Department of Human Services
Bureau of Human Service Licensing

June 4, 2021

[redacted] OWNER
THE CORRIGAN HOUSE INC
PO BOX 158
HARLEIGH, PA 18225

RE: THE CORRIGAN HOUSE
350 HAZLE TOWNSHIP BOULEVARD
HAZLE TOWNSHIP, PA, 18202
LICENSE/COC#: 20138

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/20/2021, 04/21/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *THE CORRIGAN HOUSE* **Licen e #**: *20138* **Licen e Expiration Date**: *06/24/2021*
Addre : *350 HAZLE TOWNSHIP BOULEVARD, HAZLE TOWNSHIP, PA 18202*
County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: *5704531690* **Email**: [redacted]

Legal Entity

Name: *THE CORRIGAN HOUSE INC*
Address: *PO BOX 158, HARLEIGH, PA, 18225*
Phone: *5704531690* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/14/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Rea on: *Renewal* **Exit Conference Date**: *04/21/2021*

Inspection Dates and Department Representative

04/20/2021 - On-Site: [redacted]
04/21/2021 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served**: *25*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Re ident Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *25*
Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

04/20/2021 - Full

Lead In pector: **Follow Up Type:** *POC Submission* **Follow-Up Date:** *05/21/2021*

5/26/2021 POC Submi ion

Lead Reviewer: **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/04/2021*

6/4/2021 - Document Submission

Lead Reviewer: **Follow-Up Type:** *Not Required*

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, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction **Accept**

At time of hire, staff member A had a current CNA license. After working at the facility for a few years and acquiring her med tech certification, her CNA was not renewed. A copy of diploma was requested and placed in staff chart to ensure adequate record of schooling and to meet requirements of DHS. Moving forward, administrator will check staff charting regularly to ensure all required documents are kept on file.

Completion Date: *05/13/2021*

Update - 05/26/2021

Please send/Attach proof of staff person A's H.S. diploma. 5-26-2021 MM

Document Submission **Implemented**

See attached documentation to confirm graduation from high school.

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:

Description of Violation

Staff person B was hired on [redacted], C was hired on [redacted], and D was hired on [redacted]. However, these staff persons did not complete training in the following topics: Resident Rights, Emergency Medical Plan, Mandatory reporting of abuse - OAPSA, Reporting reportable incidents and conditions.

Plan of Correction **Accept**

Although all training was given, and completed by all staff members within required time frame of hire (attached to orientation was all documentation of training) the page with staff and trainer signature was missing from the orientation packet. All three staff members were re educated on all topics and signed documentation was added to there chart to ensure compliance with DHS regulations. Moving forward, upon hire administrator ensure all documentation required is charted and checked regularly for any updating.

Completion Date: *05/13/2021*

Update - 05/26/2021

Please send/Attach proof of staff training. 5-26-2021 -MM

Document Submission **Implemented**

See attached training for staff.

65f - Training Topics

1. **Requirements**

65f - Training Topics *(continued)*

2600.

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

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Repeat Violation

Direct care staff person B did not receive training in Instruction on meeting the needs (DME & RASP) during training year 2019.

Plan of Correction **Accept**

Direct care staff person was re educated in DMEs, RASPs and pre admission screenings. Moving forward, administrator will ensure all training topics required are covered by all staff to ensure compliance with there 12 hour training per year.

Completion Date: *05/13/2021*

Update - 05/26/2021

Please send/Attach proof of staff training. 5-26-2021-MM

Document Submission **Implemented**

See attached training.

89b - Hot Water Temperature

1. **Requirements**

2600.

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

Description of Violation

On 4/21/22 at 11:00am, the hot water temperature in the North Wing bathrooms measured 124.5 degrees Fahrenheit and the water temperature in the South Wing bathrooms measured at 121.3 degrees Fahrenheit.

Plan of Correction **Accept**

The water in facility will be checked periodically through day by DCS to ensure water temperature doe not exceed 120 degrees. Moving forward, staff will notify administrator if water is not within proper range of temperature to meet regulations.

Completion Date: *05/13/2021*

Update - 05/26/2021

Within 1 week of receipt of this plan of correction:
The administrator or designee will check the water temperature in areas accessible to the residents to ensure that it is 120°F or less. Any area that exceeds this temperature will be adjusted immediately.
Checks shall be completed weekly X's 4 months. Documentation of water temperatures will be kept and maintained by the home. 5-26-20201 -MM

Document Submission **Implemented**

Please see attached temperature log checked weekly and monthly. Administrator will ensure that temperature of water is always in range to meet DHS regulations.

101j7 - Lighting/Operable Lamp

1. **Requirements**

2600.

101j7 - Lighting/Operable Lamp *(continued)*

101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident A, B, and C does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction **Accept**

Resident A and C were re educated on the importance of keeping a light within reaching distance of there bed while sleeping in the event of an emergency. (Both residents move there rooms around to there liking) Staff will ensure that residents rooms are set up to meet proper regulations for DHS upon daily rounds each shift. Resident B's room was immediately re arranged to ensure that a light was close enough to the bed (side table was moved to give oxygen to the resident during a nap at time of findings) Moving forwards, If furniture is moved in any rooms that do not meet DHS regulations staff with notify administrator and situation will be rectified.

Completion Date: *05/13/2021*

Update - 05/26/2021

Please send/Attach proof (picture) of compliance. 5-26-2021 - MM

Document Submission **Implemented**

Please see attached pictures of rooms to meet DHS regulations.

103i - Outdated Food

1. **Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The large freezer located in the pantry had 5 bags of meat patties that expired on 3/31/20, The pantry had a 15oz can of Tasty brand condensed tomato soup that had expired 3/1/20. A 50oz can of cream of celery soup did not have a date, Kens Extra Heavy Mayonaise, 5 containers, that had a manufactured date of 3/16/21, but did not have an expiration date or date item was received.

Waffles were in the kitchen freezer and not dated.

Plan of Correction **Accept**

All food was immediately disposed at time of finding. Moving forward, kitchen staff will ensure that all food is labeled and dated and within range of dates. Administrator will check with kitchen staff weekly to ensure there are no issues with outdated food or food delivery.

Completion Date: *05/13/2021*

Document Submission **Implemented**

See Above

107d Procedure Emergency Management Agency Submission

1. **Requirements**

2600.

107d - Procedure Emergency Management Agency Submission *(continued)*

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been updated since 2/4/20.

Plan of Correction **Accept**

An updated emergency preparedness plan submitted to Luzerne County emergency management program. Moving forward , the administrator will ensure that an updated copy is sent annually to the emergency preparedness planner to ensure compliance with DHS regulations.

Completion Date: *05/13/2021*

Update - 05/26/2021

Please send/Attach proof of compliance. 5-26-2021-MM

Document Submission **Implemented**

Emergency preparedness office is closed for the week of 5/31/2021 to 6/7/2021 for a Covid-19 vaccine clinic and all calls are redirected to 911. Administrator will follow up with emergency planning manager and DHS Monday, June 7th to complete and submit emergency preparedness plan to meet DHS regulations.

125a - Combustible Storage

1. **Requirements**

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

An article of residents clothing was laying behind the dryer on the dryer vent.

Plan of Correction **Accept**

Laundry room will be checked multiple times a day by DCS to ensure that it is locked and that no materials are misplaced behind washer and dryer.

Completion Date: *05/13/2021*

Update - 05/26/2021

Within 5 days of receipt of the plan of correction:
Staff will be instructed to keep combustible and flammable materials away from heat sources and hot water heaters at all times.

Document Submission **Implemented**

Staff was immediately reeducated on fire safety. Laundry room door is locked at all times to ensure no further ssues.

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 Repeat Violation

Resident #3's glucometer was not calibrated to correct time. Additionally, on 4/3/21 through 4/5/21, Resident #3 did not have ██ accuchecks completed as prescribed.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

Resident's # 3 glucometer was calibrated with the AM and PM re arranged. A new machine was ordered to ensure compliance with DHS regulations. On noted dates residents sugar was not taken due to insulin supplies not being delivered, all information was documented on MARS properly, physician was made aware and nurses note was completed to match all documentation. Moving forward, LPN will check glucometer machines weekly to ensure all calibrations are correct and staff administering insulin or taking glucose levels will continue to document properly in the event that insulin may not be given or sugar can not be taken to meet DHS regulations.

Completion Date: *05/13/2021*

Update - 05/26/2021

With in 5 days of receipt of this plan of correction:
The administrator shall ensure that a system is in place for safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.
Insulin supplies shall be monitored weekly X's 4 months.
5-26-2021 -MM

Document Submission **Implemented**

Attached med training for all staff was completed. In the event a resident runs out of supplies the home will now keep extra supply in house in event of emergency.

221a - Program Activities

1. **Requirements**

2600.
221.a. The administrator shall develop a program of activities designed to promote each resident’s active involvement with other residents, the resident’s family and the community.

Description of Violation

The home does not have a program of activities designed to promote the active involvement of residents with families and the community.

Plan of Correction **Accept**

Activities program was suspended due to COVID 19 and not all residents being fully vaccinated under the advisement of the facility medical director and department of health. As of 5/12/2021 all residents in the facility are full vaccinated and the facility will continue with a normal activities program with social distancing in place.

Completion Date: *05/13/2021*

Document Submission **Implemented**

see above and attached activities calendar.

221b - Activity Types

1. **Requirements**

2600.
221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

The home's activities program does not include any activities.

221b - Activity Types *(continued)*

Plan of Correction **Accept**

Activities program will continue in home for residents to ensure social, physical, intellectual and recreational needs. Activities program was suspended due to COVID 19 and was not re introduced the into facility until all residents were fully vaccinated to ensure the safety of the community. Moving forward, a regular activities schedule will be mplemented for residents.

Completion Date: *05/13/2021*

Document Submission **Implemented**

See above and attached activities calendar.

221c - Post Activity Calendar

1. **Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home.

Plan of Correction **Accept**

Activities program was suspended due to COVID 19 and was not re introduced into the facility until all residents were fully vaccinated to ensure the safety of the community. Moving forward, a regular activities schedule will be mplemented for residents. A monthly activities calendar is posted in the dinner area of the facility for all residents to have access to it.

Completion Date: *05/13/2021*

Update - 05/26/2021

Please send/Attach proof (picture) of compliance. 5-26-2021 - MM

Document Submission **Implemented**

Please see attached activities calendar.

225a - Assessment 15 Days

1. **Requirements**

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 was admitted to the home on [redacted], however, the resident's assessment was not completed until 1/10/20.

Plan of Correction **Accept**

Upon admission of the facility administrator will ensure that all documentation is completed fully and in a timely matter to meet the requirements of DHS regulations.

Completion Date: *05/13/2021*

225a - Assessment 15 Days *(continued)*

Update - 05/26/2021

Within 5 days of receipt of this plan of correction:
The administrator will develop a system to ensure that all assessments are done correctly, completely, and within the time frames required by this Chapter.

Document Submission **Implemented**

Administrator will ensure all paperwork is completed to meet DHS regulations fully and within a timely matter upon admission. Administrator will continue to review resident charting monthly and quarterly to ensure compliance.