Department of Human Services
Bureau of Human Service Licensing

September 27, 2021

[redacted], OWNER/ADMINISTRATOR
[redacted]

RE: SCENIC VIEW PERSONAL CARE
1305 CHURCH DRIVE
PALMERTON, PA, 18071
LICENSE/COC#: 22876

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/10/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

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: *SCENIC VIEW PERSONAL CARE* **License #:** *22876* **License Expiration Date:** *07/28/2021*
Address: *1305 CHURCH DRIVE, PALMERTON, PA 18071*
County: *CARBON* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/22/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *23* **Waking Staff:** *17*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *06/10/2021*

Inspection Dates and Department Representative

06/10/2021 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* **Residents Served:** *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *17*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *6* **Have Physical Disability:** *1*

Inspections / Reviews

06/10/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/24/2021*

9/15/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/27/2021*

9/27/2021 - Document Submission

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

25b - Contract Signatures

1. **Requirements**

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The contract dated [redacted] for resident #1 was not signed by the resident.

Plan of Correction **Accept**

Resident #1 signed and dated [redacted] contract on [redacted] and a copy of the signature page is attached. Administrator will have Resident sign contract on day of admission.

Completion Date: *07/18/2021*

Update - 09/15/2021

Within 10 days of receipt of this plan of correction:
The administrator or designee shall audit all resident records and ensure that each contract is signed by the administrator or a designee, the resident and the payer, and will be cosigned by the resident's designated person if any, if the resident agrees for residents admitted after the date shown.
Documentation of the audit shall be maintained by the home. 9-15-2021 [redacted]

Document Submission **Implemented**

Administrator has audited all contracts with residents and payer signature. spread sheet attached

42s - Privacy

1. **Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home has cameras installed in both the dining area and the common living area of the home that were currently recording those areas when the inspection was conducted.

Plan of Correction **Accept**

The cameras in the dining room and common living area are no longer recording. Upon review of Reg.2600.425 states " video monitoring of the homes interior common areas is premitted" No recording is done in the areas where the residents are bathing, dressing , changing or having any medical procedures done.

Completion Date: *06/10/2021*

Update - 09/15/2021

Upon receipt of this plan of correction:
The administrator shall monitor cameras located throughout the facility for compliance with this regulation weekly X's 3 months. 9-15-2021 [redacted]

Document Submission **Implemented**

Administrator will monitor cameras located without areas and record audit X3 weeks. Spread sheet attached

51 - Criminal Background Check

1. **Requirements**

2600.

51 - Criminal Background Check *(continued)*

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home did not have documentation of a criminal background check within 30 days of staff person A's hire date. Staff person A was hired on [redacted]

Plan of Correction **Accept**

Staff person A had a criminal background report done on [redacted] *and a copy is attached. Administrator will have background report done before employee starts working at facility.*

Completion Date: *06/10/2021*

Update - 09/15/2021

Within 10 days of receipt of this plan of correction:
The administrator or designee shall audit all staff records and ensure that all staff have a current-valid Criminal History Check done in accordance with the Older Adults Protective Services Act. 9-15-2021 [redacted]

Document Submission **Implemented**

Administrator has audited all staff records and ensures all staff has had a current Criminal History check. Audit spread sheet attached

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home had a total census of 17 residents in the home at the time of the inspection, with 5 immobile residents including 2 residents, residents #2 and #3, requiring a 2 person assist for transfers and emergency evacuations. Staff interviews indicated the home was staffing the 3rd shift hours of 11pm to 7am with only one staff person for several weeks prior. The home did not have enough staff scheduled overnight to meet the needs of residents #2 and #3.

Plan of Correction **Accept**

We are actively marketing to hire additional 11pm-7am staff. Until additional staff is hiredthe 3rd shift hours will be covered by other staff or [redacted] *and* [redacted] *the owners. Copy of add is attached*

Completion Date: *07/06/2021*

Update - 09/15/2021

Please send/Attach copy of staff schedule for the month of September 2021.
9-15-2021 MM

Document Submission **Implemented**

All shift are covered either by staff or owners . schedule attached

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.

63a - First Aid/CPR Training *(continued)*

Description of Violation

On 06/04/21 from 11pm to 7am the home's only staff person in the home was staff person A. Staff person A does not have certified training in first aid and CPR.

Plan of Correction **Accept**

Staff person A completed [redacted] CPR/ !st aid training and copies of her certificates are attached. Administrator will have at least 1 CPR/1st aid trained person on staff at all times.

Completion Date: *06/14/2021*

Update - 09/15/2021

Within receipt of this plan of correction:
The administrator will ensure that sufficient numbers of staff with the required training and certification are present in the home at all times. Documentation of staffing, training, and certification will be available to agents of the Department at any time. 9-15-2021 [redacted]

Document Submission **Implemented**

Administrator has audited all staff records / documentation and Certifications. All staff has had the required CPR training and will be present in home at all times.

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:

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

The home did not have documentation that staff persons A, B, and C were trained on their first day of work in the procedures listed in this regulation. Staff person A was hired on 02/25/21, staff person B was hired on 02/26/21, and staff person C was hired on 04/16/21.

Plan of Correction **Accept**

Staff persons A,B, and C were re-trained on the policies related to regulation 2600.65a on 7/15/21 or 07/16/21 by Melissa Levan Lpn, PCHA,ALA. Administrator will have all staff trained on the 1st day of work .

Completion Date: *07/15/2021*

Update - 09/15/2021

Please send/Attach proof of staff training as identified in your plan. 9-15-2021 [redacted]

Document Submission **Implemented**

Staff person A,B,C were trained on regulations 65a .Proof is attached

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:

2. Emergency medical plan.

Description of Violation

The home did not train staff persons A, B, and C in the required training topic emergency medical plan within 40 hours of their first day of work.

Staff person A was hired on [redacted], staff person B was hired on [redacted], and staff person C was hired on [redacted].

Plan of Correction **Accept**

Staff persons A,B, and C were re-trained on the emergency medical plan on [redacted] or [redacted] by [redacted] LPN,PCHA,ALA Copy of training sheets attached .Administrator will have new employees trained on date of hire

Completion Date: *07/16/2021*

Update - 09/15/2021

Please send/Attach proof of staff training as identified in your plan. 9-15-2021 [redacted]

Document Submission **Implemented**

Staff person A, B, C were all trained on emergency medical plan . Proof is attached

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

The half rails attached to the bed in resident room #9 did not have a cover over them to prevent possible entrapment. The grab assist bar attached to the bed in resident room #7 also did not have a cover over it to prevent possible entrapment.

Plan of Correction **Accept**

The grab assistance bar for resident #7 is covered by a pillow case. Resident #9 has the half rails covered with a sheet but a seamstress has been hired to make custom siderail covers. Pictures of temporary covers are attached. Administer will make sure all siderails are covered when orders are made by PCP

Completion Date: *07/14/2021*

Update - 09/15/2021

Please send/Attach photo of covered grab-assist bars. 9-15-2021 [redacted]

Document Submission **Implemented**

photo attached

105g - Lint Removal and Duct Cleaning

1. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

The dryers located in the home's laundry room both had a layer of lint in the lint traps when inspected. The lint traps were not immediately cleaned after use.

Plan of Correction **Accept**

Lint trap will be cleaned out after every use. Staff that washes the residents laundry will initial the log that the lint trap was cleaned . A copy of the " dryer lint log" is attached . The Administrator and/or Medtech Supervisior will check log daily.

Completion Date: *07/18/2021*

Update - 09/15/2021

Upon receipt of this plan of correction:
The administrator or designee shall spot check the facility dryers for lint as well as other hazards weekly X's 4 months. 9-15-2021 [redacted]

Document Submission **Implemented**

Administrator will spot check facility dryers for lint weekly x4 mo . spread sheet attached.

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

A plastic bag, dryer sheets, and a few paper coupons were found behind the first dryer located in the home's laundry room, posing a possible fire safety hazard.

Plan of Correction **Accept**

Staff will clean behind the dryers every shift and initial the dryer lint log when completed. A copy of the "dryer lint log" is attached
The Administrator and/or Medtech Supervisior will check log daily.

Completion Date: *07/18/2021*

Update - 09/15/2021

Upon receipt of this plan of correction:
The administrator or designee shall spot check the facility dryers for combustible or flammable materials, as well as other hazards, weekly X's 4 months. 9-15-2021 [redacted]

Document Submission **Implemented**

Administrator will spot check the facility dryers for combustibles or flammable materials and hazards weekly X4 mo . spread sheet attached

133.1 - Exit Signs

1. **Requirements**

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

133.1 - Exit Signs *(continued)*

Description of Violation

The door leading from the dining area to an open patio area was not labeled as an exit.

Plan of Correction **Accept**

The exit sign is on the door leading from the dining area to the outside patio. A picture of the Exit sign is attached. Administrator will check exit signs with monthly fire inspection of fire extinguishers.

Completion Date: *06/14/2021*

Document Submission **Implemented**

Correction was accepted

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 DME form dated [redacted] for resident #1 did not include the resident's body positioning/movement needs.
The Documentation of Medical Evaluation (DME) form dated [redacted] for resident #2 did not list the resident's pulse rate.
The DME form dated [redacted] for resident #3 did not include a medication regiment.

Plan of Correction **Accept**

Resident #1 does not need assistance with positioning and the DME was updated to reflect that. Resident #2 DME was updated with his pulse. copies of both DME's page 1 are attached. Resident #3 [redacted] med list was on the chart with her old records from moving into Scenic View. A copy of the May 2020 medlist is attached. Administrator will make sure all DMEs and med lists are completed in a timely manner.

Completion Date: *07/18/2021*

Update - 09/15/2021

Within 10 days of receipt of this plan of correction:
The administrator or designee shall audit all resident's DME's and 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. 9-15-2021 [redacted]

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

Document Submission **Implemented**

Administrator has audited all resident's DME forms and ensure all form's are filled in correctly and completely . spread sheet is attached

141b1 - Annual Medical Evaluation

1. **Requirements**

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

Description of Violation

Resident #3's most current DME was completed on [redacted]. The home did not have an annual DME completed within 12 months of that date.

Plan of Correction **Accept**

Resident #3 DME was completed on [redacted] and a copy is attached . Administrator will make sure all DME's are completed in a timely manor manner , yearly or apon a significant change.

Completion Date: *06/20/2021*

Document Submission **Implemented**

plan was accepted

183d - Prescription Current

1. **Requirements**

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The [redacted] cream found in the medication cart for resident #2 expired on [redacted].

Plan of Correction **Accept**

Resident #2 expired cream [redacted] was destroyed and a new cream is in use. A picture of the new cream is attached. Administrator and/or Medtech Supervisior will conduct cart audits on a monthly basis .

Completion Date: *06/10/2021*

Document Submission **Implemented**

Plan was accepted

183e - Storing Medications

1. **Requirements**

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Two loose pills were found in the 3rd drawer of the medication cart.
The [redacted] and the [redacted] for resident #2 were not marked with the date the pens were opened for use.
The [redacted] touch insulin pen for resident # 4 was also not marked with the date the pen was opened for use.

183e - Storing Medications *(continued)*

Plan of Correction **Accept**

Resident #2 [redacted] insulin are maked with the date opened and pictures are attached . Resident #4 Levemier was changed to a bottle and is marked with the open date. A picture is attached. All loose pills were cleaned from cart. Administrator and/or Medtech Supervisior will check cart weekly for expired dates on insulin and loose pills.

Completion Date: *07/18/2021*

Document Submission **Implemented**

Plan was accepted

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:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The insulin pens for residents #3 and #4 were stored in the medication cart without the pharmacy labels attached to or stored along with the pens.

Plan of Correction **Accept**

Resident #3 was never on insullin. Resident #2 and #4 have their insulin with pharmacy labels. Pictures are attached . Administrator and/or Medtech Supervisior will conduct med cart checks weekly.

Completion Date: *07/18/2021*

Document Submission **Implemented**

Plan was accepted

191 - Resident Right to Refuse

1. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

The home did not have documentation that residents #1, #2, and #3 were educated on the right to question or refuse a medication if the resident believed there may be a medication error.

Plan of Correction **Accept**

The residents right to refuse medication if they believe there may be a medication error was added to the Residents Right Form and is hanging on the bulletin board. A new copy is attached.

Completion Date: *07/18/2021*

191 - Resident Right to Refuse *(continued)*

Update - 09/15/2021

Within 10 days of receipt of this plan of correction:
The administrator or designee shall audit all resident records and ensure that all current and future residents have been and are educated on the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.
9-15-2021 - [redacted]

Document Submission **Implemented**

Administrator has audited all residents files and have educated all residents on the right to refuse medication if the resident believes there is an error. This is signed on the resident rights form.

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

The home did not complete a preadmission screening form for resident #1.

Plan of Correction **Accept**

Resident #1 preadmission screening form was completed on [redacted] *and a copy is attached . Administrator will complete preadmission form before resident moves into facility.*

Completion Date: *06/11/2021*

Document Submission **Implemented**

Plan was accepted

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 #1 was admitted to the home on [redacted]*. The home did not complete an initial assessment of the resident's needs as required to be documented on the Resident Assessment-Support Plan (RASP) form within 15 days of admission.*

Plan of Correction **Accept**

Resident #1 RASP was completed and signed on [redacted] *and a copy is attached .*
Administrator will have RASPs completed within the allowed time frame of DHS

Completion Date: *06/10/2021*

Document Submission **Implemented**

Plan was accepted