

Department of Human Services
Bureau of Human Service Licensing

July 1, 2021

██████████ CEO
MELODY MANOR PCH LLC
413 NORTH MCKEAN STREET
KITTANNING, PA 16201

RE: MELODY MANOR
413 NORTH MCKEAN STREET
KITTANNING, PA, 16201
LICENSE/COC#: 44676

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/12/2021, 05/13/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Janine Wenzig

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing

June 16, 2021

██████████ CEO
MELODY MANOR PCH LLC
413 NORTH MCKEAN STREET
KITTANNING, PA 16201

RE: MELODY MANOR
413 NORTH MCKEAN STREET
KITTANNING, PA, 16201
LICENSE/COC#: 44676

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 05/12/2021, 05/13/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Janine Wenzig

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: MELODY MANOR **Licen e #:** 44676 **Licen e Expiration Date:** 07/21/2021
Addr e : 413 NORTH MCKEAN STREET, KITTANNING, PA 16201
County: ARMSTRONG **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** 7245451564 **Email:** [REDACTED]

Legal Entity

Name: MELODY MANOR PCH LLC
Address: 413 NORTH MCKEAN STREET, KITTANNING, PA, 16201
Phone: 7245451564 **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 09/28/1987 **Issued By:** L&I

Staffing Hours

Re ident Support Staff: 0 **Total Daily Staff:** 34 **Waking Staff:** 26

Inspection

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 05/13/2021

Inspection Dates and Department Representative

05/12/2021 - On-Site: [REDACTED]
05/13/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 43 **Residents Served:** 30

Secured Dementia Care Unit

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

Hospice

Current Re ident : 1

Number of Residents Who:

Receive Supplemental Security Income: 12 **Are 60 Years of Age or Older:** 23
Diagnosed with Mental Illness: 18 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 4 **Have Physical Disability:** 0

Inspections / Reviews

05/12/2021 - Full

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow-Up Date: *06/13/2021*

6/16/2021 POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *06/18/2021*

7/1/2021 - Document Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Not Required*

63a - First Aid/CPR Training

1. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 5/7/21, from 2:00 p.m.-11:00 p.m., 30 residents were present in the home. During this time no staff persons were present in the home who were trained in first aid and certified in obstructed airway techniques and CPR.

On 5/9/21, from 2:00 p.m.-11:00 p.m., 30 residents were present in the home. During this time no staff persons were present in the home who were trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction

Accept

Immediately on the day of inspection, a certified CPR trainer was contacted by the administrator and agreed to do a CPR training quickly. Two days later one Staff member was trained on 5/14/21 by [REDACTED], A CPR certified trainer. Documentation attached. At no time from the day of inspection moving forward, was the staffing absent of someone trained in CPR. All other Staff files were reviewed by Administrator to check for people needing the training. All shifts on the schedule are now being reviewed by Administrator before posting. The Administrator is highlighting each CPR qualified Staff to be sure every shift has a qualified Staff present. Administration was under the impression that since she has been cpr trained for many years, and we were unable to get any Instructor in due to COVID, that she would be ok to be there. This was definitely a learning experience understanding the COVID rules. Moving forward the schedules will continue to be checked by Administrator for coverage. Documentation attached

Completion Date: 05/14/2021

Document Submission

Implemented

88a - Surfaces

1. Requirements

2600.

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

Description of Violation

On 5/12/21, there was a hole approximately 2" wide by 1" high in the right lower corner of the fire door in the first floor breezeway that joins the Melody House and Cooper House sides of the home.

The home has multiple interior fire safe areas. On 5/12/21, the following fire doors were either propped open or do not shut completely on their own:

- * Second floor fire safe area in the Cooper House breezeway - doors were propped open
- * Second floor fire safe area in the Melody House breezeway - doors do not close completely
- * First floor fire safe area in the Melody House breezeway - doors do not close completely

88a - Surfaces (continued)

Plan of Correction**Accept**

Immediately on the day of inspection 5/12/2021 all fire doors were closed by administration. On June 4, 2021 the right lower corner of the door in the first floor breezeway was repaired. Picture attached. On June 10, 2021 the doors that were not closing properly were repaired by [REDACTED] Documentation attached. Training was done by Administrator with current staff on regulation 88A on the importance of reporting anything that is in need of repair. Administration will do a monthly walk-through of the home beginning June 7, 2021. Anything found will be repaired in a timely manner.

Completion Date: 06/07/2021

Document Submission**Implemented**

93a - Handrails

1. Requirements

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 5/12/21 there was no handrail for the exterior step outside the first floor Cooper House exit by the beauty parlor.

Plan of Correction**Accept**

On June 4, 2021 exterior of the home on the Cooper House exit door. Documentation attached. A walk-through was done by administration, and all other exit doors have the proper handles. The door in question does not get used by residents. It is one step. It was cited because if it did need to be used, regulations says that it needs a rail. All other doors are within regulation.

Completion Date: 06/04/2021

Document Submission**Implemented**

184a - Labeling OTC/CAM

1. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed Novolog 100 units/ml flex pen, sliding scale with meals. The pharmacy label did not include the instructions for administration of the medication per sliding scale with meals.

184a - Labeling OTC/CAM (continued)

Plan of Correction**Accept**

On the day of inspection, 5/12/2021 a refer to MAR direction label was put on the novolog box for Resident #2. A new label was ordered through the Pharmacy to match the MAR instructions. This label came from an outside pharmacy and it did not match how we are accustomed to receiving by House Pharmacy. All other labels were looked at by administration and med tech to see that they match. Everything else matched. A training was done by Executive Director on 6/9/2021 with Med Techs to remind them to match MARS and bottles on all incoming orders.

Completion Date: 06/07/2021

Document Submission**Implemented**

225c - Additional Assessment

1. Requirements

2600.

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

Description of Violation

Resident #2's assessment, dated 12/10/2020, did not include the resident's need for assistance with eating, drinking and 2-person assistance with transferring.

Plan of Correction**Accept**

On 6/7/2021 an addendum was added by the administrator to include the need for assistance with eating and drinking for resident #2. The mobility needs were also changed to a two person assist with lifting and transferring. A training was done with all staff to remind them of the importance of reporting new needs and changes on all residents to administration. All Staff were made aware of Assessment changes. All other files were reviewed by Administrator for accuracy of mobility and care needs.

Completion Date: 06/07/2021

Document Submission**Implemented**

documentation attached