Department of Human Services
Bureau of Human Service Licensing

January 11, 2022

[redacted], ADMINISTRATOR
[redacted]

RE: WASHINGTON MANOR PERSONAL CARE HOME LLC
320 SOUTH WASHINGTON STREET
PO BOX 1935
BUTLER, PA, 16003
LICENSE/COC#: 44863

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/29/2021, 07/30/2021 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 - PUBLIC

Facility Information

Name: *WASHINGTON MANOR PERSONAL CARE HOME LLC* **License #:** *44863* **License Expiration:** *11/27/2021*

Address: *320 SOUTH WASHINGTON STREET, PO BOX 1935, BUTLER, PA 16003*

County: *BUTLER* **Region:** *WESTERN*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/24/1985* **Issued By:** *L&I*

Staffing Hours

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

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal, Complaint* **Exit Conference Date:** *08/17/2021*

Inspection Dates and Department Representative

07/29/2021 - On-Site: [redacted]

07/30/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older:** *11*

Diagnosed with Mental Illness: *25* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *1* **Have Physical Disability:** *0*

Inspections / Reviews

07/29/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/11/2021*

Inspection Dates and Department Representative *(continued)*

10/22/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/29/2021*

01/11/2022 - Document Submission

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 7/29/21, the resident privacy coding document, including the name of resident #5, was attached to the 7/2/18 licensing measuring summary in the dining room unlocked, unattended, and accessible.

Plan of Correction ***Accept***

The administrator had the page removed with resident #5 listed from the prior inspection report posted in the dining room area. The administrator will conduct monthly checks of the postings in all public areas to ensure resident privacy and that this regulation is properly followed.

Document Submission ***Implemented***

The administrator had the page removed with resident #5 listed from the prior inspection report posted in the dining room area. The administrator will conduct monthly checks of the postings in all public areas to ensure resident privacy and that this regulation is properly followed.

26b - Quality Management Plan Content

1. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's last quality management review was on 2/11/2020.

Plan of Correction ***Accept***

The care home disagrees with this violation; the administrator had two folders prepared for two inspectors with documentation of the 2020 and 2021 quality management team meetings. The care home administrator was out of facility during the inspection but told by staff that the inspector didn't want to see the prepared folders. Attached is the copy of the QMT meeting on 01-03-2021. The administrator will continue to conduct QMT meetings to ensure this regulation is followed.

Document Submission ***Implemented***

The care home disagrees with this violation: the administrator had two folders prepared for two inspectors with documentation of the 2020 and 2021 quality management team meetings. the care home administrator was out of the facility during the inspection but informed by staff that the inspector didn't want to see the prepared folders. Attached is the copy of the QMT meeting on 01-03-2021. The administrator will continue to conduct QMT meetings to ensure this regulation is followed.

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.

88a - Surfaces *(continued)*

Description of Violation

On 7/29/21, the back of the door for bedroom #5 had 2 holes in it measuring approximately 7" by 5" and approximately 7" by 2 1/2".

On 7/30/21, the carpet in bedroom #5 was stained throughout the room and sticky when stepped on.

On 7/30/21, the wall by resident #1's bed in bedroom #5 was splattered with an unknown substance.

Plan of Correction ***Accept***

Resident #1 in bedroom [redacted] throws food often and [redacted] room is cleaned daily but hadn't been in the morning of the inspection. Room#5's new carpet had been purchased on 07-15-2021 and was awaiting installation at the time of the inspection (see attached invoice). The back door was repaired and simply missed during the physical site daily inspections. The administrator will continue to conduct daily physical site inspections and add checking behind the doors to the physical site list to ensure this regulation is followed.

Document Submission ***Implemented***

Resident #1in bedroom [redacted] throws food often and [redacted] room is cleaned daily but hadn't been in the morning of the inspection. Room #5's new carpet had been purchased on 07-15-2021 and was awaiting installation at the time of the inspection (see attached invoice from Floor Fashions). The back door was repaired and simply missed during daily physical site inspections. The administrator will continue to conduct daily physical site inspections and add checking behind the doors to the physical site checklist to ensure this regulation is followed.

96a - First Aid Kit

1. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 7/30/21, the first aid kit did not include a thermometer and tweezers.

Plan of Correction ***Accept***

The administrator was out of the facility during the inspection and couldn't conduct the daily physical site checklist. A new employee used the items and placed them in a separate first aid box not the main one. Employees have been educated on returning the first aid items to the main kit (see attached) and the administrator will continue to conduct daily physical site checks plus designate an employee to do so in their place to ensure proper adherence to this requirement.

Document Submission ***Implemented***

The administrator was out of the facility during the inspection and couldn't conduct the daily physical site checklist. A new employee used the items and placed them in a separate first aid box not the main one. Employees have been educated on returning the first aid items to the main kit (see attached) and the administrator will continue to conduct daily physical site checks plus designate an employee to do so in their place to ensure proper adherence to this requirement.

103d - Storing Food Off Floor

1. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 7/30/21, 28 gallons of emergency water was stored directly on the floor in the cupboard under the steps leading to the third floor.

Plan of Correction ***Accept***

The care home disputes this violation since the food was on carpet with pad under it in a secured area (not on a bare floor) which is why this violation never occurred in prior inspections (pictures attached). The care home administrator has purchased plastic shelving and placed it under the stored water containers to raise it above the carpet level. The administrator will conduct semi-annual inspections to ensure the water bottles are on the plastic shelving at all times to ensure this regulation is properly followed.

Document Submission ***Implemented***

The care home disputes this violation since the water was on carpet with pad under it in a secure area (not on a bare floor) which is why this violation never occurred in prior inspections (pictures attached). The care home administrator has purchased plastic shelving and placed it under the stored water containers to raise it above the carpet level. The administrator will conduct semi-annual inspections to ensure the water bottles are on the plastic shelving at all times to ensure this regulation is followed.

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

On 7/30/21, at 10:38 a.m., the temperature in the upright freezer in the laundry room was 11 degrees Fahrenheit and at 4:15 p.m., it was 5 degrees Fahrenheit.

Plan of Correction ***Accept***

The care home disputes this violation because the readings stated are inaccurate. The home records the temperature daily which is documented on the freezer (picture attached). The thermometer was placed on the door which is consistently opened in the morning and throughout the day. The thermometer when placed inside the freezer records a temperature of 0 degrees or below. The administrator has instructed staff that thermometers are to be placed inside the fridges/freezers and not on the doors to ensure proper readings during the day (see photo attached). The administrator will continue to conduct daily inspections to ensure this regulation is properly followed.

Document Submission ***Implemented***

The care home disputes this violation because the readings stated are inaccurate. The home records the temperature daily which is documented on the freezer (picture attached). The thermometer was placed on the door which is consistently opened in the morning and throughout the day. The thermometer when placed inside the freezer records a temperature of 0 degrees or below. The administrator has instructed staff that thermometers are to be placed inside the freezers/fridges and not on the doors to ensure proper readings during the day (see attached). The administrator will continue to conduct daily inspections to ensure this regulation is followed.

130a - Smoke Detector 15 ft Bedroom

1. Requirements

2600.
130.a. There shall be an operable automatic smoke detector located within [redacted] each bedroom door.

Description of Violation

On 7/30/21, the nearest operable [redacted] detector to resident bedroom #4 was approximately 16 feet from the bedroom door.

Violation Withdrawn JW 1/11/22

Plan of Correction ***Accept***

The care home disagrees with this violation. The inspector measured the distance by using their feet, not a tape measure, plus no violations in all prior years have occurred. The administrator using a tape measure measured in a straight line from point A (doorway) to point B (mid-point) then to point C (at the smoke detector). The exact distance is 14 feet, 9 inches (see attached pictures). The administrator will continue to keep smoke detectors within 15 feet of all bedroom doors to ensure compliance with this regulation.

Document Submission ***Implemented***

The care home disagrees with this violation. The inspector measured the distance using their feet, not a tape measure, plus no violations in all prior years have occurred. The administrator using a tape measure, measured in a straight line from point A (doorway) to point B (midpoint) then to point C (under the smoke detector). the exact distance is 14 feet, 9 inches (see attached pictures). The administrator will continue to keep smoke detectors within 15 feet of all bedroom doors to ensure compliance with this regulation.

131f - Fire Extinguisher Inspection

1. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 7/30/21, the fire extinguisher in attic has not been inspected by a fire safety expert.

Plan of Correction ***Accept***

The home disagrees with this violation since a tagged (June 2021) extinguisher was in the attic at the time of inspection. A staff member showed the inspector the old extinguisher by the stairway but didn't show the extinguisher installed by the fire company (see attached picture). Staff has been educated on the attic extinguisher location (see attached document). The administrator has annual inspections on the extinguishers done and will continue to do so to ensure compliance with this regulation.

Document Submission ***Implemented***

The care home disagrees with this violation since tagged (June 2021) extinguisher was in the attic at the time of inspection. A staff member showed the inspector the old extinguisher by the stairway but didn't show the extinguisher installed by the fire company (see attached picture). Staff has been educated on the attic extinguisher location (see attached document). The administrator has annual inspections done and will continue to do so to ensure compliance with this regulation.

133.2 - Exit Signs Direction

1. Requirements

133.2 - Exit Signs Direction *(continued)*

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

On 7/30/21, the way to reach the exit from the third floor hallway was not immediately visible and there were no signs indicating the direction of travel to the exit. On 7/30/21, the home served 25 residents.

Plan of Correction ***Accept***

The exit signs requested have been posted as you see in the attached photos. The home doesn't agree with this violation since exit signs above each doorway were already in place and easily visible within a few feet of the newly requested signs. The administrator will continue to conduct monthly inspections that the signs are in place and not removed to ensure compliance with this regulation.

Document Submission ***Implemented***

The exit signs requested have been posted as you see in the attached photos. The home doesn't agree with this violation since exit signs above each doorway were already in place and easily visible within a few feet of the newly requested signs. The administrator will continue to conduct monthly inspections that the signs are in place and not removed to ensure compliance with this regulation.

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

Resident #1's medical evaluation, dated [redacted], and resident #3's medical evaluation, dated [redacted] did not include the medication regimen. This area was blank.

Plan of Correction ***Accept***

The administrator has reviewed and corrected all resident files since the inspection date. The administrator and one designated staff member will conduct monthly inspections of all resident files to ensure the home remains in compliance with this regulation.

Document Submission ***Implemented***

The administrator has reviewed and corrected all resident files since the inspections date. The administrator and one designated staff member will conduct monthly inspections of all resident files to ensure the home remains in compliance with this regulation.

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.

184a - Labeling OTC/CAM *(continued)*

Description of Violation

Resident #2 is prescribed, [redacted], give 6 units 3 times a day with meals and sliding scale before meals as follows:

**<70=contact office*

**70-150=0 units*

**151-200=2 units*

**200-250=4 units*

**251-300=6 units*

**301-350=8 units*

**351-400=10 units*

**>401=12 units and call MD*

On 7/30/21, the pharmacy label indicated to give 2 units 3 times daily and did not include the sliding scale.

Plan of Correction ***Accept***

The pharmacy label was corrected 07-31-2021 by the care home's pharmacy and staff has been educated on the sliding scale documentation for this resident. The administrator and one designated staff person will conduct daily reviews of the medications/EMAR to ensure that the sliding scale specifications are being followed for this resident to ensure proper compliance with this regulation.

Document Submission ***Implemented***

The pharmacy label was corrected on 07-31-2021 by the care home's pharmacy and staff has been educated on the sliding scale documentation for resident #2. The administrator and one designated staff person will conduct daily reviews of the medications/EMAR to ensure the sliding scale specifications are being followed for resident #2 to ensure proper compliance with this regulation. Note: Update, resident #2 is no longer at the care home.

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #1's assessment, dated [redacted], indicates the resident requires no assistance with ambulation; however, staff interviews indicate the resident requires hands-on assistance in ambulating and evacuation due to the fear of falling. Also, the assessment does not include the diagnoses of [redacted] as indicated on

225c - Additional Assessment (continued)

the medical evaluation, dated [redacted].

Plan of Correction ***Accept***

The administrator and one designated staff member have reviewed and corrected the file for this resident plus all care home residents since the inspection date. The administrator and designated staff member will continue to review resident files monthly to ensure compliance with this regulation.

Document Submission ***Implemented***

The administrator and one designated staff member have reviewed and corrected the file for this resident plus all care home residents since the inspection date. The administrator and designated staff member will continue to review resident files monthly to ensure compliance with this regulation.

227h - Support Plan Refuse Sign

1. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's support plan, dated [redacted], was not signed by the resident and does not indicate the resident's inability or refusal to sign.

Plan of Correction ***Accept***

Resident #1's support plan was accidentally signed by his wife whom is also a resident which caused the confusion. The support plan has been corrected by the administrator and designated staff member as of 08-2021. The administrator and designated staff member have reviewed all support plans for accuracy and will continue to do so monthly to ensure compliance with this regulation.

Document Submission ***Implemented***

Resident #1's support plan was accidentally signed by [redacted] whom is also a resident which caused the confusion. The support plan has been corrected by the administrator and designated staff member as of 08-2021. The administrator and designated staff member have reviewed all support plans for accuracy and will continue to do so monthly to ensure compliance with this regulation.