Department of Human Services
Bureau of Human Service Licensing

October 13, 2021

[redacted], DIRECTOR
[redacted]

RE: MILTON DEVELOPMENTAL SERVICES
58 WALNUT STREET, P.O. BOX 416
MILTON, PA, 17847
LICENSE/COC#: 21373

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/08/2021, 06/09/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]
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: *MILTON DEVELOPMENTAL SERVICES* **License #:** *21373* **License Expiration Date:** *06/14/2021*
Address: *58 WALNUT STREET, P.O. BOX 416, MILTON, PA 17847*
County: *NORTHUMBERLAND* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *03/17/2017* **Issued By:** *Borough of Milton*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *13* **Waking Staff:** *10*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal,Incident* **Exit Conference Date:** *06/08/2021*

Inspection Dates and Department Representative

06/08/2021 - On-Site: [redacted]
06/09/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **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: *13* **Diagnosed with Intellectual Disability:** *1*
Have Mobility Need: *0* **Have Physical Disability:** *0*

Inspections / Reviews

06/08/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/11/2021*

8/10/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/23/2021*

10/13/2021 - Document Submission

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

3c - Post Current License

1. Requirements

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 License inspection summary dated 5/31/2019 was not posted conspicuously in the home as required.

Plan of Correction **Accept**

It is now understood by me, the administrator, after speaking with Inspector [redacted], a copy of the license inspection summary is to remain posted, not just a year from the inspection date, but rather, from inspection date to inspection date. I have posted the current license inspection summary and will continue to post any further inspection summaries along with it, until the next inspection summary is completed and posted.

Completion Date: *07/11/2021*

Update - 08/10/2021

Upon receipt of this plan of correction:
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.
The administrator/designee shall monitor weekly X's 4 months for on-going compliance. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attached "License inspection summary sig sheet.docx".

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 conduct an annual quality management meeting to discuss the required quality management topics in 2020.

Plan of Correction **Accept**

A meeting was held the day of MDS's last licensure inspection for MDS II, but was not documented per state regulations. A meeting was held on 07/11/2021, regarding the quality management of MDS, and documented appropriately, as will continue after inspections in the future and as needed. See attached.

Completion Date: *07/11/2021*

Update - 08/10/2021

Please send/Attach a copy of the home's 2020 quality management plan. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attachment "201117-Quality Management Plan Guide"

65d - Initial Direct Care Training

1. Requirements

2600.

65d - Initial Direct Care Training *(continued)*

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

The home did not have documentation that staff person A completed the required direct care training course and test. Staff person A provides direct care to residents.

Plan of Correction **Accept**

Staff person A had completed the required direct care training course and test, with a passing score, prior to providing unsupervised ADL services, but was unable to print out the certificate. Staff person A retested and passed on an office computer that was connected to an operable printer, as will be done in the future. The certificate was printed and filed. See attached.

Completion Date: *06/11/2021*

Update - 08/10/2021

Please send/Attach proof of compliance. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attachment "Cert of Comp [redacted]*.pdf"*

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

The glucometer belonging to resident #1 had blood on the back of the glucometer.

Plan of Correction **Accept**

Blood was located on the rear of resident #1's glucometer. The glucometer was cleaned and sanitized immediately. In the future, staff will be trained to clean and sanitize all diabetic equipment after each use with sanitizing wipes.

Completion Date: *06/20/2021*

Update - 08/10/2021

Please send/Attach proof of staff training. 8-10-2021 [redacted]

Document Submission **Implemented**

See attached "Training Roster.pdf". All Plan of Corrections were covered in that 3.5 hour meeting.

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 Repeat Violation

The temperature of the water in the resident bathroom located in the dining area measured 140° F.
This is a repeat violation from 04/17/2019.

89b - Hot Water Temperature *(continued)*

Plan of Correction **Accept**

The resident's dining room bathroom water temperature did exceed 120 degrees F on 06/07/2021. Maintenance contacted a local plumber. A temperature adjustment was made to each of the two water heaters. The temperatures were reduced from 120 degrees F to 90 degrees F. The water in the residents restroom now registers at 100 degrees F.

Completion Date: *06/09/2021*

Update - 08/10/2021

Upon receipt of this plan of correction:
The administrator/designee shall monitor water temperature in areas accessible to residents and ensure that temperature's doesn't exceed 120 degrees. Monitoring shall be done weekly X'3 4 months. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attachment "Water Monitoring Form Bathroom.docx" and "Water and refrigerator monitoring form".

103f - Refrigerator/Freezer Temps

1. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The cooler located in the home's pantry had temperatures of 50° F and 45°F when it was checked on two separate times.

Plan of Correction **Accept**

The pantry cooler temperature registered above 40 degrees F during inspection. When one cooler door closes the other door may pop open. After both doors are closed correctly, the cooler does sustain a temperature below 40 degrees F. A noticeable sign was placed on the cooler, advising staff to be sure the doors are sealed properly before leaving the cooler. See attached

Completion Date: *06/08/2021*

Update - 08/10/2021

Upon receipt of this plan of correction:
The administrator/designee shall monitor all food requiring refrigeration and ensure that food is stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers. Temperature's shall be monitored weekly X's 4 months to ensure ongoing compliance.
8-10-2021 MM

Document Submission **Implemented**

See attached "Water and refrigerator monitoring form."

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.

121a - Unobstructed Egress *(continued)*

Description of Violation

The door leading to the pantry which is marked as an exit was locked during the initial walkthrough. The door leads to the pantry which has an exit to the parking lot and there is an exit sign above the door to indicate that it is a designated fire exit.

Plan of Correction **Accept**

The pantry storage access door to the emergency exit door had been locked accidentally, on the day of inspection, through a misunderstanding. Kitchen staff was advised, that day, by maintenance, the storage/pantry area was not to be accessed by the residents. This caused kitchen staff to lock the storage area. Kitchen staff was readvised, residents are only to use the rear storage access/exit doors during emergency situations. An additional sign was also placed on the storage door, which indicates, it is to be used only for emergency exit purposes. See attached.

Completion Date: *06/07/2021*

Document Submission **Implemented**

POC Accepted

133.2 - Exit Signs Direction

1. **Requirements**

2600.

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

The dining area has two side exit doors. The door leading to the stairwell landing from the 2nd floor leads to an exit door that is used as a fire exit in an emergency. There was no exit sign above the door in the dining room to indicate that the door leads to a designated fire exit.

Plan of Correction **Accept**

The exit sign to the side entrance of the dining hall was missing. A new sign was hung to replace the missing one. See attached.

Completion Date: *06/07/2021*

Document Submission **Implemented**

POC Accepted

141a 1-10 Medical Evaluation Information

1. **Requirements**

2600.

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

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 Documentation of Medical Evaluation form (DME) for resident #2 dated 03/12/21 was missing the resident's height and medication regiment.

Plan of Correction **Accept**

During resident #2's exam, the clinic attendant completing the examination form missed filling in the height of resident #2. Also, the medication regiment was not attached to the DME as indicated on the DME form. The medical coordinator, in the future, will review all the resident's DME forms for completion and have all noted "see attached" information stapled to the DME.

Completion Date: *07/06/2021*

Update - 08/10/2021

Within 10 days of receipt of this plan of correction:
The administrator/designee shall audit all resident's DME's and ensure they are completed entirely. The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on form DME. Attachments will be added to form DME as needed to ensure that all actions are documented. 8-10-2021 – [redacted]

Document Submission **Implemented**

Jackueine Adams performed an audit by 8/18/2021.
Bille Jo Smith performed and audit in Sept.
I, Christy Shiffer, performed an audit 10/01/2021.

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

The annual DME form for resident #3 was completed late. The current DME was completed [redacted]*; the resident's previous DME was completed* [redacted]*.*

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction **Accept**

Resident #3's DME was performed 33 days later than the annual physical exam is to be completed. By approximately [redacted], I had performed an audit on all our residents annual medical evaluations. A list was completed for future reference. The medical coordinator advised, she is now scheduling annual examination appointments approximately one month prior to their annual due date, due to possible cancelations or scheduling problems.

Completion Date: *04/25/2021*

Update - 08/10/2021

The administrator shall monitor monthly X's 4 months for ongoing compliance.
8-10-2021 -MM

Document Submission **Implemented**

See attached "Annual Exam and 1st Aid Kit Sig Sheet.jpg".

171b5 - First Aid Kit

1. **Requirements**

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The home's first aid kit stored in the vehicle used to transport residents did not contain eye coverings or a thermometer.

Plan of Correction **Accept**

A new first aid kit was purchased for the facility's transportation van by the medical coordinator. Unfortunately, that particular kit did not include eye protection or a thermometer. A thermometer and eye coverings were placed into the kit on 06/08/2021. The medical coordinator was given a copy of the required items to be included in a first aid kit, printed from the Regulatory Compliance Guide 55 Pa. Code Chapter 2600 96a.

Completion Date: *07/06/2021*

Update - 08/10/2021

Upon receipt of this plan of correction:
The administrator/designee shall monitor all contents of the first aid kit used when transporting residents for all required contents. Missing required items shall be replaced immediately. The first-aid kit shall be monitored monthly X's 4 months to ensure ongoing compliance. 8-10-2021 [redacted]

Document Submission **Implemented**

See attached "Annual Exam and 1st Aid Kit Sig Sheet.jpg".

182b - Prescription Medication

1. **Requirements**

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

182b - Prescription Medication *(continued)*

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who passes medications, did not have a current annual practicum for 2020. Staff person B was initially trained on [redacted] and the annual practicum started for 2021 included only 2 medication administration observations.
Staff person C, who passes medications, did not have a completed annual practicum for 2020. Staff person C was initially trained on [redacted] and had only 1 medication record review and 1 medication administration observation documented for 2019 and only 2 medication observations documented for 2021. No annual practicum was documented for 2020.
The home did not have current documentation of medication administration training for Staff person D, who is the home's cook and is also responsible for passing some medications.

Plan of Correction **Accept**

Staff person B and C's annual practicums had not been completed for two reasons: The personal med. tech. trainer for our facility quit her position at MDS, just after I became the administrator in April of 2020. Soon after, COVID-19 set-in and we were unable to find anyone available to complete the observations. Since that time, I have utilized the online medication training for our employees and had med. tech. trainer, [redacted], complete the observations. Staff person D's documentation was later found misplaced under some other papers on a shelf. All paperwork and observations were completed on 06/08/2021 and placed into a file for safe keeping. A new facility med. tech. trainer will be training in the near future. Please contact me with a fax number, and I will forward these documents to you.

Completion Date: *06/08/2021*

Update - 08/10/2021

Please send/Attach proof of staff person's training. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attached "[redacted] MedTrain.pdf", "[redacted] MedTrain.pdf" and "[redacted] Med Train.pdf"

183a - Original Containers and Injections

1. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Resident #4 visited family from 05/30/2021 to 06/01/2021. According to staff interview, the resident's medications, including the controlled substance [redacted] were removed from the original pharmacy labeled containers and given to family to administer during those dates. Removal of medications from original pharmacy labeled containers more than two hours prior to administration is not permitted under this regulation.

183a - Original Containers and Injections *(continued)*

Plan of Correction **Accept**

The exact amount of [redacted] needed during Resident #4's visitation were placed into a zip-lock bag, from an almost full punch card, with written instructions of the resident's name, dosage and times for the family to dispense to Resident #4. The remainder of the medication was sent in the pillow packs, stamped with Resident #4's name, date and time for administration, name of medication and dosage of each, prepackaged by Custom Care Pharmacy. In the future, the whole punch card, with the original prescription, will be given to the family, and a police report will be filed if any of the medication is missing as a calculated returned. This citation will also be reviewed during MDS' mandatory meeting on 07/11/2021.

Completion Date: *07/11/2021*

Update - 08/10/2021

Within 10 days of receipt of this plan of correction:
All medication staff will be trained regarding medication administration. The home will not remove medications from their original labeled containers prior to administering the medication to residents.
Proof of staff training shall be attached when completed. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attached "Training Roster.pdf". All Plan of Corrections were covered in that 3.5 hour meeting.

183b - Meds and Syringes Locked

1. Requirements

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

The first aid kit stored in the home's vehicle used to transport residents contained aspirin and antacid tablets. The over the counter medications were not locked and were accessible to residents.

Plan of Correction **Accept**

The medical coordinator had bought a brand new first aid kit, not checking to see what was included in the contents. The aspirin and antacid tablets were removed immediately and placed into a locked area. The medical coordinator was given a copy of the required items to be included in a first aid kit, printed from the Regulatory Compliance Guide 55 Pa. Code Chapter 2600.96(a). [redacted] *was also advised of 2600.183(b). This citation will also be reviewed during MDS' mandatory meeting on 07/11/2021.*

Completion Date: *07/06/2021*

Update - 08/10/2021

Please send/Attach proof of staff training. 8-10-2021 - [redacted]

Document Submission **Implemented**

See attached "Training Roster.pdf". All Plan of Corrections were covered in that 3.5 hour meeting.

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

The glucometer belonging to resident #1 was not calibrated to the correct time of day.

Plan of Correction **Accept**

The glucometer for resident #1 was not calibrated upon inspection, with the date being off. The glucometer was corrected that same day. Staff were trained on how to check the settings prior to use of a glucometer and the calibration of it. This citation will also be reviewed during MDS' mandatory meeting on 07/11/2021.

Completion Date: *07/11/2021*

Update - 08/10/2021

Please send/attach proof of staff training. 8-10-2021 [redacted]

Document Submission **Implemented**

See attached "Training Roster.pdf". All Plan of Corrections were covered in that 3.5 hour meeting.