Department of Human Services
Bureau of Human Service Licensing

August 23, 2021

[redacted], SENIOR DIRECTOR

RE: SOUTHMINSTER PLACE
880 SOUTH MAIN STREET
WASHINGTON, PA, 15301
LICENSE/COC#: 41593

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/24/2021, 05/25/2021, 05/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *SOUTHMINSTER PLACE* **License #**: *41593* **License Expiration Date**: *06/24/2021*
Address: *880 SOUTH MAIN STREET, WASHINGTON, PA 15301*
County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *04/11/2002* **Issued By**: *Township of South Strabane*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *62* **Waking Staff**: *47*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *05/26/2021*

Inspection Dates and Department Representative

05/24/2021 - On-Site: [redacted]
05/25/2021 - On-Site: [redacted]
05/26/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *20* **Residents Served**: *0*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *51*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

05/24/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/12/2021*

8/12/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/17/2021*

8/23/2021 - 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 5/16/21, there were 47 residents present in the home. However, there were no staff person on duty trained in first aid and certified in obstructed airway techniques and CPR present in the home from 10 p.m. until 6:00 a.m. on 5/17/21.

Plan of Correction **Accept**

All staff caregiver files were reviewed by the staff scheduler for current CPR training. In the course of the audit, it was identified that two team members needed re-certification. On May 27, 2021 both team members were trained by a certified instructor.

Staff were educated on the components of 2600.63.a. – First Aid/CPR Training.

To prevent recurrence, the staff scheduler is utilizing a spreadsheet to track all due dates for re-certification. In addition, staff are being grouped into four categories so that all staff can be captured in the four CPR trainings offered throughout each year. New-hires will be offered CPR training upon hire as needed and added to the ongoing tracking spreadsheet. The scheduler will audit the spreadsheet quarterly to ensure compliance with 2600.63.a.) Results of the audits will be forwarded to the Administrator for QA purposes.

Completion Date: *08/12/2021*

Document Submission **Implemented**

Staff CPR updated and all trainings complete. Education, records of training attached. Completion date remains 8/12/21, but audits and tracking ongoing as stated.

121a - Unobstructed Egress

1. **Requirements**

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 5/26/21 at approximately 3:25 p.m., the door located next to the physician office to exit the side of the home to the parking lot was locked. There was a code posted that must be entered into a digital keypad in order to push the door open.

121a - Unobstructed Egress *(continued)*

Plan of Correction **Accept**

Investigation into this deficiency revealed that the securing of this door was implemented as a Covid-19 precaution during the height of the pandemic. The intent was to route all resident traffic, visitors, and staff through the front entrance of the building to ensure proper screening.
Upon notification of this deficiency, the administrator disabled the keypad that had been required to exit this doorway. When tested, it was revealed that pressing the bar for five seconds did release the doors for use in the event of an emergency.
The administrator worked with building services to have the doors adjusted mechanically so that they can remain secure from the outside for safety reasons, but always unlocked, unobstructed, and available for use as an egress at all times.
To prevent recurrence, the administrator audited all doors for egress in the facility. There were no other egress doors found to be obstructed. Staff were educated on the components of 2600.121.a in team huddles.
To monitor compliance ongoing, audits of all egress doors will be completed weekly times one month, then monthly times three. Results of these audits will be presented to the safety committee for any additional recommendations as well as to the Administrator for QA purposes.

Completion Date: *08/12/2021*

Document Submission **Implemented**

Physician entry/exit doors altered to allow egress unobstructed. Completion date remains 8/12/21, but audits ongoing as stated in plan of correction. Audits attached.

141a 1-10 Medical Evaluation Information

1. **Requirements**

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

The initial medical evaluation for resident #1, admitted [redacted], did not include the date the resident was evaluated. The medical evaluation did not include the following information: height, weight, pulse rate, blood pressure and temperature. These sections were blank.

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

Plan of Correction **Accept**

The Resident Services Coordinator (RSC) reviewed the medical record for resident #1 and found that the missing information on the initial medical evaluation was completely noted on the initial admission assessment from nursing. The RSC updated Resident # 1's DME to include the height, weight, pulse rate, blood pressure, and temperature from the initial nursing admission assessment.
To identify any other residents potentially affected, the RSC audited all resident charts to ensure no blanks were present on the initial medical evaluation.
To prevent recurrence, all new admissions will be reviewed by the RSC within 30 days of their admission date to ensure completion of the initial medical evaluation. In addition, staff will be educated on the components of 2600.141.a.

Completion Date: *08/12/2021*

Document Submission **Implemented**

Plan of correction carried out as stated above. See attachment for the corrected copy of resident #1's medical evaluation information. See attachment for the initial audit of all resident charts. The completion date remains at 8/12/21, but the audits will continue as stated in the original plan of correction. See attachment for staff education on this deficiency.

181c - Self-administration Assessment

1. **Requirements**

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

On 5/26/21 at approximately 1:25 pm, there were two small round pills in a clear dosing cup setting on the coffee table in front of the couch in resident #2's room. The resident states the pills are [redacted]. The medication is brought to [redacted] at 12:30 p.m., but [redacted] doesn't like to take them until 1:30 p.m. Resident #2's assessment completed [redacted] indicates that the resident cannot self-administer medications.

Plan of Correction **Accept**

Upon notification of this deficiency, nursing went to resident #2's room to assess compliance with 2600.181.c. At that time, the resident stated [redacted] had already taken the [redacted] Staff did not locate any additional meds in the resident's room.
To prevent recurrence, all staff persons qualified to administer medications shall be re-educated on proper medication administration procedures including observing the resident taking their medications at the time of delivery. Staff will also be educated on the five rights as per policy to ensure compliance.
To monitor compliance ongoing, the Resident Services Coordinator/designee will complete random audits of 10 rooms daily times one week and weekly times three months to ensure no medications are left in resident rooms and not observed as per policy.

Completion Date: *08/12/2021*

181c - Self-administration Assessment *(continued)*

Document Submission **Implemented**

Plan of correction carried out as stated above. See attachment for education to team members regarding deficiency. See attachment for room audits. Plan of correction completion date remains 8/12/21, but the audits will continue as per the plan of correction above until completed as stated.

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:

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is prescribed [redacted]) – 1 tab by mouth three times daily for tremors. However, there was a bottle of the medication with pharmacy label that indicates take 1 tablet of 25/100 by mouth four times a day. The bottle lid was marked "TID."

Plan of Correction **Accept**

Upon notification of this deficiency, nursing applied a directional change sticker to resident #3's prescribed [redacted] bottle, directing all persons, qualified to administer medications, to the E-MAR for change in frequency.
To prevent recurrence, the Resident Services Coordinator will educate all nurses on directional change sticker utilization as well as the components of 2600.184.a.
In addition, the nursing department will complete monthly audits times three months to ensure all medications and orders coincide.
The Administrator will work with pharmacy to set up routine cart audits to monitor pharmacy labels. Findings to be forwarded to the Administrator for QA monitoring.

Completion Date: *08/12/2021*

Document Submission **Implemented**

Resident #3's [redacted] was corrected with the directional change sticker. See attachment for nurse education regarding this deficiency. The completion date remains 8/12/21 for the initial POC, but the audits will continue as stated above. The administrator is working with [redacted] on finalizing dates for the ongoing cart audits.

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #2 is ordered [redacted] 4 times daily as necessary as needed for [redacted]. On 5/25/21 at 2:50 p.m., the medication was not available in the home.

There is an entry on resident #3's May 2021 MAR for [redacted] - SA Topical twice daily for knee pain. Start date 02/08/21 End date N/A. However, on 5/25/21 at approximately 3:15 p.m., the medication was not available. The home did not have a discontinue order for the medication.

There is an entry on resident #3's May 2021 MAR for [redacted] 1 tablet by mouth every 6 hours as needed for severe pain (pain scale 8-10). Start date 07/10/20 End Date N/A. However, on 5/25/21 at approximately 3:15 p.m., the medication was not available in the home. The home did not have a discontinue order for the medication.

Plan of Correction **Accept**

For resident #2, nursing obtained an order to discontinue the [redacted] as the resident had not used for multiple months and did not feel [redacted] would need it again.
Investigation into resident #3's orders for knee pain revealed duplicative treatments. The resident had not used [redacted] for quite some time and was agreeable to discontinuing the order as he prefers the current treatments being utilized. Nursing then received an order to discontinue the [redacted]
Resident #3's [redacted] prescription has since been discontinued. The resident is followed by physicians at a pain clinic. The Norco prescription was one that had been used in the past and as the doctors updated his pain regimen, orders were not received to discontinue the old treatment. The resident's pain was managed successfully throughout and the old treatment has been discontinued.
To prevent recurrence, the Resident Services Coordinator will educate all nurses on the obtaining and discontinuation orders from physicians of PRN medications not being used. All staff persons qualified to administer medications will be re-educated on the re-order process of PRN medications. All staff will also be educated on 2600.185.a. and its components.
In order to monitor ongoing compliance, PRN medications will be audited both for discontinuation when not being utilized as well as ensuring their availability in-house when current. The Resident Services Coordinator will audit these monthly times three months. Results of the audits will be forwarded to the Administrator for QA monitoring.

Completion Date: *08/12/2021*

Document Submission **Implemented**

Plan of correction carried out as stated above. See attachment for education to staff regarding this deficiency. See education to all staff on the components of 2600.185.a. in a separate attachment. The completion date remains at 8/12/21, but the monthly audits will continue times three months as stated in original plan.

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:
7. Route of administration.

187a - Medication Record *(continued)*

Description of Violation

Resident #1 is ordered [redacted] – 1 tab by mouth once daily for supplement. However, the resident's May 2021 medication administration record (MAR) has an entry that indicates [redacted] – 2 tab by mouth once daily for supplement.

Resident #3 is ordered [redacted]] – 1 drop eye every night for [redacted] The pharmacy label for the medication indicates [redacted] - instill 1 drop in both eyes at bedtime. However, the resident's May 2021 MAR has an entry for [redacted] – 1 drop eye every night for [redacted] The MAR does not include which (or both) eye(s) as the route of administration.

Plan of Correction **Accept**

Resident #1's order for [redacted] was reviewed and clarified to be that the resident should get a total of 2,000 units per day. Investigation into the specifics identified that the resident has been getting the correct dosage since admission. The family originally supplied the facility with a bottle that contained pills that were 2,000 units each and the resident was given one pill daily at that time. In May, the family brought in a bottle that contained pills that were 1,000 units each and the nurse on duty adjusted the MAR to show that two pills should be given, but neglected to change the specific dose of each individual pill to reflect 1,000 units. Although the MAR was in error, the nursing team continued to give the correct total dose as prescribed by the physician. The MAR was adjusted to reflect the correct dosage upon notification of the error.
Resident #3's order for [redacted] was corrected to include the proper route of administration, which is both eyes.
All nurses will be re-educated on assessing physician orders to matching medication labels related to correct dosage, route, medication name, and time. Directional change labels will be applied as necessary.
The Administrator will work with pharmacy to set up routine cart audits to monitor pharmacy labels. Findings to be forwarded to the Administrator for QA monitoring.

Completion Date: *08/12/2021*

Document Submission **Implemented**

See attachment for picture of the corrected bottle of [redacted] for Resident 1. See attachment for the corrected MAR reflecting adjustment to the correct dosage for the eye drops on Resident 3. See attachment for education of team members regarding this deficiency. Audits will continue as stated in plan of correction above.

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 Violation

Resident #4's preadmission screening completed [redacted] does not indicate if the needs of the resident can be met by the services provided by the home. This section is blank.

224a - Preadmission Screen Form *(continued)*

Plan of Correction **Accept**

The preadmission screen for Resident #4 was reviewed and corrected on 7/26/2021, indicating that the needs of this resident CAN be met by the services provided by the home.
The Resident Services Coordinator/designee will complete an audit of all other residents' preadmission screenings by 8/12/2021 to ensure this section is not blank on any other assessments. Results of the audit will be forwarded to the Administrator for QA purposes.
All staff will be educated on 2600.224.a. and its components.
To prevent recurrence, the Resident Services Coordinator will review any new preadmission screenings for completion of this section as she completes the resident's assessment and support plans.

Completion Date: *08/12/2021*

Document Submission **Implemented**

See attachment for corrected copy of resident 4's preadmission screening. See attachment for audits of all residents preadmission screenings in house. See attachment for education to team members regarding this deficiency. Audits of new admission preadmission screenings being completed by the Resident Services Coordinator as discussed in plan of correction.

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

The Social and Recreational Needs section of the initial assessment for resident #4 completed [redacted] only indicates that the resident's hobbies/interests include: watching TV. All the other areas are blank to include: solitary activities, group activities, religious affiliation if any. The assessment also does not indicate a reason that "the resident does not participate in solitary or group activities . . . "

Plan of Correction **Accept**

Resident #4's 15 day assessment was reviewed and updated by the Resident Services Coordinator to include current interests.
To ensure current compliance, the Resident Services Coordinator/designee will complete an audit of all resident charts to ensure completion of the assessments. Results of the audits will be forwarded to the Administrator for QA purposes.
To prevent recurrence, the Resident Services Coordinator/designee will audit all new admission assessments for completion times three months. Results of the audits will be forwarded to the Administrator for QA purposes.
All nurses will be educated on the components of 2600.225.a., specifically noting the importance of addressing all areas and not leaving any blanks on the form.

Completion Date: *08/20/2021*

225a - Assessment 15 Days *(continued)*

Document Submission **Implemented**

See attachment for 15 day assessment corrections made to resident 4's record. See attachment for audit of all residents in house. See attachment for education to team members regarding this deficiency. Audits will continue as outlined in above plan of correction.

233c - Key-Locking Devices

1. **Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The home's secure dementia care unit (SDCU) did not have any residents at time of inspection. However, on 5/26/21 at 3:10 p.m., the door to enter the SDCU from inside the home was propped open with a rubber door stop and the magnetic lock did not engage when the door was allowed to close thus making the SDCU accessible to anybody. The magnetic lock was engaged on the exit door across from rooms #150 and #152 in the SDCU. The directions for operating the home's locking mechanism are not conspicuously posted. The code to enter into the digital key pad to unlock this exit door [redacted] was posted along the top of the door and difficult to read especially for an individual who require the use of a wheel chair.

Plan of Correction **Accept**

Upon notification from the DHS surveyor, the rubber door stop was removed and the door to enter the SDCU was locked, including the magnetic lock being engaged. It has remained secure since then to prevent any residents from entering the area.
A letter to DHS has been drafted to request the de-certifying of these beds as memory care. Post construction, the beds in this area will be for traditional living and will not require any areas to be secure.
In order to ensure the safety of all residents, the door to the neighborhood will remain secured during construction. Daily audits will be completed by the administrator/designee times 7 days, followed by weekly audits times 4 weeks, followed by monthly audits until the completion of construction on this neighborhood.
The administrator had the concierge create larger signage to be posted right at the keypads in the event that anyone needs to utilize the exit doors across from rooms #150 and #152.
To prevent recurrence, the administrator completed an audit of all other doors with keypads in the facility to ensure that there is signage conspicuously posted. In addition, staff were educated on the components of 2600.233.c.
To monitor compliance ongoing, audits of all doors with keypads will be completed weekly times one month, then monthly times three. Results of these audits will be presented to the safety committee for any additional recommendations.

Completion Date: *08/12/2021*

Document Submission **Implemented**

The entrance door to the SDCU remains secure despite the neighborhood continuing to be empty, to allow for construction. The plan remains for the SDCU beds to convert to traditional personal care beds which will require the removal of the secure doors. In the meantime, the signage was updated to conspicuously highlight the codes needed to exit. See attachment for a photo of the updated signage.
See door audits attached. Audits will continue to completion as stated in above plan of correction. See attachments for education to team members regarding this deficiency.