise* **Phone**: *7246938336* **Email**: *LLAFFEY@GMAIL.COM*

Legal Entity

Name: *LAFFEY HEALTH CARE SERVICES LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: **Issued By**:

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *46* **Waking Staff**: *35*

Inspection

Type: *Partial* **BHA Docket #**: **Notice**: *Unannounced*
Reason: *Complaint,Incident,Fine*

Inspection Dates and Department Representative

10/02/2019 - On-Site: Desmond Grace, Christine Stanley

10/03/2019 - On-Site: Desmond Grace, Christine Stanley

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served**: *34*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *34*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *12* **Have Physical Disability**: *0*

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 5/23/19 at approximately 2:30 p.m., resident #1 stood up from her chair in the living room and immediately fell to the floor hitting her head. Staff persons A, B and C and a hospice aide picked the resident up from the floor and placed her in a rocking chair in the living room. On 5/24/19 at 12:35 p.m. the resident was transported by emergency services to St. Clair Hospital's Emergency Department (ED) due to increased confusion and altered mental status related to the head injury sustained during the fall on 5/23/19. The ED completed a computed topography (CT) scan which indicated the resident had a subdural hematoma in the left parietal lobe, small sub-arachnoid and hematoma/intraparenchymal blood in the left temporal lobe. On 5/24/19, the resident was admitted to the hospital and served there until 5/30/19 when she was discharged back to the home. The resident died on resident #1's date of death due to subdermal hematoma and blunt force trauma to the head from the fall. The home did not report the resident's serious injury requiring treatment at a hospital or medical facility to the Department.

Plan of Correction (POC)

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

See Page 2A of 12

See attached.

Legal Entity Representative

Tracy Romigh — Signature

Tracy Romigh administrator — Printed Name and Title

1-15-2020 — Date

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

The above plan of correction is approved as of 2/21/2020 (Date)

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

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

Regulation: 2600 16c

The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline with 24 hrs. The violation that happened was the home did not report the incident in 24 hrs. It was the responsibility of the administrator to report the incident or assign a designated person. The violation happened because the staff were not properly trained as to when to file an incident report.

The administrator at the time completed an in-service training about 2600. 16 regulations on when to report an incident in October 2019. The new administrator who completed her 100 hr Personal Care home administrator licensing training on October 18th 2019 and completed a 6 hr training on the regulations for Abuse and Neglect and an 8 hr training on Local, State and Federal Laws on when and how to file a complaint completed another in-service training on 01-07-2020. The training went into detail about what the regulations are for reporting incidents and abuse, when you are required to fill out a report, what the form looks like, how to fill it out and who to send it to. The administrator also scheduled the mandatory Residents Rights and Elder Abuse/OAPSA 2600.65g(3&4) training for 1-23-2020 with Julie Elling a community Liaison with Gateway Hospice. Phone 412 737-2431.

The new administrator has created a communication log that will be starting on 1-16-2020(attached) to have better communication from shift to shift about what happened on the shifts prior. We will begin to utilize a incident accident report log (attached) to document all falls or incidents that do not require a Reportable Incident report. This will start on 1-16-2020. The administrator will have month staff meeting to discuss how the communication and documentation is going and leave room to discuss any issues that arise to ensure all staff are confident in when to report an incident.

Quarterly Quality Management meetings will be scheduled to add or change anything that is or is not working with communication. We had a Quality Management meeting on 1-15-2020 where all the attached forms were discussed with an implementation date of 01-16-2020. Lastly the administrator will be meeting individually every other month to do staff performance reviews and will use this time to talk about incident reports and any other issue that may arise and need further individual treatment.

Tracey Romigh Tracy M administrator 1-15-2020

4/21/2020

25a - Written Contract and Review

Regulations

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1, admitted on 5/20/19, did not have a resident-home contract completed and signed until 5/28/19.

Plan of Correction (POC)

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

The contract shall be completed within 24hrs of the residents admission. Resident # 1 admitted on 5/20/19 did Not have a signed Contract completed and signed until 5/28/19. The violation was able to occur because there were no systems in place to ensure paperwork would be completed in the absence of the administrator. The home lacked systems for reviewing records for compliance. Maing forward the new administrator audited the files starting 12-18-19 Completing the audit on 1-3-2020. A word document table (attached) was created on 12-18-19 used to track paperwork in files and anything missing. New administrator will have files completed by [redacted]-01-31-2020. An admissions check list was created with a place for a date and signature on 1-3-2020 A binder was created and during the Quality Management meeting staff were taught what paperwork needs completed on the day of admissions In the absence of the administrator, administrator will check the binder upon Return and will check all paper work in a new admissions file weekly until

See Page 3A of 12

Legal Entity Representative

Tracy Mlomyk
Signature

Tracy Romigh administrator
Printed Name and Title

1-13-20
Date

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The above plan of correction is approved as of 2/21/2020 (Date)

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

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

25a - Written Contract and Review

Regulations

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1, admitted on 5/20/19, did not have a resident-home contract completed and signed until 5/28/19.

Plan of Correction (POC)

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

everything is in the file. The Quality Management (attached) was conducted on 1-9-2020.

*If the administrator knows they will not be available on intake date a staff member on duty will be assigned the desisnee by the administration.

By 5/15/2020 The administrator or designated staff person shall audit all resident records to ensure each resident has a completed contract in their record. 2/21/2020

By 5/15/2020 The administrator shall review all new resident admissions documentation to ensure the requirements of regulation 2600.25(a) have been met. 2/21/2020

Legal Entity Representative

Signature

Tracy Ramsay administrator — Printed Name and Title

1-13-20 — Date

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

The above plan of correction is approved as of 2/21/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ 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

Resident #2's resident-home contract, dated 8/17/19 was not signed by the administrator, a designee or 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.)

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. The regulation is a contract explaining the duties and responsibilities of the legal entity. The violation that happened was resident #2 is resident-home contract was not signed by the administrator. The violation was able to happen because the home lacked systems for reviewing records for compliance. The administrator fixed the violation and signed the document on 12-11-19 for resident #2. (attached) The new administrator audited all the charts 12-18-19 & 1-3-2020. A word document table (attached) was created on 12-18-19 and was used to track paperwork in files and anything missing. New administrator will have files completed by 01-31-2020. An admissions checklist was created with a place for date and signature on 1-3-2020. A binder was created and during the Quality Management meeting on 1-9-2020 staff were taught what paperwork needs complete on the day of admissions in the absence of the administrator. Administrator will check binder upon return and will check all paperwork in a new admissions file

See Page 4A of 12

Legal Entity Representative

Tracy [signature] — Signature

Tracy Lomigh administrator — Printed Name and Title

1-13-2020 — Date

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The above plan of correction is approved as of 2/21/2020 (Date)

The above plan of correction was approved by [initials]

Plan of correction implementation status as of 4/21/2020 (Date)

☒ 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

Resident #2's resident-home contract, dated 8/17/19 was not signed by the administrator, a designee or the resident.

Repeat Violation - 2/13/19, 5/6/19

Plan of Correction (POC)

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

weekly until everything is in file. If the administrator knows they will not be available on intake date a staff member on duty will be assigned the designee by the administrator. A verification has been added to have a second person verify it was completed. (attached)

Legal Entity Representative

Tracy Mc
Signature

Tracy Romey administrator 1-13-20
Printed Name and Title Date

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

The above plan of correction is approved as of 2/21/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

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

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 5/23/19 at approximately 2:30 p.m., resident #1 stood up from her chair in the living room and immediately fell to the floor hitting her head. Staff indicated hearing a loud thud in the hallway. Staff persons A, B and C and a hospice aide picked the resident up from the floor and placed her in a rocking chair in the living room. The resident was crying in pain and stating that her head hurt. The home failed to initiate its emergency medical plan and/or seek emergency services for the resident. Instead, staff members manually picked the resident up from the chair and carried her to bed.

At 4:58 p.m., a hospice registered nurse (RN) assessed the resident and the assessment indicated that the resident had elevated, irregular, not typical vital signs, non-equal pupillary reaction to the light, the resident demonstrated steady near constant trembling, fidgeting, uneasiness, restlessness and tenseness in the hands and legs. The resident mumbled incoherently with an occasional complaint of pain via non-verbal occasional grimace, frown, moaning, and whimpering. The hospice RN was also unable to get resident #1 to focus or readily open her eyes. At 5:30 p.m., the resident was administered two 325mg Tylenol suppositories rectally and 0.5mg Morphine Sulfate was administered sublingually for pain and elevated vitals. The hospice RN remained with the resident until 6:15 p.m.

The home did not seek emergency medical treatment for resident #1 until 5/24/19 at 12:02 p.m., due to increased confusion and altered mental status. At 12:35 p.m., the resident was transported to the Emergency Department (ED) at St. Clair Hospital. The hospice RN reassessed the resident at the hospital and the resident had a golf ball size bruise to the left side of her head. The ED completed a computed topography (CT) scan which indicated that the resident had a subdural hematoma in the left parietal lobe, small sub-arachnoid and hematoma/intraparenchymal blood in the left temporal lobe. On 5/24/19, the resident was admitted to the hospital and served there until 5/30/19 when she was discharged back to the home. The resident died on resident #1's date of death due to subdermal hematoma and blunt force trauma to the head from the fall.

Plan of Correction (POC)

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

See Pages 5A an 5B of 12

See attachment

Regulation: 2600 42b.

A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. The violation was neglect because the home failed to call for medical treatment and call 911 for resident after she fell and was complaining of pain and after she was assessed at 4:58pm and had elevated, irregular, not typical vital signs, non- equal pupillary reaction to the light, the resident demonstrated steady near constant trembling, fidgeting, uneasiness, restlessness and tenseness in the hands and legs. The resident mumbled incoherently with an occasional complaint of pain via non-verbal occasional grimace, frown, moaning, and whimpering. The resident fell at 2:30pm on 5/23/19 and did not go to the hospital until 5/24/19 at 12:02pm when she had increased confusion and altered mental status. The staff/administrator should have contacted the 24 hr complaint hotline if they had any question about if they should use the emergency treatment to get guidance from the state. The administrator failed to communicate to all staff about when to send a resident for emergency medical treatment.

The administrator at the time completed an in-service training about 2600. 42 spending most of the time on 2600.42 b regulation on neglect and on when to utilize the emergency treatment to avoid creating a neglectful incident. This was completed in October 2019. The new administrator who completed her 100 hr Personal Care home administrator licensing training on October 18th 2019 and completed a 6 hr training on the regulations for Abuse and Neglect and an 8 hr training on Local, State and Federal Laws on when and how to file a complaint completed another in-service training for the staff on 01-07-2020. The training went into detail using the RCG about what the regulations are for reporting incidents and abuse, the importance of utilizing emergency treatment if there is any incident that a resident is involved in that could place the resident at risk. Anything that would change the residents baseline behaviors emergency treatment should be utilized immediately. Talked about the 24 hour hotline number that can be called if there is ever a question about when to use emergency treatment to ensure proper steps are taken immediately for the safety of the resident. Lastly, discussed what is considered neglect how this incident was looked at as neglect because emergency treatment was not utilized immediately.

The administrator also scheduled the mandatory Residents Rights and Elder Abuse/OAPSA 2600.65g(3&4) training for 1-23-2020 with Julie Elling a community Liaison with Gateway Hospice. Phone 412 737-2431.

The new administrator has created a communication log that will be starting on 1-16-2020(attached) to have better communication from shift to shift about what happened on the shifts prior. We will begin to utilize an incident accident report log (attached) to document all falls or incidents that do not require a Reportable Incident report. This will start on 1-16-2020.

All staff were trained on calling the administrator and or the 24 hr hotline if an incident happens such as a falls and the resident is hurt in pain or displaying signs that are different from the normal baseline of the resident in order, to get direction if they are unsure if emergency treatment should be utilized.

The administrator will have month staff meeting to discuss how the communication and documentation is going and leave room to discuss any issues that arise to ensure all staff are confident in when to report an incident and when to utilize emergency medical treatment.

Tracy Romigh Tracy — administrator 1-15-2020

4/21/2020

Quarterly Quality Management meetings will be scheduled to add or change anything that is or is not working with communication. And to discuss ways to continue to make the home a safe place for everyone. We had a Quality Management meeting on 1-15-2020 where all the attached forms were discussed with an implementation date of 01-16-2020. Lastly the administrator will be meeting individually every other month to do staff performance reviews and will use this time to talk about incident reports/abuse and any other issue that may arise and need further individual treatment.

Tracy Romigh

Tracy administrator 1-15-2020

4/21/2020

42b - Abuse *(continued)*

Legal Entity Representative

Signature	Printed Name and Title	Date
T Mowry	Tracy Romagh administrator	1-15-2020

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

The above plan of correction is approved as of 2/21/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

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

89b - Hot Water Temperature

Regulations

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 10/02/19, multiple areas of the home had water temperatures exceeding 120 degrees Fahrenheit to include the following:

*At 9:14 a.m., the water temperature in the sink in the men's common bathroom next to the dining room was 125.7 degrees Fahrenheit.

*At 9:15 a.m., the water temperature in the sink in the women's common bathroom next to the dining room was 125.0 degrees Fahrenheit.

*At 9:19 a.m., the water temperature in the bathroom sink of resident bedroom #17 was 148.6 degrees Fahrenheit.

*At 9:21 a.m., the water temperature in the sink in resident bedroom #20 was 150.2 degrees Fahrenheit.

*At 9:23 a.m., the water temperature in the sink in resident bedroom #19 was 149.1 degrees Fahrenheit.

Repeat Violation: 5/31/19, 5/6/19, 2/13/19 et al

Plan of Correction (POC)

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

See Page 7A of 12

See attachment

Legal Entity Representative

Tray — Signature

Tracy Romich administrator 4-15-2020 — Printed Name and Title / Date

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

The above plan of correction is approved as of 2/21/2020 (Date)

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

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

2600 89b.
Hot water temperatures in areas accessible to the resident many not exceed 120 degrees. The violation was on 10/02/19 multiple areas of the home had water temperatures exceeding 120 degrees Fahrenheit. Men's room 125.7, women's room 125.0 room #17 148.6, # 20 150.2 and #19 149.1. The maintain man and the administrator are responsible for checking the water temperatures to make sure the temperatures do not exceed 120 degrees. There was no log or any way to monitor the water temperatures up to this point. The temperatures on the water tank were turned down immediately. The one water tank that supplies the water for rooms #17,19,20 was replaced in November of 2019. The water tank that supplies the water to the men and woman's room was turned down and tested daily until all the water temperatures running off that water tank were below 120 degrees. The water tank was marked to show all staff where the temperature needs to stay to keep temperatures under 120 degrees. All the staff were showed the green marking on the heater to ensure they do not turn it past the green mark.

A hot water Temperature Log was started on December 9th 2019 and will be completed a minimum of twice a week from a least one room running off of each of the water tanks to ensure that all sinks from each water tank are below 120 degrees. This will be completed by maintain or administrator and the administrator will check it weekly to ensure it is completed. Any further issues with the temperature a plumber will be contacted.

Tray — Tracy Romig administrator 1-15-2020

4/21/2020

141a - Medical Evaluation

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #3 was admitted to the home on 8/15/19. However, the resident did not have a medical evaluation completed.

Repeat Violation: 5/31/19, 5/6/19, 2/13/19 et al

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

A resident shall have a medical evaluation by a physician, physician assistant, or certified registered nurse practioner documented on a form specified by the department with 60 days prior to admission or within 30 days after admissions. The evaluation determines the level of care needed to ensure the health and safety and well-being of the individual. During the inspection resident #3 did not have a medical evaluation in the file. The home was not in the file because the lacked systems for reviewing records for compliance. The administrator retrieved the DME that was dated 8-20-19 and placed in the file on 1-20-A. The new administrator audited all files from 12-18-19 > 1-3-2020. A word document table (attached) was created on 12-18-19. and was used to track paperwork in files and anything missing The files will be completed by 1-31-2020. An admissions checklist was created with a place for a date and signature on 1-3-2020. The administrator

Legal Entity Representative See Page 8A of 12

Tracy — Tracy Bonyo Administrator 1/3/20

Signature — Printed Name and Title — Date

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The above plan of correction is approved as of 2/21/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

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

141a - Medical Evaluation

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #3 was admitted to the home on 8/15/19. However, the resident did not have a medical evaluation completed.

Repeat Violation: 5/31/19, 5/6/19, 2/13/19 et al

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.)

Will check the check list weekly in the first month to ensure all new admit paperwork is completed by deadlines. I will also be using Tabulo pro a software system that has a dashboard that gives daily alerts on the dashboard as to what is due that day. The new administrator will check tabulo pro a minimum of once a week one month out (IN January will be working on all of February's) to make sure Doctors are Notified if the DME is due. DR [redacted] Vanorski and Dr Thimons have been to the facility 12-17-19, 1-8-2020, 1-14-2020. This system (Tabulo pro) has been in use since 1-3-2020. attached is a copy of January's dashboard, the admissions check list and word document table.

Legal Entity Representative

Signature

Tracy Roms Administrator 1-13-2020

Printed Name and Title Date

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Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by (Initials)

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Resident #4's most current medical evaluation was completed on 4/5/18.

Repeat Violation: 5/6/19, 2/13/19 et al

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 medical evaluation determines the level of care needed to ensure the health, safety and well being of the individual. The violation was the resident was admitted on 10/20/18 and the only DME in the file was dated 4/5/18 for resident #4. The resident passed away and a current DME was not completed. The only DME in her file was date 4/5/18. The violation occured because the administrator lacked systems for reviewing records for compliance. The new administrator ~~reviewed~~ audited all files from 12-18-19 → 1-3-2020. A word document table (attached) was created on 12-18-19 and was used to track paperwork in files and any they missing, the files will be completed by 1-31-2020. an admission checklist was created with a place for a date and signature on 1-3-2020 The administrator will check the checklist weekly in the First month to ensure all new admit paperwork is completed by due dates. The administrator

See Page 9A of 12

Legal Entity Representative

Signature

Tracy Konish administrator 1/4/2020
Printed Name and Title Date

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The above plan of correction was approved by (Initials)

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☐ Implemented
☒ Not Implemented

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Resident #4's most current medical evaluation was completed on 4/5/18.

Repeat Violation: 5/6/19, 2/13/19 et al

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.)

Will also be using Tabulo pro a software system that has a dashboard. that gives daily alerts on the dashboard as to what is due.. The new administrator will check tabulopro a minimum of once a week one month out (In January I will be ensuring all of January's are complete and working on February's to ensure Doctors are notified if a bME is needed or due. DR. Vanorski & Dr Thimons have been to the facility on 12-17-19, 1-8-2020, 1-14-2020. Tabulo pro has been being used by administrator since 1-3-2020.

Legal Entity Representative

Tracy Romp
Signature

Tracy Romp Administrator 1/14/2020
Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted into the home on 5/20/19. However, the resident did not have a pre-admission screening completed by the home.

Repeat Violation: 5/31/19

Plan of Correction (POC)

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

A pre-admission screening determination shall be made with 30 days prior to admissions to ensure the needs of the resident can be met by the services provided by the home. The administrator did not have a pre-admissions screening completed for resident #1. resident #1 passed away and a screening was not completed. The home lacked systems for reviewing records for compliance. An audit was completed on 12-18-19 > 1-3-2020. A word document table was created (attached) on 12-18-19 and was used to track paperwork in files and anything missing. The files will be completed by 1-31-2020. An admissions checklist was created with a place for a date and signature, on 1-3-2020. The administrator will be in charge of scheduling the admission and will not schedule the admission until a pre-screening is completed. The administra

See Page 10A of 12

Legal Entity Representative

Signature

Tracy Lemyx administrator 1-14-20
Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted into the home on 5/20/19. However, the resident did not have a pre-admission screening completed by the home.

Repeat Violation: 5/31/19

Plan of Correction (POC)

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

Will have another staff member sign off on the signature verfication for the pre-screeing before and admission date is scheduled within 30 days prior.

By 5/15/2020 The administrator or designated staff person shall audit all resident records to ensure a preadmission screening has been completed for each resident and the home is capable of meeting the resident's needs. 2/21/2020

By 5/15/2020 The administrator shall review all new resident admissions documentation to ensure each resident has had a preadmission screening completed and the home can meet the needs of the resident. 2/21/2020

Legal Entity Representative

Tracy Lay — Signature

Tracy Lomigo administrator — Printed Name and Title

1-14-20 — Date

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Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

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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

There was no written initial assessment completed for resident #1 admitted 5/20/19, resident #2 admitted 8/17/19 and resident #3 admitted 8/15/19.

Repeat Violation: 5/31/19, 5/6/19, 2/13/19 et al

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 initial assessment is to provide information and become acquainted with the residents overall status and develop an accurate assessment of the residents medical, personal care, behavioral health and psychosocial needs. The violations that occured were there was no initial assessment completed for resident #1, #2, #3. The violation was able to occur because the home lacked systems for reviewing records for compliance. The administrator completed the initial assessment for resident #3 on 12-11-19 (attached). The initial assessment for resident #2 on 10/08/19. (attached). Resident #1 did not receive an initial assessment and passed away before one could be completed. The new administrator completed an audit from 12-18-19 → 01-03-2020. a word document table (attached) was created on 12-18-19 and used to track paperwork in files and anything missing. New administrator will have files completed by 01-31-2020. a checklist for new admission was created on 1-3-2020 and will be check weekly until all paperwork for new admit is completed in the.

Legal Entity Representative

See Page 11A of 12

Tracy Signature

Tracy Lomigh administrator 1-13-20
Printed Name and Title Date

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☒ 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

There was no written initial assessment completed for resident #1 admitted 5/20/19, resident #2 admitted 8/17/19 and resident #3 admitted 8/15/19.

Repeat Violation: 5/31/19, 5/6/19, 2/13/19 et al

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.)

first month. On top of ensuring all new admit paperwork is in files on time, I will be using Tabulo pro a software system that has a dashboard that gives daily alerts as to what is due that day. The new administrator will check Tabulo a minimum of once a week one month out (Example ensuring all of Jan's are done and looking at what is due in February) to make sure Doctor's are notified if it is a POME and all other paperwork is completed by due date.. attached a copy of January's dash board, the admissions check list and the word document table. All systems are in place and have been in use since 1-3-2020..

Legal Entity Representative

Tray — Signature

Tracy M Romagh administrator — Printed Name and Title

1-13-20 — Date

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Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

225c - Additional Assessment

Regulations

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #4 requires care from a hospice services provider. However, the resident's assessment, dated 10/30/18, does not access the resident's need for hospice services.

Resident #5's initial assessment dated 5/3/19, was not updated to reflect the resident's change in care needs to include home health services with physical and occupational therapy as indicated on the resident's medical evaluation, dated 5/20/19.

Plan of Correction (POC)

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

any orders that were sent by the DR's that would require a change in assessment. all additions will be completed if not documented by 1-31-2020. This form will be used also moving Forward immediately to document any changes that would require an additional assessment. A binder was created. Also, during the Quality management training on 1-9-2020 It was discussed what one considered a change in status that would need to be documented. The administrator will check the forms weekly to ensure No orders are missed in daily communication.

See Pages 12A and 12B of 12

See Page 12A and 12B of 12

Legal Entity Representative

Signature | Tracy Mahoney Printed Name and Title | 1-14 2020 Date

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The above plan of correction is approved as of 2/21/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

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

225c - Additional Assessment

Regulations

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #4 requires care from a hospice services provider. However, the resident's assessment, dated 10/30/18, does not access the resident's need for hospice services.

Resident #5's initial assessment dated 5/3/19, was not updated to reflect the resident's change in care needs to include home health services with physical and occupational therapy as indicated on the resident's medical evaluation, dated 5/20/19.

Plan of Correction (POC)

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

A resident shall have a written initial assessment with 15 days of admission, anually, and If the condition of the resident significantly changes prior to the anual assessment. It is the responsibility of the administrator to ensure all paperwork is completed. The home lack's systems for reviewing records for compliance. The administrator fixed #4 residents ON 01/07/09 and added the change sheet to her file. #4 required care from hospice. Resident #5 assessment was not updated before she was discharged fuom Victoria Manor ON 10-21-19. An audit was completed by the administrator ON 12-18-19 → 1-3-2020. a word document was created ON 12-18-19 (attached) and is being used to document

Legal Entity Representative

Signature

Printed Name and Title: Administrator

Date: 1-14-2020

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Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

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

225c - Additional Assessment

Regulations

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #4 requires care from a hospice services provider. However, the resident's assessment, dated 10/30/18, does not access the resident's need for hospice services.

Resident #5's initial assessment dated 5/3/19, was not updated to reflect the resident's change in care needs to include home health services with physical and occupational therapy as indicated on the resident's medical evaluation, dated 5/20/19.

Plan of Correction (POC)

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

Administration scheduled a training for 1-23-2020 with designated staff on how to complete a RASP and all information that is required to be placed in assessment in order to have an accurate assessment. Administration will complete all assessments and updates until training is completed.

Legal Entity Representative

Signature

Tracy Lamb administration 1-14-2020
Printed Name and Title Date

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The above plan of correction is approved as of 12/21/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

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

Violation Report

Facility Information

Name: *VICTORIA MANOR PERSONAL CARE HOME*
Address: *100 ROSE COURT,, OAKDALE, PA 15071*
County: *ALLEGHENY*
Region: *WESTERN*
License Number: *44642*

Administrator

Name: *Kathy Krise*
Phone: *724-693-8336*
Email: *LLAFFEY@GMAIL.COM*

Legal Entity

Name: *LAFFEY HEALTH CARE SERVICES LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP*
Date: *09/17/1997*
Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *47*
Waking Staff: *35*

Inspection

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

Inspection Dates and Department Representative

12/30/2019 - On-Site: Trish Bartlett, Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38*
Residents Served: *36*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *1*
Have Mobility Need: *11*
Are 60 Years of Age or Older: *36*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

3c - Post Current License

Regulations

2600.

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

Description of Violation

The current Provisional License issued by the Department for September 13, 2019 to March 13, 2020 was not posted in a conspicuous and public place in the home.

Plan of Correction (POC)

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

See Page 2A of 40

See attachment

Legal Entity Representative

Signature

Tracy Romish administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

3C. Post Current License

The old administrator did not have the License in a conspicuous place in the home. The License that was not posted in a conspicuous was immediately placed in the entry way of Victoria Manor so the residents, families, and visitors are aware of the regulatory compliance status of the home.

The administrator will check the license monthly to make sure it is in a conspicuous place. The administrator has a check list of monthly duties and will sign off that she has checked the license and it is in the approved conspicuous place.

Tracy Romisch administrator

Tracy 2-19-2020

4/21/2020

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 ceased to breathe. However, the death was not reported to the Department.

Resident #2 ceased to breathe. However, the death was not reported to the Department.

Plan of Correction (POC)

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

See Page 3A of 40

See attachment

Legal Entity Representative

Tracy — Signature

Terry Romig, administrator 2-19-2020 — Printed Name and Title / Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☒ Not Implemented

16C. Written Incident Report

The violation happened because the staff were not properly trained as to when to file an incident report.

The administrator at the time completed an in-service training about 2600. 16 regulations on when to report an incident in October 2019.

Reportable Incidents reports were completed and sent in to DHS on 2/19/2020. (attached).

The new administrator who completed her 100 hr Personal Care home administrator licensing training on October 18th 2019 and completed a 6 hr training on the regulations for Abuse and Neglect and an 8 hr training on Local, State and Federal Laws on when and how to file a complaint completed another in-service training on 01-07-2020. The training went into detail about what the regulations are for reporting incidents and abuse, when you are required to fill out a report, up to an including deaths, what the form looks like, how to fill it out and who to send it to. The administrator also scheduled the mandatory Residents Rights and Elder Abuse/OAPSA 2600.65g(3&4) training for 1-23-2020 with Julie Elling a community Liaison with Gateway Hospice. Phone 412 737-2431.

The new administrator had an Abuse, Mistreatment and Reporting training on 01/07/2020. She also had a Quality management meeting on 1-15-2020 on the past plan of corrections plans which 16C was covered in entirety.

A binder was created that has 2600.16 Reportable Incidents and conditions posted in the binder for all the staff to see and read. Copies were printed from the DHS website for the Incident reports that need to be used for reporting 16c reportable incidents. All staff are aware of where the binder is kept and what to reference for an incident in the building. Administrator or designee will check the binder two times a weekly. To make sure all reportable incidents are sent and that the final report is completed.

The new administrator has created a communication log that will be starting on 1-16-2020 (attached) to have better communication from shift to shift about what happened on the shifts prior. We are utilizing an incident accident report log (attached) to document all falls or incidents that do not require a Reportable Incident report. This will start on 1-16-2020. The administrator or designee will check the communication log twice a week. The administrator will have monthly staff meeting to discuss how the communication and documentation is going and leave room to discuss any issues that arise to ensure all staff are confident in when to report an incident up to and including deaths.

Quarterly Quality Management meetings will be scheduled to allow for communication to add or change anything that is or is not working with communication. We had a Quality Management meeting on 1-15-2020 where all the attached forms were discussed with an implementation date of 01-16-2020. Lastly the administrator will be meeting individually monthly to do staff performance reviews and will use this time to talk about incident reports and any other issue that may arise and need further individual treatment.

Tracy Romig

Tracy administrator

2-19-2020

17 - Record Confidentiality

Regulations

2600.

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

Description of Violation

At approximately 9:45 a.m., the medication room door was unlocked and open. Numerous confidential resident documents were on the medication cart and were unlocked, unattended, and accessible to include:

* Resident #3's empty medication bottle labeled Atorvastatin 20mg take one daily.

* A binder containing resident #4's preadmission screening dated 11/13/17.

* Resident #5's documentation of medical evaluation dated 11/13/17.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Page 4A of 40

see attachment

Legal Entity Representative

Signature

Tracy Lamish administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

17- Record Confidentiality
2600 17. This protects resident's privacy and ensures the homes comply with other applicable laws.

The medication door room was closed immediately to protect the resident's confidentiality.

I do not know what the old administrator's explanation for why it was unlocked is because she is no longer the administrator. There was a staff meeting on 2/5/2020 that the administrator went into great detail about confidentiality and HIPPA. Discussed the 2600 17 regulation of how 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. A Big posting was also placed on the Door stating door must me closed at all times. And a HIPPA and confidentiality training was completed February 19, 2020 by Julie Elling Gateway Hospice. And a Residents rights training was completed on 1,23,2020 by Julie Elling Gateway Hospice. There will be a walk- through of the building 3 times a week by the administrator or designee to check all open areas to ensure there is no paperwork, files or resident's confidential records. This will also be discussed at the quarterly Quality Management Meeting to ensure resident's records are remaining confidential.

Tracy Romyh Tr

administrator 2-19-2020

4/212020

51 - Criminal Background Check

Regulations

2600.

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

Description of Violation

Direct care staff person A started working in the home on 6/6/19. However, the home did not request a criminal history background check.

Plan of Correction (POC)

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

See Page 5A of 40

Legal Entity Representative

Signature

Tracy Romich Administrator 2-19-2020

Printed Name and Title Date

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Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

Regulation 2600 51. Criminal Checks-
.All staff members are to have a criminal background check in order to work.

Direct care Staff A did not have a criminal background check because the administrator during this inspection (Kathleen Krise) at the time did not have systems in place to ensure all personal files have everything in them from when the previous administrator left in September (Susan DeLuca). The new administrator (Tracy Romigh) audited all personal files and finished the auditing on 1/31/2020. All background checks have been completed for all staff persons working at the facility. On 01/07/2020 a background check was completed on Staff A. (Attached).
Administrator talked with Amy a worker on 2/05/2020 at the Department's Criminal Background Record Unit 717-265-7887 to get a full education on all the requirement for a Criminal Background Check.

Moving forward the Administrator will be in charge of hiring, setting up start dates with the new employees to ensure all Staffing requirement are in the files on time. A start date for new hires will not be scheduled until a Criminal background check is completed and handed in to the Administrator.

Tracy Romigh
administrator
2-19-2020

4/21/2020

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, started working in the home on 1/27/16. However, the staff person B does not have documentation of a high school diploma, GED diploma, or active registration status on the Pennsylvania Nurse Aide registry. Staff person B provided direct care services to resident #6 on 12/1/19 and 12/2/19, 12/7/19 and 12/8/19, and 12/10/19.

Plan of Correction (POC)

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

See Page 6A of 40

Legal Entity Representative

Signature

Tracy Ramsey administrator
Printed Name and Title

2/4/2020
Date

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

The above plan of correction is approved as of 2/25/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

Regulation 2600 54. Direct Care Staff
All staff members shall have a High school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct Care Staff B did not have a copy of his high school diploma because the administrator during this inspection at the time did not have systems in place to ensure all personal files have everything in them from when the previous administrator left in September. Staff member B brought in his High school diploma. (attached). All other staff member's files were updated and any staff missing anything was brought in and added to files.

Moving forward the Administrator will be in charge of hiring, setting up start dates with the new employees to ensure all Staffing requirement are in the files on time. A check list (attached) will be used to check and ensure all staff have everything they need for the first day, then checked weekly to ensure it is in the files with the 30 days. The administrator will check the files weekly for new hires to make sure everything is in the files. Staff that do not have the required paperwork in on the designated times will be taken off the schedule until everything is handed in.

Tracy Konigh

administrator

2-19-2020

4/21/2020

65a - FS Orientation 1st Day

Regulations

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Direct care staff person A started working in the home on 6/6/19. However, the staff person A did not receive training in any of the training topics in accordance with regulation 2600.65(a) prior to or on the first day of work.

Direct care staff person M worked in the home from 3:00 p.m. to 11:00 p.m. on 12/25/19 to 12/27/19. However, staff person M did not receive training in any of the training topics in accordance with regulation 2600.65(a) prior to or on the first day of work.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Page 9A of 40

See attachment

Legal Entity Representative

Signature

Tracy Ross Administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

[X] Implemented

[ ] Not Implemented

65a FS Orientation 1st Day

2600 65.a. Prior to or during the first day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that include: 1.Evacuation procedures, 2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. 3. The designated meeting place outside the building or within the fire- safety area in the event of an actual fire. 4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable. 5. The locations and use of fire extinguishers. 6. Smoke detectors and fire alarms. 7. Telephone use and notification of emergency services. This is to ensure all staff persons are immediately trained to respond to an emergency situation.

The old administrator is no longer and employee with Victoria Manor. Staff A and M stated she went over all the information on the first day but there was no documentation in the file. The orientation was completed with staff A and M. (Attached).
An audit was completed on all personal files to ensure all personnel files have everything they need in them for current employee's. Every file has been updated. Moving forward The Administrator will be in charge of hiring, setting up start dates with new employees to ensure all staffing requirements are in the files and on time. A start date will be scheduled with the administrator and a minimum of 1 hour will be allotted to go over all First day hiring information in accordance with regulation 2600 65a.

Tracy Romigh

administrator

2-19-2020

4/21/2020

65b - Rights/Abuse 40 Hours

Regulations

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Direct care staff person A started working in the home on 6/6/19. However, staff person A did not receive training in any topics in accordance with regulation 2600.65b within 40 scheduled working hours.

Direct care staff person M worked in the home from 3:00 p.m. to 11:00 p.m. on 12/25/19 to 12/27/19. However, staff person B did not receive training in any topics in accordance with regulation 2600.65b within 40 scheduled working hours.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Page10A of 40

Legal Entity Representative

Signature | Printed Name and Title: Tracy Romyn Administrator | Date: 2/19/2020

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

65b- Rights/abuse 40 hrs

2600 65 b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have and orientation that includes the following. This is to ensure that all staff persons working in the home are familiar with resident's rights, mandated reporting and the procedures for responding to a medical emergency.

The old administrator is no longer and employee with Victoria Manor. Staff A and M stated she went over all the information on the first day as well as the first 40 hours but there was no documentation in the file. The orientation was completed with staff A and M. (Attached).

An audit was completed on all personal file and everything was updated if it was not in the file. The Administrator will be in charge of hiring, setting up start dates with new employees to ensure all staffing requirements are in the files and on time. A start date will be scheduled with the administrator and a minimum of 1 hour will be allotted to go over all First day hiring information in accordance with regulation 2600 65a. After the orientation there will be a 40 hour training week that the new staff will shadow a veteran staff. The veteran staff will be assigned each day to go over sections of the 40 hour training to make sure all sections are completed and signed off on. After the 40 hrs the Administrator will meet with the staff to make sure all sections are completed and to see if the staff has any questions on anything learned before they start on the floor alone.

Tracy Romigh

administrator

2-19-2020

4/21/2020

65d - Initial Direct Care Training

Regulations

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, started working in the home on 1/27/16, and provided unsupervised ADL services to residents on 12/2/19 to 12/3/19 and 12/7/10 to 12/10/19. However, direct care staff person B has not completed the Department-approved direct care training course or passed the staff person competency test.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Page 11A of 40

Legal Entity Representative

Signature | Printed Name and Title: Tracy Romich Administrator | Date: 2/9/2020

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The above plan of correction is approved as of 2/25/2020 (Date)

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

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

Regulation 2600 65d.

Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following: 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Direct care staff B started on 1/27/16 did not complete the Department-approved direct care training course or passed the staff person competency test because the administrator during this inspection at the time did not have systems in place to ensure all personal files have everything in them from when the previous administrator left in September. The new administrator audited all personal files and finished the auditing on 1/31/2020.
Staff person B as well as anyone else who did not have one in their file completed the Completed and successfully passed the training. (Attached is Staff person B's).

Moving forward the Administrator will be in-charge of hiring, setting up start dates with the new employees to ensure all Staffing requirement are in the files on time. A start date for new hires will not be scheduled until the Department-approved direct care training course is successfully completed.

Tracy Romigh

Administrator

2-19-2020

4/21/2020

65e - 12 Hours Annual Training

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

Description of Violation

Direct care staff person B, started working in the home on 1/27/16 and did not receive any of the required 12 hours of annual training in the training year January 1, 2018 to December 31, 2018.

Direct care staff person K, started working in the home on 6/23/14, and did not receive any of the required 12 hours of annual training in the training year January 1, 2018 to December 31, 2018.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Pages 12A and 12B of 40

Legal Entity Representative

Signature

Tracy Ramsey Administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

65e-12 Hours Annual Training
2600. 65.e. Direct care staff shall have at least 12 hours of annual trainings relating to their job duties.

In 2019 I have the Basic Insulin Administration Training for 7/22/19 for Staff B, and Staff K. (attached).

Moving forward the new administration knows all the trainings that need to be completed annually as well the that staff person orientation can be included in the 12 hrs of training for the first year of employment. All the trainings include 1. Medication self-administration training 2. Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, 3, Care for resident with dementia and cognitive impairments. 4. Infection control and general principles of cleanliness and hygiene and areas with mobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, 5. Personal care services needs of the residents, 6. Safe management techniques. 7. Care for residents with mental illness or mental retardation. 8. Fire safety 9. Emergency preparedness procedures and crisis emergency situation. 10. Resident rights. 11 The Older Adult Protective Services Act. 12, Falls and accident prevention and 13. New population groups.
2020

1. 1/7/2020. Abuse and mistreatment 2600. 42B and When to fill out and incident report 2600.16c on 01/07/2020. Completed by administrator then had someone come in on 1/23/2020 below to do one as well.
2. 1/23/2020. Abuse reporting/Residents Rights/OAPSA was completed on 1/23/2020 by Julie Elling Gateway Hospice and community Liaison.
3. 01/15/2020. Quality Management meeting to go over all implementations from the last plan of correction submitted in December 2019. As well as all forms created and expectations for the home moving forward.
4. 01/23/2020 Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation had support plan on 1/23/2020 by the administrator.
5. 05/11/2020. Medication Administration training was completed on 2/8/2020 By Amy Pomzoo for staff member B. Staff member K had medication administration on 5/11/2019 (attached). And her annual med check on 11/4/19.
6. 2/11/2020. First Aid/CPR on 2/11/2020 Completed by Victor Knight 814530 for Kems paramedics.
7. 02/19/2020 Emergency Preparedness and HIPPA and Confidentiality scheduled with Julie Elling Gateway Hospice and Community Liaison.
8. 03/03/2020 Older Adult Protective Services Act scheduled with Rachael Caddy OSPTA Home Health &Hospice.
9. 03/11/2020 Diabetic Training scheduled with Grane Hospice.

Tracy Romeo Administrator

2-19-2020

4/21/2020

10. 03/18/2020 Infectious Control and Fall and Prevention scheduled with Julie Elling Gateway Hospice and Community Liaison. Staff B and K had a Fall Prevention Training from Medcom.com on 2/10/2020.
11. 03/25/2020 Fox rehab Keith Barrett Physical therapist will be completed Care for residents with mental illness and or mental retardation and on 4/2/2020 Care for residents with dementia and cognitive impairment.
12. 4/09/19 Julie Ellings Gateway Hospice will be doing personal care services needs for residents.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional. All staff had files audited and all staff who do not have 12 hrs of training for 2019 will have additional trainings added to 2020 to ensure they meet the 2020 12 plus all hrs for 2019. This will be done by 3/25/2020. During the Quality Management meeting that is held quarterly all staff trainings will be reviewed in accordance with 65e. To ensure all staff currently employed have training and anyone missing training can be scheduled to complete trainings.

Tracy Romyk administratr

2-19-2020

4/21/2020

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B, started working in the home on 1/27/16 and did not receive any of the required training topics for the training year January 1, 2018 to December 31, 2018 to include:
* Medication self-administration training
* Instruction on meeting the needs of residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
* Care for residents with dementia and cognitive impairments
* Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration.
* Personal care service needs of the resident.
* Safe management techniques.
* Care for residents with mental illness or intellectual disabilities or both, if the population is served in the home.

Direct care staff person K started working in the home on 6/23/14 and did not receive any of the required training topics for the training year January 1, 2018 to December 31, 2018 to include:
* Medication self-administration training
* Instruction on meeting the needs of residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
* Care for residents with dementia and cognitive impairments
* Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration.
* Personal care service needs of the resident.
* Safe management techniques.
* Care for residents with mental illness or intellectual disabilities or both, if the population is served in the home.

Repeat violation 2/13/19 et all

65f - Training Topics *(continued)*

Plan of Correction (POC)

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

See Pages 14A and 14 B of 40

Legal Entity Representative

Signature

Tracy Romig administrator 2/9/2020
Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

65f-Training Topics

With the old administrator being gone I do not know what training were done in 2018 other than a Using the glucometer on 1/25/18 by staff B and staff K. Also, (attached the safe management techniques are in the 40 hour orientation that staff B signed on 2/1/16 and Staff K on 6/8/19. And I had both of them complete the infectious control and Body Mechanic on 1/5/2020.
I have no way of knowing if the staff completed the training in 2018. I could not find any sign in sheets other than what is attached. The staff stated they did complete training every year but I have no documentation.

In 2019 I have the Basic Insulin Administration Training for 7/22/19 for Staff B, and Staff K.

Moving forward the new administration knows all the trainings that needs to be completed annually, as well the that staff person orientation can be included in the 12 hrs of training for the first year of employment. All the trainings include 1. Medication self-administration training 2. Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, 3, Care for resident with dementia and cognitive impairments. 4. Infection control and general principles of cleanliness and hygiene and areas with mobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, 5. Personal care services needs of the residents, 6. Safe management techniques. 7. Care for residents with mental illness or mental retardation. 8. Fire safety 9. Emergency preparedness procedures and crisis emergency situation. 10. Resident rights. 11 The Older Adult Protective Services Act. 12, Falls and accident prevention and 13. New population groups.

2020 trainings done and scheduled.

1. 1/7/2020. Abuse and mistreatment 2600. 42B and When to fill out and incident report 2600.16c on 01/07/2020. Completed by administrator then had someone come in on 1/23/2020 below to do one as well.
2. 1/23/2020. Abuse reporting/Residents Rights/OAPSA was completed on 1/23/2020 by Julie Elling Gateway Hospice and community Liaison.
3. 01/15/2020. Quality Management meeting to go over all implementations from the last plan of correction submitted in December 2019. As well as all forms created and expectations for the home moving forward.
4. 01/23/2020 Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation had support plan on 1/23/2020 by the administrator.

5. 05/11/2020. Medication Administration training was completed on 2/8/2020 By Amy Pomzoo for staff member B. Staff member K had medication administration on 5/11/2019 (attached). And her annual med check on 11/4/19.

Tracy Romney Administrator 2-19-2020

4/21/2020

6. 2/11/2020. First Aid/CPR on 2/11/2020 Completed by Victor Knight from Kems Paramedics 814530. for B and K.
7. 02/19/2020 Emergency Preparedness and HIPPA/ confidentiality scheduled with Julie Elling Gateway Hospice and Community Liaison.
8. 03/03/2020 Older Adult Protective Services Act scheduled with Rachael Caddy OSPTA Home Health &Hospice.
9. 03/11/2020 Diabetic Training scheduled with Grane Hospice.
10. 03/18/2020 Infectious Control and Fall and Prevention scheduled with Julie Elling Gateway Hospice and Community Liaison.
11. 03/25/2020 Fox rehab Keith Barrett Physical therapist will be completed Care for residents with mental illness and or mental retardation and on 4/2/2020 Care for residents with dementia and cognitive impairment.
12. 4/09/19 Julie Ellings Gateway Hospice will be doing personal care services needs for residents.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional. All staff files were audited and all staff who do not have 12 hrs of training for 2019 will have additional trainings added to 2020 to ensure they meet the 2020 12 plus all hrs for 2019. This will be done by 3/25/2020. During the Quality Management meeting that is held quarterly all staff trainings will be reviewed in accordance with 65f. To ensure all staff currently employed have training and anyone missing training can be scheduled to complete trainings.

Tracy Tracy Romey
administrator
2-19-2020

4/21/2020

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Direct care staff person B started working in the home on 1/27/16, and did not receive any of the required annual training in the training year January 1, 2018 to December 31, 2018 to include:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
* Emergency preparedness procedures and recognition and response to crises and emergency situations.
* Resident rights.
* The Older Adult Protective Services Ace (35 P.S. 10225.101 – 10225.5102).
* Falls and accident prevention.
*New population groups that are being served at the home that were not previously served.

Direct care staff person K started working in the home on 6/23/14 and did not receive any of the required annual training in the training year January 1, 2018 to December 31, 2018 to include:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
* Emergency preparedness procedures and recognition and response to crises and emergency situations.
* Resident rights.
* The Older Adult Protective Services Ace (35 P.S. 10225.101 – 10225.5102).
* Falls and accident prevention.
*New population groups that are being served at the home that were not previously served.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Pages 15A and 15B of 40

65g.Annual Training Content.

With the old administrator (Kathleen Krise) being gone I do not know what training were done in 2018 other than a Using the glucometer on 1/25/18 by staff B and staff K. On 2/6/2018 staff K had a 1 hr Foley Catheter Care training. Also, (attached the safe management techniques are in the 40 hour orientation that staff B signed on 2/1/16 and Staff K on 6/8/19. And I had both of them complete the infectious control and Body Mechanic on 1/5/2020.
I have no way of knowing if the staff completed the training in 2018. I could not find any sign in sheets other than what is attached. The staff stated they did complete training every year but I have no documentation.

In 2019 I have the Basic Insulin Administration Training for 7/22/19 for Staff B, and Staff K.

Moving forward the new administration knows all the trainings that needs to be completed annually, as well the that staff person orientation can be included in the 12 hrs of training for the first year of employment. All the trainings include 1. Medication self-administration training 2. Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, 3, Care for resident with dementia and cognitive impairments. 4. Infection control and general principles of cleanliness and hygiene and areas with mobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, 5. Personal care services needs of the residents, 6. Safe management techniques. 7. Care for residents with mental illness or mental retardation. 8. Fire safety 9. Emergency preparedness procedures and crisis emergency situation. 10. Resident rights. 11 The Older Adult Protective Services Act. 12, Falls and accident prevention and 13. New population groups.
2020

1. 1/7/2020. Abuse and mistreatment 2600. 42B and When to fill out and incident report 2600.16c on 01/07/2020. Completed by administrator then had someone come in on 1/23/2020 below to do one as well.
2. 1/23/2020. Abuse reporting/Residents Rights/OAPSA was completed on 1/23/2020 by Julie Elling Gateway Hospice and community Liaison.
3. 01/15/2020. Quality Management meeting to go over all implementations from the last plan of correction submitted in December 2019. As well as all forms created and expectations for the home moving forward.
4. 01/23/2020 Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation had support plan on 1/23/2020 by the administrator.

5. 05/11/2020. Medication Administration training was completed on 2/8/2020 By Amy Pomzoo for staff member B. Staff member K had medication administration on 5/11/2019 (attached). And her annual med check on 11/4/19.

6. 2/11/2020. First Aid/CPR on 2/11/2020 Completed by Victor Knight ID number 814530 from Kems Paramedics for B and K.

Tracy Romyn Administrator

2-19-2020

4/21/2020

7. 02/19/2020 Emergency Preparedness And HIPPA Confidentiality scheduled with Julie Elling Gateway Hospice and Community Liaison.
8. 03/03/2020 Older Adult Protective Services Act scheduled with Rachael Caddy OSPTA Home Health &Hospice.
9. 03/11/2020 Diabetic Training scheduled with Grane Hospice.
10. 03/18/2020 Infectious Control and Fall and Prevention scheduled with Julie Elling Gateway Hospice and Community Liaison. Staff B and K took a Fall Prevention training from Medcom (attached) as well on 2/10/2020.
11. And Gary Hamilton the Building and Code Fire Official for North Fayette is finding someone to do the fire safety training for March.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional. All staff files were audited and all staff who do not have 12 hrs of training for 2019 will have additional trainings added to 2020 to ensure they meet the 2020 12 plus all hrs for 2019 missing. To ensure they have 24 hr in 2020. This will be done by 3/25/2020. During the Quality Management meeting that is held quarterly all staff trainings will be reviewed in accordance with 65g. To ensure all staff currently employed have training and anyone missing training can be scheduled to complete trainings.

Tracy Romyn
administrator
2-19-2020

4/21/2020

65g - Annual Training Content *(continued)*

Legal Entity Representative

Signature | Printed Name and Title | Date

Tiffany Romyn administrator 2-19-2020

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

81b - Resident Personal Equipment

Regulations

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #7's enabler is not secured to the bed and pivots approximately four inches towards and away from the side of the bed posing an entrapment hazard.

Resident #8's two bed enablers, on each side of the bed, measuring approximately 36 inches long by 12 inches high with 9 openings measuring approximately 4 inches wide, are not secured to the bed. Both enablers pivot approximately two to four inches towards and away from the sides of the bed as well as pivot approximately two inches up and down, posing an entrapment hazard on both sides of the bed.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Page 17A of 40

Legal Entity Representative

Signature

Tracy Lamy Administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

2600 81b –Resident Personal Equipment

81. B. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Clean assistive devices that are in good repair are less likely to cause injury or illness to residents.

Resident #7's enabler is not secured to the bed and pivots approximately four inches toward and away from the side of the bed posing and entrapment hazard.
Resident #8's two bed enablers, on each side of the bed, measuring approximately 36 inches long by 12 inches high with 9 openings measuring approximately 4 inches wide, are not secured to the bed. Both enablers pivot approximately two to four inches towards and away from the sides of the bed as well as pivot approximately two inches up and down, posing and entrapment hazards on both sides of the bed.

This was able to happen because there was not a system and check list for the maintenance man to check monthly to make sure all devices are clean and working properly.
Paul the maintenance man check both devices and fixed them immediately putting bolts in the metal to prevent them from moving or shaking.

Moving forward a schedule and sign off sheet was created to check all wheelchairs, walkers, and apparatus. Checking the enablers will be documented on a sign-off sheet. He will be conducting a monthly check and sign off to make sure all devices are functioning properly. Administrator will oversee to make sure this is done monthly.

Tracy Romyk
administrator

2-19-2020

4/21/2020

82c - Locking Poisonous Materials

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 11:55 a.m., the housekeeping cart was unlocked, unattended, and accessible in the hallway to the left of the home's entrance. Residents assessed to be not safe to use or avoid poisons included: resident #5, resident #7, resident #8. Multiple poisonous materials were accessible on the cart to include:

* A one qt bottle of Mr. Clean Multipurpose cleaner approximately ¾ full with a manufacturer's warning indicating, "If swallowed, call physician or poison control."

* A 1.4 quart, full bottle of Mr. Clean Multi-surface cleaner, with a manufacturer's warning indicating, "If swallowed, call physician or poison control."

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.)

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Legal Entity Representative

Signature

Printed Name and Title: administrator

Date: 2-19-2020

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

82C- Locking Poisonous Materials

2600 82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.
This protects residents who are unable to safely use or avoid poisonous materials from illness, injury, or death related to misuse of accessible poisons.

At 11:55am the housekeeping cart was unlocked, unattended, and accessible in the hallway to the left of the home's entrance. Residents assessed to be not safe to use or avoid poisons included: resident #5, #7, #8. A on qt bottle of Mr. Clean Multipurpose cleaner approximately ¾ full with manufacturer's warning indicating, "If swallowed, call physician or poison control." And a 1.4 qt, full bottle of Mr. Clean Multi-surface cleaner, with a manufacturer's warning indicating , " If swallowed call physician or poison control." This was able to happen because the cleaning lady was not aware that she needed to have these products locked up at all times.

A lock box was purchased to ensure that all hazardous cleaning supplies are locked at all times.

The cleaning lady as well as all staff during the February5,2020 Training discussed poisonous materials being looked at all time, what is considered poisonous materials (even materials not considered "poisonous" may still be a hazard to residents who cannot safely use them.) Using examples of mouthwash to a dementia resident who doesn't understand could drink it.

Moving forward hazardous items will be locked at all time and any new staff hired during orientation will be taught what hazardous materials are and how they are to be kept. The cleaning staff will check the home three times a week to ensure that poisonous materials are not accessible to residents. The administrator will check to make sure the check are being competed weekly.

Tracy Romijn Administrator 2-19-2020

4/21/2020

85e - Trash Outside Home

Regulations

2600.

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

Description of Violation

At approximately 9:05 a.m. there were two soiled, uncovered twin mattresses leaning against the home's exterior trash dumpster at the front of 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.)

See Page 19A of 40

Legal Entity Representative

Signature

Tracy Romsa administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

85e
2600. 85e

Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents. This is important to prevent rodent or insect infestation that could raise the risk of the interior of the home becoming infested.

At approximately 9:05 am there were two soiled, uncovered twin mattresses leaning against the home's exterior trash dumpster at the front of the building. This was able to happen because the old administrator did not explain to the staff in detail what the trash policy is. They did not know that a mattresses was considered trash. The mattresses were thrown away.

During the February 5th staff meeting Administrator went over the trash policy explaining the trash bin needs to have all trash in the container and the lid closed covering the trash bin. There is not allowed to be any trash left leaning on the trash container or anywhere around it. All trash is to be in the trash bin with the lids closed. If there is excess trash the waste management company will be called to come empty if it is before the regularly scheduled pick up day. Staff were told they need to get ahold of the head of maintenance to call waste management. The head of maintenance was made aware of this and was given the phone number to call if necessary.

Administrator and maintenance man will continue to watch and check the trash container 3 x a week, and if it appears the home is accumulating more trash on a regular basis we will contact waste management and order a larger trash compactor to ensure all trash is thrown away and covered. Administrator will check the maintenance checklist monthly to make sure it is being completed.

Tracy Romig Administrator

2-19-2020

4/21/2020

96a - First Aid Kit

Regulations

2600.

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

Description of Violation

The home's first aid kit under the nurse's station sink did not include gauze pads, antiseptic, and tweezers.

Plan of Correction (POC)

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

See Page 20A of 40

Legal Entity Representative

Signature

Tracy Rony Administrator 2/19/2020
Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

96a- First Aid Kit

2600. 96 The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye covering and tweezers.
The homes portable first aid kit under the nurse's station sink did not include gauze pads, antiseptic, and tweezers. The First Aid kit is needed to ensure the home has the equipment to provide first aid in the even of an injury. The portable first aid kit was check and the gauze pads, antiseptic, and tweezers were added. The home also ordered a supplementary kit as a back- up. The first aid kit was checked and stocked on Feb 7th 2020.
In order to ensure all items are always in the first aid kit The day light med tech will check the kit on the first Monday of every month and order any and all supplies necessary to ensure the first aid kit is always stocked with necessary supplies. The Administrator will sign off on the sheet month as a way to check to ensure it is completed. The administrator went over this on Feb 5, 2020 with all the staff about reporting it to a med tech if something is taken out. She then went over in detail with all the med tech about checking the first aid kit on the first Monday of every month. As well as went over the check list with them to ensure there were no further questions.

Tracy Romyn administrator

2-19-2020

4/21/2020

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

From 9/14/17 to 4/16/19, the home's safe evacuation time, determined by a fire safety expert, was 3 minutes and 29 seconds. The home exceeded the safe evacuation time to include:

* On 1/12/19 at 7:00 a.m. evacuated in 3 minutes and 36 seconds.
* On 3/4/19 at 11:00 p.m. evacuated in 3 minutes and 38 seconds.

From 4/16/19 to 10/15/19, the home's safe evacuation time, determined by a fire safety expert, was 3 minutes and 41 seconds. The home exceeded the safe evacuation time to include:

* On 5/14/19 at 2:00 a.m. evacuated in 3 minutes and 54 seconds.
* On 8/16/18 at 3:00 a.m. evacuated in 3 minutes and 42 seconds.
* On 11/17/18 at 2:00 a.m. evacuated in 3 minutes and 56 seconds.
* On 5/14/19 at 2:00 a.m. evacuated in 3 minutes and 54 seconds.
* On 8/3/19 at 6:00 a.m. evacuated in 3 minutes and 47 seconds.

From 10/15/19 to 12/30/19, the home's safe evacuation time, determined by a fire safety expert, was 4 minutes and 2 seconds. The home exceeded the safe evacuation time to include:

* On 12/10/19 at 10:00 p.m. evacuated in 4 minutes and 5 seconds.

Plan of Correction (POC)

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

See Pages 21A and 21B of 40

Legal Entity Representative

Signature

Tracy Ramey administration 2-19-2020

Printed Name and Title Date

132 d- Evacuation
Evacuation within the maximum evacuation time prevents fire-related death and injury.

Attached are the 2017, 2018 and 2019 evacuation forms It 2018 form was not presented to the state therefore they did not have the time correct.

09/14/17 the evacuation time was 3 minutes 29 seconds
09/22/18 the evacuation time was 7 minutes 10 seconds
04/16/19 the evacuation time was 3 minutes 41 seconds
10/15/19 the evacuation time was 4 minutes 2 seconds.

All the evacuation forms are attached and a letter from the Oakdale Chief explaining why he increased the time to 4 minutes 2 seconds on 10/15/19 form the 3 minutes 41 seconds on 04/16/19. With the 09/22/18 time being 7 minutes 10 seconds the 1/12/19, 3/4/19 and 11/17/18 would have been within the evacuation time.
The 05/14/19 the 8/16/18 and the 08/3/19 and 12/10/19 were all late and another fire drill was not completed. The Administrator failed to complete another fire drill in the month to have one in that month with the correct time.

Moving forward we will no longer be using Oakdale Hose Company we will be using Township of North Fayette fire department. On 12/17/19 Gary Hamilton from Township of North Fayette Came in to do an inspection of the facility. We had a few things to fix which have been done. He will be back out in March to check and make sure all areas fixed. At this time he will do a Fire Drill and establish the maximum safe evacuation time. He stated until then we are to continue to use the 10/15/19 evacuation time of 4 minutes and 2 seconds decided by William Hartman Jr from Oakdale Hose Company. Also the New Administrator understand that if a fire drill exceeds the time allotted additional fire drill needs to be completed in that month to ensure evacuation time is done before it exceeds the maximum time and that all staff and residents are able to evacuate in time allotted.
Also on 2/5/2020 during the staff meeting fire drills were talked about in detail. What are current time is 4 minutes and 2 second any feedback as to what has and hasn't worked with residents who might be more difficult, and any issues for the fire chief when he come in March to do the fire safety training and the Fire drill. Administrator will be in charge of assigning monthly fire drills to ensure they are completed and done at different shifts and at different times.
A meeting is going to be conducted on 2/27/2020 with the residents to go over fire drills and the fire drill evacuation plan. We will begin to have additional fire drills on each shift to get all staff and residents familiar with evacuations. One additional fire drill will be conducted in February and 3 fire drills will be conducted in the month of march one on each shift with the minimum amount of staff scheduled on each shift. A fire drill on 1/3/2020 at 11:00 am was completed and it was evacuated in 4 minutes 1 second. The administrator will conduct a midnight fire drill before the end of February. Also the facility and resident's mobility needs were look into to see if anyone with more significant mobility needs can be moved closer to an

Tracy Tracy Romyn Administrator 2-19-20

4/21/2020

exit door. At this time the residents with mobility needs are as close to an exit as they can be. The administrator will continue to do the fire drills to ensure the evacuation time is under the set 4 minutes 2 seconds. If the staff cannot complete the fire drills in the set evacuation time additional staff will have to be added. The administrator will discuss Fire drills at the Quarterly Quality Management meeting to discuss any issues and ways to ensure all staff and residents are able to evacuate in the time allotted.

Tracy Romp

Administrator

4-19-2020

4/21/2020

132d - Evacuation *(continued)*

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Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

132g - Fire Drills Days/Times

Regulations

2600.

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

Description of Violation

According to the staff schedule and staff interviews, there are only two staff persons on duty for sleeping hours between 11:00 p.m. and 7:00 a.m. However, Fire drills held on the dates and times were conducted with more than two staff persons to include:

* On 3/2/18 at 6:00 a.m., four staff participated in the fire drill.
* On 4/7/18 at 12:00 a.m., three staff participated in the fire drill.
* On 7/8/18 at 6:00 a.m., four staff participated in the fire drill.
* On 3/4/19 at 11:00 p.m., three staff participated in the fire drill.
* On 8/3/19 at 6:00 a.m., three staff participated in the fire drill.

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.)

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Legal Entity Representative

TM — Signature

Tracy Romich administrator — Printed Name and Title

2/19/2020 — Date

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☒ Implemented

☐ Not Implemented

132 g- Fire Drills Days/Times

Staggering drill dates and times ensures that staff and residents are prepared to respond to different fire scenarios, and that staff on all shifts are properly trained in evacuation procedures.

The old administrator counted herself as a person to help with fire drills at 6:00am because she worked 6-3. She is the one who set the alarms off and did not stagger the times.
A fire drill was conducted on 1/3/2020 at 11:00 am with 3 staff and it was evacuated in 4 minutes. A second fire drill will be completed in February on the midnight shift with the typical staff scheduled to ensure all residents and staff can be evacuated in the allotted time frame. In the month of March a fire drill will be conducted on each shift 7-3, 3-11 and 11- 7 with staggered times. Also the Administrator will schedule the Fire drills to ensure they are at different times of the day and on different days of the week to ensure residents and staff are prepared to respond to different fire scenarios. Administrator will review the fire drills monthly to ensure the drills are held on different days of the week, at different times of the day and night, and with the minimal amount of staff on each shifts. The fire drills will be discussed at the Quarterly Quality assurance meeting to ensure the drills are held on different days of the week, at different times of the day and night, and with the minimal amount of staff on each shifts.

Tracy Romy

administrator

2-19-2020

4/21/2020

141a - Medical Evaluation

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #6 was admitted to the home on 11/25/19. However, the initial medical evaluation was not completed.

Repeat violation 2/13/19 et all, 5/6/19, 5/31/19

Plan of Correction (POC)

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

See Page 24A of 40

Legal Entity Representative

Signature

Tracy Romp administrator 2-19-2020

Printed Name and Title Date

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Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

The above plan of correction was approved by (Initials)

141a- Medical Evaluation

Accurate medical information helps homes decide whether a resident's needs can be met at the home, helps the home develop accurate assessments and support plans, and ensures that residents' medical needs will be met.
During the inspection resident #6 was admitted the home on 11/25/19, However, the initial Medical Evaluation was not completed. A DME was completed on 12/19/19 by Dr. Vanarski. (attached). The DME was completed however the administrator at the time did not have it filed and it was in a pile of papers the new administrator found. The DME was found on 1/5/2020 and placed in the file.

The new administrator that started on 12/9/19 did a complete audit of all the files. She spent the month of January updating all files to get everything into files. The administrator created a table to document what each file has and what is missing. All files were updated and all proper documentation completed and placed in files. Moving forward the new administrator created a table to track when DME's are to be completed. The Dashboard on Tabulapro will also be used to check the current month and the next month to plan for Doctors to be contacted for anyone due the following month. The administrator will check Tabula Pro and her spread sheet weekly to ensure nothing is being missed and to match it up with the Doctor's scheduled times in the building. Victoria Manor is now working with PCMA they come into the home once a week to see their patients. This new practice coming in weekly will make it easier to ensure a DME will be completed on time. All paperwork will be filed immediately by the administrator.

Tracy Tracy Romigh administrator

1-19-2020

4/21/2020

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Resident #5's medical evaluation was completed on 11/13/17. However, the annual medical evaluation was not completed until 11/14/19.

Repeat violation 2/13/19 et all, 5/6/19

Plan of Correction (POC)

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

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Legal Entity Representative

Signature

Tracy Romney administrator 2-19-2020
Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

141b1- Annual Medical Evaluation

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

Resident # 5's medical evaluation was completed on 11/13/17. However, the annual medical evaluation was completed on 11/14/19. The 2018 medical evaluation on 12/08/18 was not made available to the auditor. The 12/08/19 is in the file (all DME's for resident # 5 are attached). The old administrator is gone for me to find out why it was not available because when the new administrator did an audit it was in the file.

The new administrator that started on 12/9/19 did a complete audit of all the files. She spent the month of January updating all files to get everything into files. The administrator created a table to document what each file has and what is missing. All files were updated and all proper documentation completed and placed in files.

Moving forward the new administrator created a table to track when DME's are to be completed. The Dashboard on Tabulapro will also be used to check the current month and the next month to plan for Doctors to be contacted for anyone due the following month. The administrator will check Tabula Pro and her spread sheet weekly to ensure nothing is being missed and to match it up with the Doctor's scheduled times in the building. Victoria Manor is now working with PCMA they come into the home once a week to see their patients. This new practice coming in weekly will make it easier to ensure a DME will be completed on time. All paperwork will be filed immediately by the administrator.

Tracy Tracy Romigh Administrator

2-19-2020

4/21/2020

162c - Menus Posted

Regulations

2600.

162.c. Menus, 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 posted for the periods 12/15/19 to 12/21/19 and 12/22/19 to 12/28/19. The menus for the current week of 12/29/19 to 1/4/20 and the following week of 1/5/20 to 1/11/20 were not posted.

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.)

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Legal Entity Representative

Signature

Tracy Kurz administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

162c- Menus Posted

2600 162.c. Menus, 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. A "Conspicuous and public place" means that the menu is a t a height where each resident can see it (including a height appropriate for residents in a wheelchair. Having a menu that is prepared one week in advance and is followed is beneficial for residents so they can plan their meals in advance.

The menu was immediately completed for the correct weeks.

The new Administrator has had several meeting with the kitchen staff about menus, food, kitchen responsibilities to make sure everything in the kitchen is completed. Both kitchen staff have been taught how to order food, how to write a menu and what the kitchen regulations are. One staff has been assigned the responsibility of ordering food and writing the menu to ensure the meals on the menu are being ordered and a menu is created on time. If that person is unavailable the back-up kitchen staff knows it is their responsibility to complete the task of writing the menu and ordering food. The administrator will oversee the menus to ensure it is up on time and correct. The food is ordered on the second and fourth Wednesday of the month and the menu are written every Friday and posted Every Sunday for the week in advance. It the assigned person is off on that Sunday it will be written ahead of time and given to the kitchen staff working on Sunday or the kitchen staff will complete the responsibility of writing the menus. The administrator will check weekly to ensure the menu is posted correctly.

Tracy Romijn

Tracy Romijn

administrator

2-19-2020

4/21/2020

183b - Meds and Syringes Locked

Regulations

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At approximately 11:40 a.m. two of resident #8 medications were unlocked, unattended, and accessible on the resident's bedside table to include:

* Sodium Chloride 0.65% nasal spray, 1.5 ounce bottle, administer 1 nasal spray q3hr.

* Hydrocortisone 2.5% cream, 28gm tube, apply externally twice a day only as needed.

At approximately 9:45 a.m., the door to the medication room was unlocked and open. Numerous medications for resident #9 were on top of the medication cart and were unlocked, unattended, and accessible to include:

* medication card containing 17 tablets of 40mg Pantoprazole.

* medication card containing 20 tablets of 10mg Amlodipine.

* medication card containing 20 tablets of 25mg Metoprolol.

Repeat violation 2/13/19 et all

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.)

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Legal Entity Representative

Signature

Printed Name and Title: administrator

Date: 2-19-2020

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Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

183b- Meds and Syringes Locked

2600. 183. B Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room. Medications and syringes will be safe from contamination, spillage or theft and residents who are unable to self-administer medications will be safe from harming themselves with the medications.
A safe was given to resident # 8 to lock her medications up. The medication room door was locked immediately as well.
#8 was assessed by a doctor and given permission by the Doctor to self-administer because the Doctor felt she could administer the medication safely. However, it is the homes responsibility to provide assistance as needed by helping the resident remember the schedule for taking medication, storing the medication in a secure place and offering the resident the medication at the prescribed time. There were no system to make this happen.
Resident # 8 was discharged and currently there are no residents that self-administer. But if and when one is given permission to self-administer they will be given a lock box to secure the medication. They will be added to the MAR just like if they were being given meds by the Med tech. The Med-tech will go to the residents and prompt them to take their medications and to see if they need any assistance during the scheduled med time and then check back to make sure they took the medication and everything is back in the secure box. Also, as a second checks and balance we will use are resident/Staff sections list. Each staff is assigned a group of residents to take care of for the shift. That staff will check on the resident throughout the shift to make sure no medications are left out. If we get a resident who self-administers their name will be highlighted and a Star will be put next to their name.

#9 I do not know what the old administrator's explanation for why it was unlocked is because she is no longer the administrator. There was a staff meeting on 2/5/2020 that the administrator went into great detail about confidentiality and HIPPA. Discussed the 2600 17 regulation of how 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. A Big posting was also placed on the Door stating door must me closed at all times. And a HIPPA and confidentiality training has been scheduled for February 19, 2020 by Gateway Hospice. Also, a Residents rights training was completed on 1,23,2020 by Gateway Hospice. The Administrator will check weekly on the assigned staff if there is a resident that self-administers. There will be a walk- through of the building 3 times a week by the administrator or designee to check all open areas to ensure there is no paperwork, files or resident's confidential records. This will also be discussed at the quarterly Quality Management Meeting to ensure resident's records are remaining confidential.

Tracy Tracy Romyn administrator

2-19 2020

183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #6 was prescribed Levemir Flex Pen inject 30 units subcutaneously at bedtime. A Novolog Flex Pen, dated 12/28 was rubber banded to the prescribed Levemir Flex Pen, in the medication cart. However, the resident was not prescribed Novolog Flex Pen.

Plan of Correction (POC)

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

See Pages 28A and 28B of 40

Legal Entity Representative

Signature

Printed Name and Title: Tenley Posey Administrator

Date: 2/7/2020

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

183d- Prescription Current
This is to ensure the home does not keep medications that are for residents no longer living in the home or that have been discontinued.

When talking with the Med tech they stated they were waiting for the pharmacy to come and take it and did not a process in place for what to do with meds when they were discontinued. The Novolog pen was immediately removed and given to the pharmacy.

When meeting with the med techs it was determined that the computer system was difficult to understand and was not user friendly. The pharmacy (Jefferies) was unable to see what Victoria Manor put in the MAR and Victoria Manor was not able to see what Jefferies pharmacy put in the MAR. Therefore, there was no one able to check to see what Jefferies had on the MAR and what Victoria Manor had on the MAR to cross check. Jeffries was unable to send a pharmacist to inventory the med cart other than one time they came after the inspection on 1/6/2020 making it difficult to catch an error. And Victoria Manor staff had no systems in place to inventory the carts.

The new administrator has started from scratch with medication. Jefferies Pharmacy was being used by the Agency and is no longer the pharmacy. Health Direct a pharmacy that's main distribution is Personal care homes was brought in. This change over in pharmacies allowed Tracy to start fresh and start over. The pharmacy came in did a presentation with all Med techs teaching them the computer system Quickmar that is very user friendly. They have been working with her and the agency to match each residents MAR up with all the Doctors orders and helped the agency get all the Doctors orders for the medications so the MAR and the medication all match up. This pharmacy will put in all the order for the Doctors and will not leave it up to the Med Tech's to put the orders in any more. All the residents will be on the same medication refill cycle so we will not have to order medications that are running low the pharmacy will have the cycle and re-order them. The pharmacy will be distributing the medication in rolls with all the resident's medications in each time. There will not be bubble packs any more. (Example all of resident 8 am meds will be in one package. You will not be able to get to the next time medication until the first time is given. This will help prevent missed medication. The new MAR system has all the times that Glucose checks are to be taken if a medication has to have a BP or respiration first they will not be able to give medication until the BP is complete. The pharmacy will be doing cart/MAR checks twice a month to ensure all MAR's and medications match up and nothing is in the carts that do not belong. A daily list for the Med tech have been started with each shift with responsibilities. Each day and each shift will be responsible to make sure they are checking for D/C meds, doing audits on med carts, order supplies. We also are know faxing and have a binder for all faxes to the pharmacy and Dr's office if a med is getting low and it is not something Health Direct has oversight on. We will be faxing the Dr. Office Daily and Heath Direct to ensure medications are always available. (Since Health Direct will be in charge of the medication cycle to make sure meds do not run out. This would only be with residents that do not use health direct.) Another great addition to the MAR is when a new med is put in it will be in green and left on the MAR for 7 days in Green. If a MED is D/C it will stay in red on the MAR for 7 days to remind staff daily in case there is an

Tracy Tracy Romig Administrator
4/21/2020 2-19-2020

oversight to make sure it gets taken out of the Med cart and sent back to the pharmacy. The pharmacy will be taking back D/C meds and will come in and ask for the meds when they drop off medications to ensure it is taken out of the building. We are also faxing each time a resident refuses their meds to the Doctors office and the Doctor's office and Victoria manor decided if a resident refuses the Med 5 days in a row it will be D/C and the Doctor will come in and talk to the residents. The administrator will be checking daily to make sure all the plans above are completed. Currently the MAR and MEDs are all matched up and the new Health Direct system will be in fill effect on 2/17/2020. Health Direct will be in next week to monitor the be here to answer any question if any issues arise. Two Health direct representatives have been assisting with all the change.

All the Med tech have been trained throughout the entire process with the Administrator and Health Direct to make sure there is no confusion. Health Direct will be auditing the cart on 3.2.2020 and a designated med tech from Victoria Manor will audit the cart in the week on 2/23/20 to 2/29/2020. The carts will be audited once a month from health direct and once a month for a designated med tech. The administrator will check month to make sure all checks were complete.

Tiffany Romine
administrator
2-19-2020

4/21/2020

183e - Storing Medications

Regulations

2600.

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

Description of Violation

Resident #6's Humalog 100U/ml bottle was one half used and had multiple needle stick marks in the bottle top. However, the medication was not dated when opened according to manufacturer's instructions.

Plan of Correction (POC)

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

See Pages 29A and 29B of 40

Legal Entity Representative

Signature

Tracy Rom Administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

183 e- Storing Medications
This ensures the medications will be stored in a manner that prevents damage or loss.

The date was added to the Humalog and the Doctor and pharmacy was contacted.

When meeting with the med techs it was determined that the computer system was difficult to understand and was not user friendly. The old pharmacy was unable to see what Victoria Manor put in the MAR and Victoria Manor was not able to see what Jefferies pharmacy put in the MAR. Therefore, there was no one able to check to see what Jefferies had on the MAR and what Victoria Manor had on the MAR to cross check. Jeffries was unable to send a pharmacist to inventory the med cart other than one time they came after the inspection on 1/6/2020 making it difficult to catch an error. And Victoria Manor staff had no systems in place to inventory the carts.

The new administrator has started from scratch with medication. The old Pharmacy was being used by the Agency and is no longer the pharmacy. Health Direct a pharmacy that's main distribution is Personal care homes was brought in. This change over in pharmacies allowed Tracy to start fresh and start over. The pharmacy came in did a presentation with all Med techs teaching them the computer system Quickmar that is very user friendly. They have been working with her and the agency to match each residents MAR up with all the Doctors orders and helped the agency get all the Doctors orders for the medications so the MAR and the medication all match up. This pharmacy will put in all the order for the Doctors and will not leave it up to the Med Tech's to put the orders in any more. All the residents will be on the same medication refill cycle so we will not have to order medications that are running low the pharmacy will have the cycle and re-order them. The pharmacy will be distributing the medication in rolls with all the resident's medications in each time. There will not be bubble packs any more. (Example all of resident 8 am meds will be in one package. You will not be able to get to the next time medication until the first time is given. This will help prevent missed medication. The new MAR system has all the times that Glucose checks are to be taken if a medication has to have a BP or respiration first they will not be able to give medication until the BP is complete. The pharmacy will be doing cart/MAR checks twice a month to ensure all MAR's and medications match up and nothing is in the carts that do not belong. A daily list for the Med tech have been started with each shift with responsibilities. Each day and each shift will be responsible to make sure they are checking for D/C meds, doing audits on med carts, order supplies. We also are know faxing and have a binder for all faxes to the pharmacy and Dr's office if a med is getting low and it is not something Health Direct has oversight on. We will be faxing the Dr. Office Daily and Heath Direct to ensure medications are always available. (Since Health Direct will be in charge of the medication cycle to make sure meds do not run out. This would only be with residents that do not use health direct.) Another great addition to the MAR is when a new med is put in it will be in green and left on the MAR for 7 days in Green. If a MED is D/C it will stay in red on the MAR for 7 days to remind staff daily in case there is an oversight to make sure it gets taken out of the Med cart and sent back to the pharmacy. The pharmacy will be taking back D/C meds and will come in and ask for the meds when they drop off medications to ensure it is taken out of the building. We are also faxing each time a resident

Tracy Tracy Romagh Administrator
4/21/2020 2-14-2020

refuses their meds to the Doctors office and the Doctor's office and Victoria manor decided if a resident refuses the Med 5 days in a row it will be D/C and the Doctor will come in and talk to the residents. The administrator or designated person will check daily to make sure all the plans above are completed. Currently the MAR and MEDs are all matched up and the new Health Direct system will be in fill effect on 2/17/2020. Two Health direct representatives have been assisting with all the change.
All the Med tech have been trained throughout the entire process with the Administrator and Health Direct to make sure there is no confusion. Health Direct will be auditing the cart on 3.2.2020 and a designated med tech from Victoria Manor will audit the cart in the week on 2/23/20 to 2/29/2020. The carts will be audited once a month from health direct and once a month for a designated med tech. The administrator will check month to make sure all checks were complete.

Tracy Roy administrator
2-19-2020

4/21/2020

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:

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #6 was prescribed Humalog 100U/ml soln, inject 4 units subcutaneously three times a day with meals, and inject units per sliding scale before meals as follows:

70-140 = 0 units,

41-180 = 1 unit

181-220 = 2 units

221-260 = 3 units

261-300 = 4 units

301-340 = 5 units

>340 = 6 units and call MD

However, the medication label only indicated 100U/ml and did not indicate the dosages or instructions.

Repeat violation 2/13/19 et all

Plan of Correction (POC)

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

See Pages 30A and 30B of 40

Legal Entity Representative

Signature

Tracy Long administrator 2-19-2020

Printed Name and Title Date

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The above plan of correction is approved as of 2/25/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

184a- Labeling OTC/CAM
This reduces the possibility that medication will be administered to the wrong resident or improperly administered.

The Doctor and pharmacy was contacted immediately to make sure the accurate order was available. The pharmacy fixed the MAR to make sure the medication and MAR matched correctly.
The medication was labeled correctly however the MAR did not match the Dr's order. This was because the pharmacy did not put the order in correctly and the Med techs did not know how to put in the MAR, however it is the Med techs responsibility to contact the pharmacy immediate if there is a discrepancy with the Medication and the MAR.
This was able to happen because there was no system in place to check the med cart and no one auditing the cart to prevent these type of med errors.

When meeting with the med techs it was determined that the computer system was difficult to understand and was not user friendly. The old pharmacy was unable to see what Victoria Manor put in the MAR and Victoria Manor was not able to see what Jefferies pharmacy put in the MAR. Therefore, there was no one able to check to see what Jefferies had on the MAR and what Victoria Manor had on the MAR to cross check. Jeffries was unable to send a pharmacist to inventory the med cart other than one time they came after the inspection on 1/6/2020 making it difficult to catch an error. And Victoria Manor staff had no systems in place to inventory the carts.

The new administrator has started from scratch with medication. The old Pharmacy was being used by the Agency and is no longer the pharmacy. Health Direct a pharmacy that's main distribution is Personal care homes was brought in. This change over in pharmacies allowed Tracy to start fresh and start over. The pharmacy came in did a presentation with all Med techs teaching them the computer system Quickmar that is very user friendly. They have been working with her and the agency to match each residents MAR up with all the Doctors orders and helped the agency get all the Doctors orders for the medications so the MAR and the medication all match up. This pharmacy will put in all the order for the Doctors and will not leave it up to the Med Tech's to put the orders in any more. All the residents will be on the same medication refill cycle so we will not have to order medications that are running low the pharmacy will have the cycle and re-order them. The pharmacy will be distributing the medication in rolls with all the resident's medications in each time. There will not be bubble packs any more. (Example all of resident 8 am meds will be in one package. You will not be able to get to the next time medication until the first time is given. This will help prevent missed medication. The new MAR system has all the times that Glucose checks are to be taken if a medication has to have a BP or respiration first they will not be able to give medication until the BP is complete. The pharmacy will be doing cart/MAR checks twice a month to ensure all MAR's and medications match up and nothing is in the carts that do not belong. A daily list for the Med tech have been started with each shift with responsibilities. Each day and each shift will be responsible to make sure they are checking for D/C meds, doing audits on med carts, order supplies. We also are now faxing and have a binder for all faxes to the pharmacy and Dr's

Tracy Tracy Romyck Administrator 2-19-2020

office if a med is getting low and it is not something Health Direct has oversight on. We will be faxing the Dr. Office Daily and Heath Direct to ensure medications are always available. (Since Health Direct will be in charge of the medication cycle to make sure meds do not run out. This would only be with residents that do not use health direct.) Another great addition to the MAR is when a new med is put in it will be in green and left on the MAR for 7 days in Green. If a MED is D/C it will stay in red on the MAR for 7 days to remind staff daily in case, there is an oversight to make sure it gets taken out of the Med cart and sent back to the pharmacy. The pharmacy will be taking back D/C meds and will come in and ask for the meds when they drop off medications to ensure it is taken out of the building. We are also faxing each time a resident refuses their meds to the Doctors office and the Doctor's office and Victoria manor decided if a resident refuses the Med 5 days in a row it will be D/C and the Doctor will come in and talk to the residents. The administrator will be checking daily to make sure all the plans above are completed. Currently the MAR and MEDs are all matched up and the new Health Direct system will be in fill effect on 2/17/2020. Health Direct will be in next week to monitor the be here to answer any question if any issues arise. Two Health direct representatives who have been assisting with all the change.

All the Med tech have been trained throughout the entire process with the Administrator and Health Direct to make sure there is no confusion. We are also posting and looking for a nurse to come in weekly to also oversee the cart to ensure all medication errors are avoided. Health Direct will be auditing the cart on 3.2.2020 and a designated med tech from Victoria Manor will audit the cart in the week on 2/23/20 to 2/29/2020. The carts will be audited once a month from health direct and once a month for a designated med tech. The administrator will check month to make sure all checks were complete.

Tracy Tracy Romyl administrator

2-19-2020

4/21/2020

187a - Medication Record

Regulations

2600.

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

3. Name of medication.
6. Dose.

Description of Violation

Resident #7 was prescribed Levothyroxine 100mch, take one tablet daily on Monday, Tuesday, Wednesday, Thursday, and Friday starting 9/22/19. The medication card was filled on 12/28/19 and two tablets were removed from the card. However, the medication is not indicated on the December 2019 medication administration record (MAR).

Resident #7 was prescribed AZO Cranberry 250/30mg, take two tablets once daily starting 9/23/19 for recurrent UTI. However, staff person C indicated the medication was administered but was not indicated on the December 2019 MAR.

Resident #7 was prescribed Atenolol 25mg, take ½ tablet daily (12.5mg) started 10/9/19. However, the December 2019 medication administration record (MAR) indicated take one tablet daily.

Resident #6 was prescribed Humalog 100U/ml inject 4 units subcutaneously three times a day with meals and per sliding scale before meals as follows:
70-140 = 0 units
141-180 = 1 unit
181-220 = 2 units
221-260 = 3 units
261-300 = 4 units
301-340 = 5 units
>340 = 6 units and call MD
However, the number of units administered was not recorded from December 1 to 29, 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.)

See Pages 33A, 33B, and 33C of 40

187a- Medication Record
2600 187a A medication record shall be kept to include the following for each resident for whom medications are administer. 3.Name of medication 6. Dose. This is to ensure the home's staff persons will be able to track all medications a resident receives and to ensure all medications are administer as prescribed.

Resident # 7 was prescribed Levothyroxine 100 much, take one tablet daily on Monday, Tuesday, Wednesday, Thursday, Friday starting 9/22/19. The medication card was filled on 12/28/19 and two tablets were removed from the card. However, the medication is not indicated on the December 2019 medication administration record MAR.

Resident # 7 was prescribed AZO Cranberry 250/30 mg. take two tablets once daily starting 09/23/19 for recurrent UTI. However, staff person C indicated the medication was administer but was not indicated on the December 2019 MAR

Resident #7 was prescribed Atenolol 25mg, take ½ tablet daily (12.5mg) started 10/9/19. However, the December 2019 medication administration record (MAR) indicated take one tablet daily

Resident # 6 was prescribed Humalog 100 U/mlsoln, injected 4 units subcutaneously three times a day with meals, and inject units per sliding scale meals as follows:
70-140 =0 units
41-18-=1 units
181-220=2 units
221-260= 3units
261-300 = 4 units
301-340=5 units
>340=6 units and call MD
However, the number of units administered was not recorded from December 1 to 29, 2019.

The new pharmacy will be putting all the orders in the MAR. All the medications are matched up that are in the Cart with the Mar health direct did a cart audit to make sure they have everything matched up as they are switching over the carts from the old pharmacy. The new pharmacy will be putting everything on the MAR now and will be checking twice a month to make sure all medications and MARs match up. The New Pharmacy Health Direct will be ordering the medications and if there is something that needs ordered there is a check list for Med techs for each day to check medications to ensure we do not miss ordering medications. The Dr will see the patient within a week and the pharmacy will fill the scripts sent by the Doctor and then they will be on an a month cycle and all the medications will be automatically re-ordered.

Tracy Mc Tracy Romigh Administrator
2-13-2020

When meeting with the med techs it was determined that the computer system was difficult to understand and was not user friendly. The pharmacy (Jefferies) was unable to see what Victoria Manor put in the MAR and Victoria Manor was not able to see what Jefferies pharmacy put in the MAR. Therefore, there was no one able to check to see what Jefferies had on the MAR and what Victoria Manor had on the MAR to cross check. Jeffries was unable to send a pharmacist to inventory the med cart other than one time they came after the inspection on 1/6/2020 making it difficult to catch an error. And Victoria Manor staff had no systems in place to inventory the carts.

The new administrator Tracy Romigh has started from scratch with medication. Jefferies Pharmacy was being used by the Agency and is no longer the pharmacy. Health Direct a pharmacy that's main distribution is Personal care homes was brought in. This change over in pharmacies allowed Tracy to start fresh and start over. The pharmacy came in did a presentation with all Med techs teaching them the computer system Quickmar that is very user friendly. They have been working with her and the agency to match each residents MAR up with all the Doctors orders and helped the agency get all the Doctors orders for the medications so the MAR and the medication all match up. This pharmacy will put in all the order for the Doctors and will not leave it up to the Med Tech's to put the orders in any more. All the residents will be on the same medication refill cycle so we will not have to order medications that are running low the pharmacy will have the cycle and re-order them. The pharmacy will be distributing the medication in rolls with all the resident's medications in each time. There will not be bubble packs any more. (Example all of resident 8 am meds will be in one package. You will not be able to get to the next time medication until the first time is given. This will help prevent missed medication. The new MAR system has all the times that Glucose checks are to be taken if a medication has to have a BP or respiration first they will not be able to give medication until the BP is complete. The pharmacy will be doing cart/MAR checks twice a month to ensure all MAR's and medications match up and nothing is in the carts that do not belong. A daily list for the Med tech have been started with each shift with responsibilities. Each day and each shift will be responsible to make sure they are checking for D/C meds, doing audits on med carts, order supplies. We also are now faxing and have a binder for all faxes to the pharmacy and Dr's office if a med is getting low and it is not something Health Direct has oversight on. We will be faxing the Dr. Office Daily and Heath Direct to ensure medications are always available. (Since Health Direct will be in charge of the medication cycle to make sure meds do not run out. This would only be with residents that do not use health direct.) Another great addition to the MAR is when a new med is put in it will be in green and left on the MAR for 7 days in Green. If a MED is D/C it will stay in red on the MAR for 7 days to remind staff daily in case, there is an oversight to make sure it gets taken out of the Med cart and sent back to the pharmacy. The pharmacy will be taking back D/C meds and will come in and ask for the meds when they drop off medications to ensure it is taken out of the building. We are also faxing each time a resident refuses their meds to the Doctors office and the Doctor's office and Victoria manor decided if a resident refuses the Med 5 days in a row it will be D/C and the Doctor will come in and talk to the residents. The administrator will be checking daily to make sure all the plans above are completed. Currently the MAR and MEDs are all matched up and the new Health Direct system will be in fill effect on 2/17/2020. Health Direct will be in next

Tracy Romigh Administrator 2-13-2020 4/21/2020

week to monitor the be here to answer any question if any issues arise. Craig Taylor and Darrin McClintock are the Health direct representatives who have been assisting with all the change. All the Med tech have been trained throughout the entire process with the Administrator and Health Direct to make sure there is no confusion. We are also posting and looking for a nurse to come in weekly to also oversee the cart to ensure all medication errors are avoided. Until we get one Health Direct will come to audit the Medication Carts.

Tracy Konigs
Administrator
2-13-2020

4/21/2020

187a - Medication Record *(continued)*

Legal Entity Representative

Signature | Printed Name and Title | Date

Tracy Romey administrator 2-19-2020

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Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

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

187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 was prescribed Quetiapine Fumarate 200mg, take 2 tablets at bedtime for behavioral disturbances. However, the medication was not administered on from 12/26/19 to 12/29/19. The medication was not available in the home.

Resident #6 was prescribed Donepezil HCl 23mg, take one tablet by mouth once daily for Alzheimer's disease. However, the medication was not administered from 12/27/19 to 12/29/19. The medication was not available in the home.

Repeat violation 2/13/19 et all, 5/6/19, 5/31/19

Plan of Correction (POC)

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

See Page 35A and 35B of 40

Legal Entity Representative

Signature

Tracy Roy administrator 2-19-2020
Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented
☐ Not Implemented

187d- Follow Prescriber's Orders
2600 187 d. The home shall follow the directions of the prescriber. Ensure the residents receive medications and treatments as ordered by a physician.

It was fixed immediately. The Dr was contacted and the order was sent over to the pharmacy to be filled. A reportable incident was sent to DHS (attached) on 2/19/2020. This was able to happen because there was no system in place to make sure medications do not run out. No one was in charge of ordering medications. Health Direct will be ordering the medications and if there is something that needs ordered there is a check list for Med techs for each day to check medications to ensure we do not miss ordering medications.

When meeting with the med techs it was determined that the computer system was difficult to understand and was not user friendly. The pharmacy (Jefferies) was unable to see what Victoria Manor put in the MAR and Victoria Manor was not able to see what Jefferies pharmacy put in the MAR. Therefore, there was no one able to check to see what Jefferies had on the MAR and what Victoria Manor had on the MAR to cross check. Jeffries was unable to send a pharmacist to inventory the med cart other than one time they came after the inspection on 1/6/2020 making it difficult to catch an error. And Victoria Manor staff had no systems in place to inventory the carts.

The new administrator has started from scratch with medication. Jefferies Pharmacy was being used by the Agency and is no longer the pharmacy. Health Direct a pharmacy that's main distribution is Personal care homes was brought in. This change over in pharmacies allowed Tracy to start fresh and start over. The pharmacy came in did a presentation with all Med techs teaching them the computer system Quick mar that is very user friendly. They have been working with her and the agency to match each residents MAR up with all the Doctors orders and helped the agency get all the Doctors orders for the medications so the MAR and the medication all match up. This pharmacy will put in all the order for the Doctors and will not leave it up to the Med Tech's to put the orders in any more. All the residents will be on the same medication refill cycle so we will not have to order medications that are running low the pharmacy will have the cycle and re-order them. The pharmacy will be distributing the medication in rolls with all the resident's medications in each time. There will not be bubble packs any more. (Example all of resident 8 am meds will be in one package. You will not be able to get to the next time medication until the first time is given. This will help prevent missed medication. The new MAR system has all the times that Glucose checks are to be taken if a medication has to have a BP or respiration first they will not be able to give medication until the BP is complete. The pharmacy will be doing cart/MAR checks twice a month to ensure all MAR's and medications match up and nothing is in the carts that do not belong. A daily list for the Med tech have been started with each shift with responsibilities. Each day and each shift will be responsible to make sure they are checking for D/C meds, doing audits on med carts, order supplies. We also are now faxing and have a binder for all faxes to the pharmacy and Dr's office if a med is getting low and it is not something Health Direct has oversight on. We will be

Tracy Romigh Administrator 4/21/2020
2-19-2020

faxing the Dr. Office Daily and Heath Direct to ensure medications are always available. (Since Health Direct will be in charge of the medication cycle to make sure meds do not run out. This would only be with residents that do not use health direct.) Another great addition to the MAR is when a new med is put in it will be in green and left on the MAR for 7 days in Green. If a MED is D/C it will stay in red on the MAR for 7 days to remind staff daily in case there is an oversight to make sure it gets taken out of the Med cart and sent back to the pharmacy. The pharmacy will be taking back D/C meds and will come in and ask for the meds when they drop off medications to ensure it is taken out of the building. We are also faxing each time a resident refuses their meds to the Doctors office and the Doctor's office and Victoria manor decided if a resident refuses the Med 5 days in a row it will be D/C and the Doctor will come in and talk to the residents. The administrator will be checking daily to make sure all the plans above are completed. Currently the MAR and MEDs are all matched up and the new Health Direct system will be in fill effect on 2/17/2020. Health Direct will be in next week to monitor the be here to answer any question if any issues arise. Two Health direct representatives have been assisting with all the change.

All the Med tech have been trained throughout the entire process with the Administrator and Health Direct to make sure there is no confusion. Health Direct will be auditing the cart on 3.2.2020 and a designated med tech from Victoria Manor will audit the cart in the week on 2/23/20 to 2/29/2020. The carts will be audited once a month from health direct and once a month for a designated med tech. the administrator will check weekly all the forms the med tech are to complete if a medication is running out. The designated med tech will check daily and order any medication needed.

Tracy Tracy Comigt Administrator
2-19-2020

4/21/2020

190a - Completion Medication Course

Regulations

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff person B, hired on 1/27/16, did not successfully complete the Department-approved annual medication administration practicum for January 1, 2019 to December 30, 2019 in order to continue to administer medications. The most recent education was dated 6/9/17. However, staff person B administered medication to resident #6 on 12/2/19 to 12/3/19, 12/7/19 to 12/10/19 to include:

* Clonazepam 0.5mg tab, take one tablet twice a day.
* Senna 8.6mg tab, take 2 tablets by mouth at bedtime.
* Quetiapine Fumarate 200mg, take two tablets by mouth at bedtime.
* Phospha 250neutral tablet, take one tablet by mouth four times a day.
* Melatonin 3mg, take two tablets by mouth at bedtime.
* Levetiracetam 500mg, take two tablets by mouth twice daily.
* Humalog 100U/ml soln, inject subcutaneously three times a day with meals.
* Levemir 100U/ml soln, inject 30 units subcutaneously at bedtime.
* Celecoxib 200mg cap, take one cap by mouth daily

Repeat violation 2/13/19 et all, 5/6/19

Plan of Correction (POC)

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

See Page 36A of 40

Legal Entity Representative

Signature

Tracy Romyl administrator 2-19-2020

Printed Name and Title Date

190a –Completion Medication Course

2600 190a A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose, and ear drop prescription medications and epinephrine injections for insect bites or other allergies. This is to ensure the staff persons will be trained in the proper procedures to safely and correctly administer medications to residents.

The old administrator stated he had his annual practicum evaluations but could not find his paperwork their fore staff B was suspended for passing medications immediately. This was able to happen because there was no identified place for the Medication Administration information to be stored.
An RN who completed the Office of Developmental Program's "train the trainer" and is trained to Train the medication administration training completed a medication training on 2/8/2020 that staff B took again. He was also trained in suppositories, nebulizers, eye drops/ ointment and ear drops. (attach) A Practicum observer will be utilized to ensure the annual medication administration practicum is completed to keep the staff in compliance. She will be back July 6, 2020.

The new administrator understands that no one can pass medications unless they complete The Department's approved medication administration course and then complete the annual practicum requirements each year. She will ensure that everyone who passes the medication course will also meet their annual requirements. And a record of the training will be kept including the staff person trained, the date, source, name of the trainer and documentation that the course was successfully completed. A Medication Binder has been created to put each individual person's medication administration course paperwork to ensure paperwork does not get lost or misplaced. A table was created with each Med Tech date as to when they had their last annual practicum requirements and when they are due next and the Administrator has added them to her month calendar. All trainings will be reviewed at each Quality Assurance Meeting that are held quarterly to ensure that a training doesn't expire and all trainings are completed.

Tracy Romyl
Administrator
02-19-2020

4/21/2020

190a - Completion Medication Course *(continued)*

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The above plan of correction is approved as of 2/25/2020 (Date)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

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

Direct care staff person B, did not successfully complete the Department-approved diabetes patient education program within the past 12 months. The most recent education was dated 6/9/17. Staff person B administered diabetic medication to resident #6 at 4:00 p.m. on 12/2/19 and 12/3/19, 12/7/19 and 12/8/19, and 12/10/19 to include:

* Humalog 100U/ml soln, inject subcutaneously three times a day with meals.
* Levemir 100U/ml soln, inject 30 units subcutaneously at bedtime.

Repeat violation 2/13/19 et all, 5/6/19

Plan of Correction (POC)

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

See Pages 38A and 38B of 40

Legal Entity Representative

Signature | Printed Name and Title | Date

Tracy Kemp administrator 2-19-2020

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

190 B- Insulin Injections

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 two years, as well as successful completion of a Department- approved diabetes patient education program with the past 12 months. This is to ensure the staff person is proper trained and know the procedures to safely and correctly administer medication to residents.

Direct care staff person B, did not successfully complete the Department- approved diabetes patient education program within the past 12 months. The most recent education was dated 6/9/17/ Staff person B administered diabetic medication to resident # 6 at 4:00pm on 12/2, 12/3, 12/7, 12/8. And 12/10/19.

Staff B was immediately removed from passing medication. With the old administrator being gone I do not know what training were done in 2018 other than a Using the glucometer on 1/25/18 by staff B.
I have no way of knowing if the staff completed the training in 2018. I could not find any sign in sheets. The staff stated they did complete training every year but I have no documentation.

In 2019 I have the Basic Insulin Administration Training for 7/22/19 for Staff B. (attached)
In 2020 Staff B completed the Medication Administration training on 2/8/2020 and he will be taking the Diabetic Training on 3/5/2020 schedule by OSTPA hospice. He will not pass medication until he has competed the Diabetic Training.

Moving forward the new administration knows all the trainings that needs to be completed annually, as well the that staff person orientation can be included in the 12 hrs of training for the first year of employment. All the trainings include 1. Medication self-administration training 2. Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, 3, Care for resident with dementia and cognitive impairments. 4. Infection control and general principles of cleanliness and hygiene and areas with mobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, 5. Personal care services needs of the residents, 6. Safe management techniques. 7. Care for residents with mental illness or mental retardation. 8. Fire safety 9. Emergency preparedness procedures and crisis emergency situation. 10. Resident rights. 11 The Older Adult Protective Services Act. 12, Falls and accident prevention and 13. New population groups.
2020

1. 1/7/2020. Abuse and mistreatment 2600. 42B and When to fill out and incident report 2600.16c on 01/07/2020. Completed by administrator then had someone come in on 1/23/2020 below to do one as well.
2. 1/23/2020. Abuse reporting/Residents Rights/OAPSA was completed on 1/23/2020 by Julie Elling Gateway Hospice and community Liaison.

Tracy Tracy Ramsey Administrator 2-19-2020

4/21/2020

3. 01/15/2020. Quality Management meeting to go over all implementations from the last plan of correction submitted in December 2019. As well as all forms created and expectations for the home moving forward.
4. 01/23/2020 Instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation had support plan on 1/23/2020 by the administrator.

5. 05/11/2020. Medication Administration training was completed on 2/8/2020 By Amy Pomzoo for staff member B. Staff member K had medication administration on 5/11/2019 (attached). And her annual med check on 11/4/19.

6. 2/11/2020. First Aid/CPR on 2/11/2020 Completed by from Kems Paramedics for B and K.
7. 02/19/2020 Emergency Preparedness And HIPPA Confidentiality scheduled with Gateway Hospice and Community Liaison.
8. 03/03/2020 Older Adult Protective Services Act scheduled with OSPTA Home Health &Hospice.
9. 03/11/2020 Diabetic Training scheduled with Grane Hospice.
10. 03/18/2020 Infectious Control and Fall and Prevention scheduled with Gateway Hospice and Community Liaison. Staff B and K took a Fall Prevention training from Medcom (attached) as well on 2/10/2020.
11. And the Building and Code Fire Official for North Fayette is finding someone to do the fire safety training for March.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional. The Diabetic training will be discussed and checked at the quarterly Quality Assurance meetings to make sure all staff have the required training including the Diabetic Training.

T Nay Tracy Konieja administrator

2-19-2020

4/21/2020

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 #6 was admitted to the home on 11/25/19. However, the initial assessment was not completed.

Repeat violation 2/13/19 et all, 5/6/19, 5/31/19

Plan of Correction (POC)

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

See Page 39A of 40

Legal Entity Representative

Signature

Tracy Ramsey
Printed Name and Title

2-19-2020
Date

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The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

225.a Assessment 15 Days

This allows the home to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

Resident #6 was admitted to the home on 11/25/19. However, the initial assessment was not completed. The initial assessment was completed on 12/02/19 but was not made available to the auditor. The old administrator is gone to ask why it was not made available. When the new administrator was doing an audit of all the charts it was in the file.

The new administrator that started on 12/9/19 did a complete audit of all the files. She spent the month of January updating all files to get everything into files. The administrator created a table to document what each file has and what is missing. All files were updated and all proper documentation completed and placed in files.

The new administrator created a check list for new residents' sign and date for all new residents. There is a verification page that the will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. Three designated staff have been selected to check to make sure all residents files are completed. All three were trained on 1.23.2019 on Initial support plans and how to write them and when they are due. I will take turns with each new resident and assign one of the three to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files and on time.

Tray Tracy Romyn Administrator

2-19-2020

4/21/2020

251b - Record Entries Legible

Regulations

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used to change information on the date and payment responsibility sections of resident #7's contract dated August 17, 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.)

See Page 40A of 40

Legal Entity Representative

Tray — Signature

Tracy Romich Administrator — Printed Name and Title

Date

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

The above plan of correction is approved as of 2/25/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☒ Implemented

☐ Not Implemented

Regulations 2600 251 b- Record Entries Legible

251 b. The entries in a resident record must be permanent, legible, dated and signed by the staff person making the entry. Permanent means that entries are not erased or covered with correction fluid/tape. A line should be drawn through errors or changes such that the original entry is still legible. The benefit of this is to make sure that the resident's record content is permanent, legible, dated and signed by the staff person making the entry to help ensure that information stared in the record is detailed, accurate and unaltered.

Corrective fluid was used to change information on the date and payment responsibility section of resident # 7's contract dated August 17, 2019. This error was made by the old Administrators. A new contract was filled out and signed to have a copy in the file with signatures from the payees to make sure paying parties agree with the amount written over the corrective fluid.

A staff meeting was held on February 5, 2020 and one of the topics in the meeting was the correct way to fix an error on resident's documentation. The Administrator went into detail about what is considered resident documents, ranging from progress notes to all written documentation in the resident's files. Any documents filled out by a staff member will be handed in and proofread by the administrator before placed in files. New hires will be trained during the 40hr orientation /training about documents how to document and the correct way to fix an error on a resident document.

Tracy Tracy Romizek administrator 05-5-2020

45/21/2020

Violation Report

Facility Information

Name: *VICTORIA MANOR PERSONAL CARE HOME* License Number: *44642*
Address: *100 ROSE COURT, OAKDALE, PA 15071*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Tracy Romigh* Phone: *724-693-8336* Email: *admin@vmassistedliving.com*

Legal Entity

Name: *LAFFEY HEALTH CARE SERVICES LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *46* Waking Staff: *35*

Inspection

Type: *Partial* BHA Docket #: Notice: *Unannounced*
Reason: *Monitoring*

Inspection Dates and Department Representative

03/10/2020 - On-Site: Trish Bartlett, Cindy Mulick, Desmond Grace

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* Residents Served: *38*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *3*
Have Mobility Need: *8*
Are 60 Years of Age or Older: *38*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *1*

65e - 12 Hours Annual Training

APR 10 2020

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

Description of Violation

Direct care staff person A only received 6 hours of training of the required 12 hours of annual training during the January 1, 2019 to December 31, 2019 training year.

Direct care staff person B only received 6 hours of training of the required 12 hours of annual training during the January 1, 2019 to December 31, 2019 training year.

Direct care staff person C only received 6 hours of training of the required 12 hours of annual training during the January 1, 2019 to December 31, 2019 training year.

Repeat Violation 2/13/19 et al

Plan of Correction (POC)

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

See Page 2A of 17

Legal Entity Representative

Tracy — Signature

Tracy Romigh administrator — Printed Name and Title

4-8-2020 — Date

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The above plan of correction is approved as of 4/16/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

65e-12 Hours Annual Training
2600. 65.e. Direct care staff shall have at least 12 hours of annual trainings relating to their job duties.

There was an inspection on Dec 30th 2019 under the old administrator, When the new administrator took over on Jan 3rd 2020 she was the one who had to do the plans of correction for the December audit. She spoke in detail with Jon Kimberland and come up with a plan of correction for this violation. When the plans of correction were handed in for the Dec 30th 2019 audit they were approved.
All staff files have been audited and the plan of correction is that the staff who did not have all the 2019 trainings will do all the 2020 trainings as well as the hours each staff were missing for 2019. I have (attached) what trainings have been completed already in 2020. As of this date Staff A and B have 19.5 hours of training and Staff C has 25.5 hrs because he had to do the entire medication administration training. A few other trainings were cancelled due to the COVID-19 lock downs. All other trainings on the attached sheets will be scheduled as soon the COVID- 19 lock down is lifted.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional.
During the Quality Management meeting that is held quarterly all staff trainings will be reviewed in accordance with 65e. To ensure all staff currently employed have training and anyone missing training can be scheduled to complete trainings.

Tracy Traylor administrator
4-8-2020

4/21/2020

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:
* Medication self-administration training
* Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, and medical evaluation and support plan.
* Care for residents with dementia or cognitive impairments.
* Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration.
* Care for residents with mental illness or intellectual disabilities.

Direct care staff person B did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:
* Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, and medical evaluation and support plan.
* Care for residents with dementia or cognitive impairments.
* Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration.
* Care for residents with mental illness or intellectual disabilities.

Direct care staff person C did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:
* Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, and medical evaluation and support plan.
* Care for residents with dementia or cognitive impairments.
* Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration.
* Care for residents with mental illness or intellectual disabilities.

Repeat Violation 2/13/19 et al

65f - Training Topics *(continued)*

Plan of Correction (POC)

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

See Page 4A of 17

Legal Entity Representative

Tracy M — Signature

Tracy Romig administrator — Printed Name and Title

4/8/2020 — Date

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

The above plan of correction is approved as of 4/16/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

65f-Training Topics

There was an inspection on Dec 30th 2019 under the old administrator, When the new administrator took over on Jan 3rd 2020 she was the one who had to do the plans of correction for the December audit. She spoke in detail with Jon Kimberland and come up with a plan of correction for this violation. When the plans of correction were handed in for the Dec 30th 2019 audit they were approved.
All staff files have been audited and the plan of correction is that the staff who did not have all the 2019 trainings will do all the 2020 trainings as well as the hours each staff were missing for 2019. I have (attached) what trainings have been completed already in 2020. As of this date Staff A and B have 19.5 hours of training and Staff C has 25.5 hrs because he had to do the entire medication administration training. A few other trainings were cancelled due to the COVID-19 lock downs. All other trainings on the attached sheets will be scheduled as soon the COVID- 19 lock down is lifted. All training A,B,C were missing in 65f training were completed by A,B,C staff members.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional.
During the Quality Management meeting that is held quarterly all staff trainings will be reviewed in accordance with 65f. To ensure all staff currently employed have training and anyone missing training can be scheduled to complete trainings.

Tracy Tracy Romigh Administrator

4-8-2020

4/21/2020

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Direct care staff person A did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
* Emergency preparedness procedures and recognition and response to crises and emergency situations.
* The Older Adult Protective Services Act.

Direct care staff person B did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
* Emergency preparedness procedures and recognition and response to crises and emergency situations.
* The Older Adult Protective Services Act.

Direct care staff person C did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
* Emergency preparedness procedures and recognition and response to crises and emergency situations.
* The Older Adult Protective Services Act.

Direct care staff person D did not receive training for the required training topics during the January 1, 2019 to December 31, 2019 training year as follows:

* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
* Emergency preparedness procedures and recognition and response to crises and emergency situations.
* The Older Adult Protective Services Act.

Repeat Violation 2/13/19 et al

65g - Annual Training Content *(continued)*

Plan of Correction (POC)

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

See Page 6A of 17

Legal Entity Representative

Tray
Signature

Tracy Romigh administration 4-8-2020
Printed Name and Title Date

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The above plan of correction is approved as of 4/16/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented
☒ Not Implemented

65g. Annual Training Content.

There was an inspection on Dec 30th 2019 under the old administrator, When the new administrator took over on Jan 3rd 2020 she was the one who had to do the plans of correction for the December audit. She spoke in detail with Jon Kimberland and come up with a plan of correction for this violation. When the plans of correction were handed in for the Dec 30th 2019 audit they were approved.
All staff files have been audited and the plan of correction is that the staff who did not have all the 2019 trainings will do all the 2020 trainings as well as the hours each staff were missing for 2019. I have (attached) what trainings have been completed already in 2020. As of this date Staff A and B have 19.5 hours of training and Staff C has 25.5 hrs because he had to do the entire medication administration training. All other trainings on the attached sheets will be scheduled as soon the COVID- 19 lock down is lifted. Emergency preparedness and The older adult protective services Act were completed with staff A, B, and C, fire safety was cancelled by the Fire Chief that was scheduled for April 1st 2020 due to COVID-19 lock down. It will be scheduled as soon as the lock down is over.

All training will be scheduled by the Administrator with sign in sheets kept in a Mandatory Training Binder with staff person trained name, date, source, content, length of each course and copies of any certificates received. The administrator also created a binder for each training for staff who start after the date an outside training is completed. For trainings that do not require a professionally trained instructor. (First Aid/CPR, diabetic, fire safety, medication administration) are all training that much be taught by a professional.
During the Quality Management meeting that is held quarterly all staff trainings will be reviewed in accordance with 65g. To ensure all staff currently employed have training and anyone missing training can be scheduled to complete trainings.

Tracy Tracy Romyn Administrator
4-8-2020

4/21/2020

81b - Resident Personal Equipment

Regulations

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1's bed had an uncovered enabler bar on the right side of the bed near the resident's pillow area, with an opening measuring approximately 12 inches wide by approximately 14 inches high, posing an entanglement hazard. Also, the enabler moved easily approximately 6 inches away from the side of the bed, posing an entrapment hazard.

Repeat Violation 2/13/19 et al

Plan of Correction (POC)

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

See Page 7A of 17

Legal Entity Representative

Signature

Tracy Romig Administrator 4-8-2020

Printed Name and Title Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/21/2020 (Date)

☐ Implemented

☒ Not Implemented

2600 81b –Resident Personal Equipment

81. B. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Clean assistive devices that are in good repair are less likely to cause injury or illness to residents.

Resident # 1 enabler was immediately removed.
The new administrator was given a lesson by the auditor to understand the entire function of an enabler. And what is considered appropriate and what is considered hazardous. All enablers in the building were checked that day and resident # 1 enabler was removed while the auditor was in the building.

Update 4-20-20 current all enablers were removed to prevent hazardous issues. To avoid hazardous issues all enabler were removed and moving forward we will not be using enablers in the building.

Moving forward a schedule and sign off sheet was created to check all wheelchairs, walkers, and apparatus. Checking the enablers will be documented on a sign-off sheet. The administrator or maintenance man will be conducting check and weekly checks and sign off to make sure all devices are functioning properly. Administrator will oversee to make sure this is done weekly.

Tracy M Kay Tracy M Romyn Administrator
4-20-20

4/21/2020

89b - Hot Water Temperature

Regulations

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At approximately 9:43 a.m., the water temperature at the sink in the men's common restroom next to the dining room, measured approximately 134.5 degrees Fahrenheit.

At approximately 9:46 a.m., the water temperature at the sink in the women's common restroom near the dining room, measured approximately 128.4 degrees Fahrenheit.

Repeat Violation 2/13/19 et al, 5/6/19

Plan of Correction (POC)

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

See Page 8A of 17

Legal Entity Representative

Tracy Mclamp — Signature

Tracy Mclamp Administrator — Printed Name and Title

4/8/2020 — Date

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2600 89b.

During the inspection I showed the auditor how each water tank gage was marked to make sure the temperature did not go over 120.0 degree's Fahrenheit. She could see that it had been touched and moved off the marker. We turned down the heater to the marked and when she checked the water heater around 1:00pm it was at 113 degrees. (attached) I have since then had our maintenance man put on a locked box over the controls to prevent anyone from turning the controls to ensure it says under 120.0 degree's.

A hot water Temperature Log was started on December 9th 2019 and will continue to be completed a minimum of twice a week from a least one room running off of each of the water tanks to ensure that all sinks from each water tank are below 120 degrees. This will be completed by maintain or administrator and the administrator will check it weekly to ensure it is completed. Any further issues with the temperature that does not have to do with the control panel a plumber will be contacted.

Tracy Tracy Romigh 4-8-2020
Administrator

4/21/2020

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

[redacted] VIOLATION WITHDRAWN 4/21/2020

Resident #3's documentation of medical evaluation, dated 12/20/19, was incomplete. The following areas were blank:

* Resident's temperature.
* Resident's medication list was not attached

[redacted] VIOLATION WITHDRAWN 4/21/20202

Resident #5's documentation of medical evaluation, dated 11/12/19, did not include a list of the resident's medications or an attached list of medications.

Repeat Violation 2/13/19 et al, 5/6/19, 5/31/19

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction (POC)

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

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Legal Entity Representative

Signature

Printed Name and Title

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141a 1-10 Medical Evaluation Information

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

All residents DME forms were corrected and attached.

[redacted]

Resident # 3 blanks for temperature and mediation list were added attached

[redacted]

Resident # 5 medication list was added and attached.

The new administrator that started on 12/9/19 did a complete audit of all the files. She spent the month of January updating all files to get everything into files. The administrator created a table to document what each file has and what is missing. All files were updated and all proper documentation was placed in files. Now that everything is in the file the administrator is now going back through the files to make sure all forms are filled out correctly and there are no blanks on any form that was already filled out prior. This will be completed by 4/30/2020.

The new administrator created a check list for new residents' sign and date for all new residents. There is a verification page that will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner and everything is filled out correctly. Every assessment is looked over by a second pair of eyes. Three designated staff have been selected to check to make sure all residents files are completed correctly. I will take turns with each new resident and assign one of the three to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files on time and completed correctly. The administrator will check the forms again after the staff have signed off to make sure all forms are correct and in the files.

Tracy Tracy Roney 4-20-20 - Administrator

4/21/2020

183b - Meds and Syringes Locked

Regulations

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

There were unlocked medications in resident #6's night stand in resident's shared bedroom to include:

* Approximately 6 tablets of 81mg aspirin.
* Ten gel caps of Imodium 4mg antidiarrheal.

Repeat Violation 2/13/19 et al

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.)

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Legal Entity Representative

Signature

Printed Name and Title

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The above plan of correction was approved by (Initials)

183b- Meds and Syringes Locked

2600. 183. B Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room. Medications and syringes will be safe from contamination, spillage or theft and residents who are unable to self-administer medications will be safe from harming themselves with the medications.

Resident #6 is not permitted to have medications in her room. The medication was removed from resident #6's room. This was given to her by her son without the home being made aware and she had it hidden in a draw. During admission the families are explained the medication policy and how all medications are to be given to the med tech to be placed on the MAR including any over the counter medications. After this incident the son was contacted and again reminded of the medication procedure. Staff went to all residents and asked them if anyone had any medications in room. Residents that cannot understand or communicate on their own the families were called to ask them if the residents have ever been given any medications that were not checked it to the med tech. This time was also used to remind them of the medication procedure.

Moving forward residents will be asked weekly if they have any medications in their room that is not in the medication cart. Rooms will be check with the residents present weekly to ensure there are no medications in the room. And upon admissions the administrator will go into more detail about the seriousness of medications being left in a room with families and what the procedure is to make sure all medications are signed to the med tech.

Tracy Tracy Ramsey 4-20-20
Administrator

4/21/2020

183e - Storing Medications

Regulations

2600.

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

Description of Violation

Resident #6 was prescribed Levemir Flextouch pen 100u/ml. Inject 30 units sub q, daily at bedtime. The medication flex pen in the medication cart was not dated when opened and there were approximately 60 units of 100 u remaining in the flex pen.

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.)

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Legal Entity Representative

Signature

Tracy Lamoy Administrator 4-8-2020

Printed Name and Title Date

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183 e- Storing Medications
This ensures the medications will be stored in a manner that prevents damage or loss.

The pharmacy was contacted to find out the date it was sent to the Home and the date was added.

The new administrator has started from scratch with medication.
The old Pharmacy that was being used by the Agency and is no longer the pharmacy. A new pharmacy that's main distribution is Personal Care Homes was brought in. The date that the New Pharmacy has to be completely changed over was 3/16/2020. The Pharmacist came In on 3/16/20 on that day to do a Cart audit to make sure everything is completed done, dates on everything and the Medication and the MAR matching complete. That date we have had a Med Tech do an audit on 3/24, 3/31 to make sure all meds have dates names and all medications are matching the MAR.

There will be a CART audit twice a month and the Pharmacist will be doing a quarterly cart audit to ensure all medications in the MED cart match with the MAR. And that all names and Dates are on all bottles, pens, and any medications not bought in by the pharmacy.
The administrator will oversee the Medication Cart and Cart Audits.

Tracy Tracy Romig Administrator
4-8-2020

4/21/2020

187a - Medication Record

Regulations

2600.

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

6. Dose.

Description of Violation

Resident #6 was prescribed Levemir Flextouch pen 100u/ml inject 30 units subcutaneously daily at bedtime. However, the resident's March 2020 medication administration record indicated Levemir Flextouch pen 100u/3ml.

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.)

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Legal Entity Representative

Signature

Tracy Romigh Administrator
Printed Name and Title

4-8-2020
Date

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187a- Medication Record
This is to ensure the home's staff persons will be able to track all medications a resident receives and to ensure all medications are administer as prescribed.

The correct medication was in the cart it was written wrong on the MAR. The Pharmacy was contacted when the auditor was here and after they talked to the auditor because they were disagreeing with her initially they change the way the order was written on the MAR to reflect 100u/ml inject 30 units. This was changed during the audit.

Moving forward there will be a CART AUDIT twice a month. The pharmacy puts in all our orders so the Med Tech doing our CART AUDIT monthly will check to make sure all medications on the MAR match how it is written by the Doctor. There were also lists created for the Med Tech for them to check on medications daily to make sure when a medication is added to the MAR it matches the order from the Doctor. The administrator will oversee the Cart Audit and Cart to ensure the medication in the CART is matching the MAR.

Tracy Kemp Tracy M

Administrator

4-8-2020

4/21/2020

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 #4's initial assessment, dated 1/5/20, did not indicate an assessment for: supervision. medication administration, and solitary or group activities. These areas were blank. The following areas were marked as not applicable: securing health care, doing laundry, shopping, securing and using transportation, managing finances, making and keeping appointments, and obtaining seasonal clothing.

Resident #7's initial assessment, dated 1/2/20, did not indicate an assessment for: supervision, the ability/inability to self-administer medications, tactile touch needs. dental needs, and dietary needs. These areas were blank. The resident's assessment did not include the resident's diagnoses of syncope, lack of coordination, weakness, and cognitive communication diagnosis. The following areas were marked as not applicable: securing and using transportation, managing finances, managing and keeping appointments, obtaining clean seasonal clothing, managing health care, and securing health care.

Resident #8's initial assessment, dated 8/17/19, did not indicate an assessment for judgement. This section was blank. The following areas were marked as not applicable: hobbies/interests, solitary activities, group activities. and religious affiliation if any.

Repeat Violation 2/13/19 et al, 5/6/19, 5/31/19

Plan of Correction (POC)

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Legal Entity Representative

Signature

Tracy Romyn Administration
Printed Name and Title

4-8-2020
Date

225.a Assessment 15 Days

This allows the home to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

All three Assessments were completed for resident #4, #7 and # 8.(Attached) The auditor went over the Assessments with the Administrator to explain how each question needs to be answered. The administrator was checking box E if the resident did not do the assessment and did not know that even if they don't do laundry to check the box based off the letter they would be if they had to do laundry themselves. The Assessments were fixed and moving forward The assessments will be completed based off what the resident can and cannot do regardless if they do or don't do it at the facility. And that each and every box will be checked and answered even if they do not participate or cannot participate.

The new administrator created a check list for new residents' sign and date for all new residents. There is a verification page that will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. And that every assessment is looked over by a second pair of eyes. Three designated staff have been selected to check to make sure all residents files are completed correctly. I will take turns with each new resident and assign one of the three to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files on time and completed correctly.

Tracy Mc Tracy Romyl 4-8-2020

Administrator

4/21/2020

225a - Assessment 15 Days *(continued)*

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☒ Not Implemented

225c - Additional Assessment

Regulations

2600.

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

1. Annually.

Description of Violation

Resident #5's annual assessment dated, 11/29/19, did not indicate the resident's dietary care needs. The dietary area was blank.

[redacted] VIOLATION WITHDEAWN 421/2020

Plan of Correction (POC)

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

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Legal Entity Representative

T Nagy — Signature

TRACY Ramich administrator — Printed Name and Title

4-8-2020 — Date

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225.C Additional assessment

Resident # 5 and [redacted] plans were correct attached. Resident #5 was able to happen because there were no systems in place to check completion and [redacted]. It was updated and attached.

Moving forward the administrator will meet weekly with all outside services and update their charts as agencies start services and end services. The administrator created a spread sheet of all residents receiving services for outside sources. The administrator will check the files monthly of these residents to make sure all information is updated and in files.

The new administrator created a check list for new residents' sign and date for all new residents. There is a verification page that will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner and everything is filled out correctly. Every assessment is looked over by a second pair of eyes. Three designated staff have been selected to check to make sure all residents files are completed correctly. I will take turns with each new resident and assign one of the three to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files on time and completed correctly. The administrator will check the forms again after the staff have signed off to make sure all forms are correct and in the files.

Tracy Romig
Administrator 4-8-2020

4/21/2020

227c - Support Plan Revision

Regulations

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #3's support plan, dated 12/20/19, did not indicate the frequency of services or responsible party for diagnoses of: Diabetes, Hypertension, Discitis. Benign prostate hypertrophy, and how back pain.

[redacted]

VIOLATION WITHDRAWN 4/21/2020

[redacted]

VIOLATION WITHDRAWN 4/21/2020

Plan of Correction (POC)

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

See Page 17A of 17

Legal Entity Representative

Signature

Printed Name and Title: Terry Romisch Administrator

Date: 4-8-2020

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227.a Support Plan 30 Days

2600 227.a. A resident requiring personal services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form. This ensures that each resident's needs are met, and that accountability for meeting those needs is firmly established.

Resident # 3, [redacted]all had their support plans updated to make sure all blanks were filled in. (attached).
The administrator did an audit when she started to make sure all correct forms were in the resident's files. Since the inspection the administrator has been going through each assessment and support plan of all the residents to make sure all the RASP's are completed correctly and all areas are filled out properly. Everything is being fixed and completed. They will be all be completed by April 30th 2020.

A check list for new residents' sign and date for all new residents was created. There is a verification page that the will be checked off by a second staff within the first month to ensure all paperwork is done in a timely manner. The Administrator will take turns with each new resident and assign one of the three designated to be in charge of the new resident to oversee the file as the verification person to make sure all the forms are in the files on time and completed correctly.

Tracy Tracy Lamp 4-8-2020
Administrator

4/21/2020