

Department of Human Services
Bureau of Human Service Licensing

July 7, 2021

[REDACTED] ADMINISTRATOR

MORKEL INC
466 HIGH STREET
DERRY, PA 15627

RE: SUNSET RIDGE PERSONAL CARE
HOME
466 HIGH STREET
DERRY, PA, 15627
LICENSE/COCC#: 42883

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/10/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jody Garvey

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *SUNSET RIDGE PERSONAL CARE HOME* License #: *42883* License Expiration Date: *05/02/2021*
Address: *466 HIGH STREET, DERRY, PA 15627*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7246943105* Email: [REDACTED]

Legal Entity

Name: *MORKEL INC*
Address: *466 HIGH STREET, DERRY, PA, 15627*
Phone: *7246943105* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/17/1999* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *24* Total Daily Staff: *37* Waking Staff: *28*

Inspection

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *02/10/2021*

Inspection Dates and Department Representative

02/10/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* Residents Served: *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *11* Are 60 Years of Age or Older: *7*
Diagnosed with Mental Illness: *11* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

02/10/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/11/2021*

Inspections / Reviews (*continued*)

3/12/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow Up Type: *POC Submission*Follow-Up Date: *03/16/2021*

4/15/2021 POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *04/30/2021*

6/2/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/07/2021*

7/7/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil fuel burning device or appliance. If there is not at least 15 feet between the fossil fuel burning device and the door that leads out of the enclosed area to the rest of the building, then the carbon monoxide detector should be placed just outside of the door, unless the manufacturer's instructions indicate otherwise.

The home's boiler room did not have enough space for the carbon monoxide detector to be placed at least 15 feet from fossil fuel burning boiler and the carbon monoxide detector was not placed just outside the door. The carbon monoxide detector was located approximately 10 feet from the boiler room door.

Plan of Correction

Accept

Rampart Security, Inc was contacted to correct this once again. The detector was moved to the location the state inspector indicated on March 18, 2019 to correct a citation. The carbon monoxide detector is hard wired (not battery operated), so it needs to be moved by our security monitoring company, Rampart Security, Inc. They moved the carbon monoxide alarm on Thursday, March 18, 2021, the detector was moved so that it is just outside of the boiler room.

The administrator insured that the carbon monoxide alarm was placed in the proper location on March 18, 2021 when Rampart Security relocated it. The administrator will check on the detector monthly to ensure that it is not moved.

The administrator will insure that the carbon monoxide alarm is placed in the proper location on March 18, 2021 when Rampart Security relocates it.

Completion Date: 03/18/2021

Document Submission

Implemented

Please find attached supporting documents:

- 1) Invoice from Rampart Security*
- 2) Letter from Rampart Security*
- 3) Photograph of new location for detector*

26a - Quality Management Plan

1. Requirements

2600.

- 26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not establish and implement a quality management plan and had not conducted a quality management plan review within the last year.

26a - Quality Management Plan (continued)

Plan of Correction Accept

The Home does have a Quality Management Plan. A copy will be attached to this report. At the beginning of 2020, when the COVID-19 pandemic began, all information distributed by the PA Department of Human Services and Center for Disease Control was printed and placed in a binder. All staff members reviewed the information and signed off on the QMP between March 30 and April 2, 2020. This binder has been used as a resource throughout the year. As 2020 presented itself as a unique year, the Administrator regrettably neglected to conduct any other reviews.

The Home started a Quality Management Plan for 2021. The first subject covered was a discussion on possible side effects to watch for after the residents received their second COVID-19 vaccine. This review was on February 24, 2021.

The Administrator will insure that QMP review is conducted every other month throughout 2021, thus in February, April, June, August, October and December; and any other time a review is warranted.

Completion Date: 12/31/2021

Document Submission Implemented

See attached documentation

54a - Direct Care Staff

1. Requirements

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 A, hired [REDACTED] does not have a high school diploma, GED diploma or active registration status on the Pennsylvania nurse aide registry.

Plan of Correction Accept

Direct care staff person A does have a copy of their high school diploma, however it had been misfiled. It was located in another employee's file and properly placed in staff person A's file. A copy is attached to this report.

In the future, the Administrator will review all new employee's files. This will be done once new employees finish the initial training and pass the competency test. The home has created a checklist of all documents that should be included in employee files to ensure that no documents are missing.

Completion Date: 03/30/2021

Document Submission Implemented

See attached documentation

65a - FS Orientation 1st Day

1. Requirements

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:

65a - FS Orientation 1st Day (continued)

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-safe 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 location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff member A, hired [REDACTED] and staff member B, hired [REDACTED], did not receive orientation training in any of topics specified in 2600.65.a.

Plan of Correction

Accept

All new Direct Care Staff are scheduled for a four hour orientation session at the Home before working an actual shift. Staff person A completed this training on [REDACTED]. Staff person B was trained on [REDACTED]. A copy of these trainings are attached to this report.

In the future, the Administrator will review all new employee’s files. This will be done once new employees finish the initial training and pass the competency test. The home has created a checklist of all documents that should be included in employee files to ensure that no documents are missing.

The Administrator will check employee files twice a year in June and December to insure all documents required by Regulation 2600 are included.

Completion Date: 01/25/2021

Document Submission

Implemented

See attached documentation

65b - Rights/Abuse 40 Hours

1. Requirements

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:
1. Resident rights.
 2. Emergency medical plan.
 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
 4. Reporting of reportable incidents and conditions.

Description of Violation

Staff member A, hired [REDACTED] and staff member B, hired [REDACTED], did not receive training in any of topics specified in 2600.65.b.

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction

Accept

Direct Care Staff A and B had the necessary training within their first 40 hours of scheduled work. Direct Care Staff A's training was completed between [redacted] and [redacted]. Direct Care Staff B's training was completed between [redacted] and [redacted]. Staff training list showing the dates of training is attached to this report.

In the future, the Administrator will review all new employee's files. This will be done once new employees finish the initial training and pass the competency test. The home has created a checklist of all documents that should be included in employee files to ensure that no documents are missing.

The Administrator will check employee files twice a year in June and December to insure all documents required by Regulation 2600 are included.

Completion Date: 02/10/2021

Document Submission

Implemented

See attached documentation

85d - Trash Receptacles

1. Requirements

2600.

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

Description of Violation

At approximately 10:30 a.m., there was an uncovered trash can, containing approximately 12" of discarded tissues and paper towels in the first floor common bath/shower room.

Plan of Correction

Accept

The trash container originally had a lid, but it had become unattached and misplaced. A new trash container has been purchased and is in use in the bathroom / shower room.

The Administrator has directed all Direct Care Staff to immediately make note of any trash containers without a lid in place in the future.

The Cleaning staff will check daily to insure that all garbage containers have lids on them.

Completion Date: 03/08/2021

Document Submission

Implemented

During each shift, the aides will check to insure that the trash container in the bathroom has a lid in place. See attached documentation.

100b Removal Snow/Obstructions

1. Requirements

2600.

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

100b - Removal Snow/Obstructions (continued)

Description of Violation

At approximately 10:40 a.m., two exits from the back activity room leading to and including a back deck and walkway, were covered in approximately 2" of snow and ice accumulation.

Plan of Correction

Accept

The deck is the home's only designated smoking area. Smoking is at designated times. Residents who smoke will not wait to have recent snow removed before smoking, thus causing the snow to become padded down. Before the day of inspection this area had experienced several days of snowing. The home had been constantly working on salting and removing snow, however on February 10th snow remained on the deck. The deck was completely cleared by the evening of February 10th.

The Administrator has made snow removal from the deck a priority. Currently the only help the home has found for snow removal on the deck is a student who comes after school. The Administrator is actively seeking someone who can come and remove the snow before it gets packed down.

Until someone to remove the snow is hired, when it is snowing Direct Care Staff will check the deck hourly and apply salt when needed to avoid the snow to accumulate.

Completion Date: 02/20/2021

Document Submission

Implemented

During inclement weather aides will check the deck during each shift to insure the surface of the deck is safe and free of any obstacles. No residents will be permitted on the deck until it is safely cleared. See attached documentation.

109b - Rabies Vaccination

1. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Repeat Violation

At approximately 10:50 a.m., two cats were on the outside rear deck of the home and food and water bowls were present for the cats. However, the home does not have a current certificate of rabies vaccination for either of the cats.

Repeat Violation: 1/16/20

109b - Rabies Vaccination (continued)

Plan of Correction

Accept

Stray cats have been a problem at the home for some time. Several residents are "cat lovers" and buy food for the cats... so of course the cats keep coming back. The residents have been told they may not feed the cats any longer.

The Home is trying to find a shelter to take the stray cats; however they all say there is no more room for cats. If the cats are not feed they should go elsewhere. The Home will continue to enforce the "no feeding cats" policy and try to find accommodations for the stray cats.

In the meantime, by the end of April, the administrator will take the cats to the vet for rabies vaccines.

Completion Date: 04/30/2021

Document Submission

Implemented

We have scheduled [REDACTED] of [REDACTED] to visit the home on June 8th, 2021 to perform rabies vaccinations on the stray cats that frequent the deck and grounds of the home.

Documentation will follow once it is received

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on 7/17/19 and there was no documentation in the resident's record, from the resident's physician, that the annual medical evaluation could be conducted at a later date.

Resident #2's most recent medical evaluation was completed on 11/18/19 and there was no documentation in the resident's record, from the resident's physician, that the annual medical evaluation could be conducted at a later date.

Resident #3's most recent medical evaluation was completed on 10/1/19 and there was no documentation in the resident's record, from the resident's physician, that the annual medical evaluation could be conducted at a later date.

Plan of Correction

Accept

Residents whose evaluations were due before the COVID-19 Pandemic had been completed. As of March 16, 2020 all medical offices were closed, thus making it impossible to schedule Annual Medical Evaluation for the remaining residents. The year 2020 was a unique year.

The Administrator is scheduling Doctor's appointments for all residents to have Annual Medical Evaluations completed. These will all be in the Resident's files by June 1, 2021.

The Home has developed a chart to facilitate tracking when all resident documents need renewed, ie: Assessments, DME's, etc.

Completion Date: 06/01/2021

141b1 - Annual Medical Evaluation (continued)

Document Submission

Implemented

All Residents of the home have current Medical Evaluations, except two residents, these two residents have appointments on June 10th and June 21st, 2021.

See attached documentation for copies of Residents #1 and #3... Resident #2 is no longer a resident of the home

142b - Refusal-Medical Treatment

1. Requirements

2600.

142.b. If a resident refuses routine medical or dental examination or treatment, the refusal and the continued attempts to educate and inform the resident about the need for health care shall be documented in the resident's record.

Description of Violation

Resident #2 was prescribed Nasal Saline Relief-insert 2 sprays into each nostril 4x daily. The resident refused the medication on multiple occasions to include: 8 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., on 2/2/21, 2/5/21, 2/6/21, 2/7/21, 2/8/21 and 2/9/21. However, the home had no documentation of continued attempts to educate and inform the resident about the need for health care.

Plan of Correction

Directed

Resident #2 routinely took the Nasal Saline Relief Spray during the summer and fall, but now says he does not need it. The Doctor has been contacted about making the medicine a PRN but has not gotten back to the home about this. In the meantime the resident has signed a form saying he has been informed about the medicine but does not need it.

Residents are always educated on the importance of taking the prescribed medications they refuse. In the future Residents who continually refuse medication will be asked to sign a form that will be attached to the medical record.

The Administrator has informed Direct Care Staff who administer medication to repost to [redacted] immediately when a resident is refusing medications. If a resident is refusing medications for more than three consecutive days, the administrator will contact the resident's doctor for direction on how to proceed.

(Directed)-

By 4/25/21, all staff responsible for administering medications will be educated §2600.142(b) and reporting resident refusals to the prescriber within 24 hours, unless otherwise instructed by the prescriber in accordance with §2600.187(c). Documentation will be submitted to the Department. **(J.G. 4/15/21)**

Completion Date: 02/12/2021

Document Submission

Implemented

See attached documentation

162e - Menu Changes

1. Requirements

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

162e - Menu Changes (continued)

Description of Violation

The menu posted for 2/10/21 indicated that lunch would consist of turkey fi lets in gravy, mashed potatoes, mixed vegetables, and grapes. However, the lunch meal provided to the residents on 2/10/21 consisted of sweet and sour meatballs, bocelli, jello and peaches.

Plan of Correction

Accept

The home attempts to follow the menu posted, however sometimes unforeseen circumstances may cause the need to make a change. On the day of the inspection, a meal that is complicated to prepare was on the menu. The DCS person was needed to assist with the inspection, so the menu was changed to a simpler to prepare meal. The home always post any changes to the menu. On February 10th the substituted menu was posted on the bulletin board by kitchen. The menu posted that day is attached to this report.

The Home always prepares a nutritious and balanced meal for its residents. The DCS will post any changes to the menu by 10 am the days changes need to be made.

The administrator will insure that each month's menu is posted by the 25th of the previous month.

Completion Date: 03/25/2021

Document Submission

Implemented

See attached documentation

185a - Implement Storage Procedures

1. Requirements

2600.

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

Description of Violation

Resident #1's glucometer was not calibrated to the current date and time and resident #3's glucometer was not calibrated to the current time.

Plan of Correction

Accept

Residents #1 and #3 had the glucometers calibrated to the correct date and time the day following inspection. This glucometers are being checked daily. For an unknown reason this type of glucometer "the easy touch type" becomes uncalibrated for date and time when used.

The home has five residents who test with glucometers, two of the residents have a newer model which never becomes uncalibrated. Residents #1 and #3 are eligible for the newer model glucometer, this change has been requested. DCS have been directed to check the "newer" model glucometers once a week and the older model daily

Completion Date 04/30/2021

Document Submission

Implemented

A chart has been created to insure that Glucometers are checked daily
See attached documentation

186a - Authorized Prescriber

1. Requirements

2600.

186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Repeat Violation

Resident #1's Allopurinol 300mg with a pharmacy label that indicated-take 1 tablet by mouth every day for gout, was present in the medication cart. However, the home did not have a written prescriber's order for the medication.

Repeat Violation: 1/16/20

Plan of Correction

Accept

The Home does not receive prescription orders for the residents. Prescriptions are sent directly to the pharmacy from doctor's offices. This medication is current for Resident #1, however the pharmacy neglected to include it on the MARS. A corrected MARS was delivered by the pharmacy in the evening of February 10th, listing the medication which was added to this resident's medication listings. A Copy is attached.

In the future, the Administrator will request a copy of any prescriptions added during the course of a month from the pharmacy and include it in the MARS Binder.

On the first day of each month the administrator will revise the MARS to insure that all medications have a copy of the prescriber's orders (prescription) in the MARS Binder.

Completion Date: 02/10/2021

Document Submission

Implemented

When refills for residents medications arrive each month, they are being checked against the MARS for that month. Doing this will insure that all medications being given to residents are currently prescribed. To maintain a record of medication changes the home has created a chart.

See attached documentation

187a - Medication Record

1. Requirements

2600.

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

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

187a - Medication Record (continued)

14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1's Allopurinol 300mg with a pharmacy label that indicated-take 1 tablet by mouth every day for gout, was present in the medication cart. However, the medication was not included on the resident's February 2021 medication administration record (MAR).

Plan of Correction

Directed

The pharmacy neglected to list this medicine on the MARS for Resident #1 in February. The medication was current for this resident. A MARS for this resident was delivered by the Pharmacy in the evening of February 10th and became part of the resident's MARS for February.

The Home is now checking the MARS listed medications against the medicines actually in the "Medicine on Time" containers before the start of each month. Any discrepancies found can then be reported to the pharmacy before the start of the month. The administrator will request a corrected MARS from the pharmacy by the 1st Day of each month.

(Directed)

By 4/25/21, all staff responsible for administering medication will be educated on §2600.187(a). Documentation will be submitted to the Department. (J.G. 4/15/21)

Completion Date: 02/10/2021

Document Submission

Implemented

The MARS are being checked against our medication dispensing system 'Medicine on Time' (MOT's) plastic carriers as soon as they arrive prior to the beginning of the month. Any discrepancies will be checked with the pharmacy and corrected. To facilitate reporting and maintain a record of discrepancies a chart has been created. See attached documentation

224a - Preadmission Screen Form

1. Requirements

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 Repeat Violation

Resident #2 was admitted [REDACTED] however, no preadmission screening form was completed for the resident.

Repeat Violation: 1/16/20

224a - Preadmission Screen Form (continued)

Plan of Correction

Directed

Resident #2 was admitted directly from [REDACTED] In cases like this all required forms are requested from the facility – the departmental Medical Evaluation, MA-51 if applicable and Pre-Admission Screening. The Screening was not done and was not missed until now.

This resident now has the Pre-Admission Screening completed by the Home’s Administrator in his file. All other resident files have been checked to ensure a Pre-Admission Screening is included.

The Administrator will check all resident files twice a year in January and July to insure that all documents required by Regulation 2600 are present in the file.

(Directed)

By 4/25/21, all staff responsible for admissions will be educated on §2600.224(a) and the requirement that a determination be made within 30 days prior to admission indicating if the needs of the resident can be met by the services provided by the home. Documentation will be submitted to the Department. (J.G. 4/15/21)

Completion Date: 03/04/2021

Document Submission

Implemented

See attached documentation

225c - Additional Assessment

1. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on 10/29/19 and resident #2's most recent assessment was completed on 12/19/19.

Plan of Correction

Accept

New Assessments have been completed for Residents #1 and #2 and placed in their files. A copy of these Assessments is attached to this report.

The Home has developed a chart to facilitate tracking renewal dates of all documents required by Regulation 1600 in resident Files. All resident Assessments will be up to date by May 30th, 2021.

The Administrator will check all resident files twice a year in January and July to insure that all documents required by Regulation 2600 are present in the file.

Completion Date: 03/10/2021

Document Submission

Implemented

See attached documentation