Department of Human Services
Bureau of Human Service Licensing

November 10, 2021

[redacted] OWNER
[redacted]

RE: THE FOUNTAINS AT INDIANA
2720 WEST PIKE ROAD
INDIANA, PA, 15701
LICENSE/COC#: 45298

Dear [redacted],

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

Sincerely,
[redacted]

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: *THE FOUNTAINS AT INDIANA* **License #:** *45298* **License Expiration Date:** *07/01/2022*
Address: *2720 WEST PIKE ROAD, INDIANA, PA 15701*
County: *INDIANA* **Region:** *WESTERN*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *06/01/2021* **Issued By:** *White Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *16* **Waking Staff:** *12*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Interim* **Exit Conference Date:** *09/09/2021*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served:** *8*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *All* **Capacity:** *40* **Residents Served:** *8*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *8*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

09/09/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/16/2021*

Inspections / Reviews *(continued)*

10/15/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date**: *10/22/2021*

11/10/2021 - 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 home's licensing inspection summary, dated 6/11/2021, was not posted in a conspicuous and public place in the home.

Plan of Correction **Accept**

This was fixed at the time of inspection. The License and license inspection had been posted on bulletin board prior to opening. It was re-posted at the time of inspection. A new enclosed bulletin board will be placed on the wall with secure plexi-glass to ensure all postings remain on the bulletin board. The new enclosed bulletin board has been ordered and upon receipt will be installed and all required postings will be placed in the enclosed bulletin board by the administrator. The Administrator will audit the enclosed bulletin board monthly to ensure all required documentation is posted.

Completion Date: *10/07/2021*

Document Submission **Implemented**

Please see attached picture of certificate on bulletin board

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

House Bill No. 1785, The Influenza Awareness Act of 2016, requires that preparation and publication of information relating to the Influenza Awareness Act and the influenza vaccine is posted in a public place in the facility year-round. The Influenza Awareness information was not posted in the home.

Plan of Correction **Accept**

Influenza Awareness Act and influenza vaccine information was placed on the bulletin board on 10/7/2021. This will be moved to the new enclosed bulletin board by the administrator when it is received and installed. The administrator will audit the bulletin board monthly to ensure all required postings are in place.

Completion Date: *10/07/2021*

Document Submission **Implemented**

please see attached picture of influenza awareness information on bulletin board

51 - Criminal Background Check

1. Requirements

2600.

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).

51 - Criminal Background Check *(continued)*

Description of Violation

Direct care staff person A, started working in the home on [redacted]. However, the home did not complete a criminal history background check until [redacted]

Plan of Correction **Accept**

A background check was obtained prior to Direct care staff person A's employment. This background check was noted to be missing upon an audit of staff member A's file. A new background check was obtained immediately. The administrator will obtain a background check on all new hired staff prior to the first day of employment. A employment file check list has been created so that the administrator can track each required employee file item and ensure that all items are completed prior to the first day of employment. (please see attached employee file check list)

Completion Date: *10/07/2021*

Document Submission **Implemented**

please see attached documentation

54a - Direct Care Staff

1. **Requirements**

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction **Accept**

Staff person B had been asked to provide high school diploma several times by the administrator and did not. The administrator will obtain high school diploma, GED or active registry status prior to the first day of employment. An employee file check list will be completed prior to the first day of employment to ensure that all required qualifications are met. (please see attached employee file check list) please see the attached copy of staff member B's high school diploma

Completion Date: *10/07/2021*

Document Submission **Implemented**

please see attached diploma with transcripts

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 9/6/21, 8 residents were present in the home. From 7:00 a.m. until 7:00 p.m., there were no staff working in the home certified in in first aid, CPR, and obstructed airway techniques.

In addition, on 9/7/21, there were 8 residents present in the home. From 7:00 a.m. until 7:00 p.m. and from 11:00 p.m. until 7:00 a.m. (9/8/21), there were no staff working in the home certified in in first aid, CPR, and obstructed airway techniques.

Plan of Correction **Accept**

After the inspection 3 employees provided current CPR cards. At the time of the inspection a CPR/ First Aid class was already scheduled for 9/24/2021. (please see the attached sign in sheet for this class) The CPR/First Aid cards have been received from that class and placed in each employee's chart that attended the training. The administrator will maintain the employee file check list on each employee file and audit this check list every 6 months to ensure an employee trained in CPR/First Aid is in the building at all times.

Completion Date: *10/07/2021*

Document Submission **Implemented**

please see attached sign in sheet for scheduled CPR/First Aid class and CPR/First Aid cards from staff already certified

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

Staff person A, whose first day of work was [redacted], did not receive orientation on any of the required topics under regulation 2600.65a prior to or on the first day of work.

Staff person C, whose first day of work was [redacted], did not receive orientation on any of the required topics under regulation 2600.65a prior to or on the first day of work.

Plan of Correction **Accept**

Staff person A, B & C have completed orientation on the required topics on 10/9/21. All newly hired staff will be orientated on all required topics prior to the first day of work. The administrator will utilize and employee file check list to ensure that all orientation and required topics are completed prior to the first day of work going forward. (please see attached employee file check list)

Completion Date: *10/09/2021*

65a - FS Orientation 1st Day *(continued)*

Document Submission **Implemented**

please see corrected documentation for employee A,B & C. Please see attached employee file checklist

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:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, started working in the home on [redacted]. However, direct care staff person A did not receive training in any topics required in accordance with regulation 2600.65b.

Staff person C, started working in the home on 6/1/21. However, direct care staff person A did not receive training in any topics required in accordance with regulation 2600.65b.

Plan of Correction **Accept**

Staff person A, B & C, have completed orientation on the required topics on 10/9/21. All newly hired staff will be orientated on all required topics prior to the first day of work or within 40 scheduled working hours. The administrator will utilize and employee file check list to ensure that all orientation and required topics are completed prior to the first day of work or within 40 scheduled working hours going forward. (please see attached employee file check list)

Completion Date: *10/09/2021*

Document Submission **Implemented**

Please see attached staff person A,B & C corrected orientation and employee file check list

82a - Poisonous Materials

1. **Requirements**

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

There was an unlabeled spray container with approximately 16 ounces of purple liquid in the corner cabinet in the kitchenette. Staff indicated the liquid was "Fabuloso" cleaner that had been refilled into a clear container.

Plan of Correction **Accept**

A new system of obtaining, storing and using poisonous materials has been purchased and will be installed in the laundry room in a secure locked cabinet. All staff have been educated on not putting any chemical into any unlabeled container and that all chemicals must stay in original containers. The administrator will do an audit in the building daily to ensure that all chemicals are in the original containers and that no chemicals are unsecured. (please see the attached sign in sheet for education on poisonous materials)

Completion Date: *10/07/2021*

82a - Poisonous Materials *(continued)*

Document Submission **Implemented**

New poisonous materials secure locked cabinet installed and all poisonous materials are locked up in secure locked cabinets in secure locked laundry room. Please see education for staff regarding poisonous materials and attached picture of locking system for chemicals

82c - Locking Poisonous Materials

1. **Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

The following poisonous materials were unattended and accessible in the kitchenette:

Five containers of Lysol Wipes on the counter and in the corner cabinet with a manufacture's label indicating, "First Aid: Call a Poison Control Center or doctor for treatment advice."
Two containers of disinfectant wipes in the corner cabinet with a manufacture's label indicating ""First Aid: Call a Poison Control Center or doctor for treatment advice."
A spray bottle of "Fabuloso" in the corner cabinet with an manufacture's label indicating "If Swallowed, Contact a poison control center or doctor immediately." on the original container used to refill the spray bottle
A container of Sani-cloth wipes on the counter with a manufacture's label indicating "First Aid: Call a poison control center of healthcare professional for treatment advice."

Not all the residents of the home, including resident # 1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction **Accept**

All staff have been educated on the proper storage of all chemicals. (please see training sign in sheet and training overview) A new system of obtaining, storing and using chemicals has been purchased to secure chemicals in a laundry room that is locked.

All unlocked poisonous materials were moved to a locked location on the day of inspection.

[redacted] *10/15/21*

Completion Date: *10/08/2021*

Document Submission **Implemented**

please see staff education on poisonous materials and new chemical locking system installed. all chemicals are kept in secure cabinets in secure locked laundry room

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.

96a - First Aid Kit *(continued)*

Description of Violation

The first aid kit in the kitchenette does not include scissors.

Plan of Correction **Accept**

First aid kit had scissors placed in kit originally and someone removed them. Scissors were added to the first aid kit at the time of inspection. An audit sheet is placed in the first aid kit and staff will audit weekly to ensure all required items are in the first aid kit.
whenever staff take an item from the kit they will replace it immediately.

Completion Date: *10/08/2021*

Document Submission **Implemented**

scissors were put in first aid kit at time of inspection and the kit is audited weekly. the regulation was copied with the listing of items to be in first aid kit and placed in the kit so every staff member is aware of what is required in the kit.

103e - Left Overs

1. **Requirements**

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The following food items were unlabeled, undated in the main kitchen of the PCH building:
Three brown bags of french fries in the freezer
Clear bag of breaded fish or chicken in the freezer

Plan of Correction **Accept**

The french fries and breaded fish/chicken in the freezer came in on a food service truck in this packaging. The food service provider does not label or date some items ordered. All food items coming into the facility will be labeled and dated upon arrival to the facility. The cook in the kitchen will audit all freezers weekly to ensure that all items are dated and labeled upon receipt into the facility. Any items that are not labeled or dated will be disposed of immediately

Completion Date: *10/08/2021*

Document Submission **Implemented**

audits by kitchen staff are done when food is arriving to facility to ensure it is dated and all freezers are checked weekly by the kitchen staff to ensure all items are dated and labeled

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

At 11:03 a.m., the temperature in the double door stainless steel refrigerator in the SDCU kitchen was 44.4 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction **Accept**

The temperature to the double door stainless steel refrigerator in the SDCU kitchen was adjusted to be below 40degrees F. An audit sheet has been placed near the SDCU double door stainless steel refrigerator so that nightshift staff can audit the temperature daily to adjust the temperature and ensure the proper temperature is maintained.

Completion Date: *10/11/2021*

Document Submission **Implemented**

please see attached audit sheet that is placed by all refrigerators and freezers. the temperature is audited nightly

103g - Storing Food

1. **Requirements**

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The following food items were opened and unsealed in the main kitchen in the PCH building:
Clear bag of bow tie pasta in the dry food storage area
Clear bag with 2 waffles in bag in the freezer
Clear bag with 5 pieces of breaded fish in the freezer
A 5 pound bag of North Atlantic Sea Clam Meat in the freezer
A clear bag with 6 pieces of bacon in the stainless steel cooler

In addition, the following food items were opened and unsealed in the kitchen in the SDCU building:
Clear bag with 5 waffles in bag in white chest freezer
A 13 ounce bag of potato chips in the dry storage area
A white sleeve of Saltine crackers in the dry storage area

Plan of Correction **Accept**

All items that were not sealed at the time of inspection have been discarded. All staff have been educated in the proper storage of all food in the kitchen. The Dietary staff will audit all food items in the kitchen weekly to ensure that all food is in closed/sealed containers.

Completion Date: *10/11/2021*

Document Submission **Implemented**

kitchen staff audit the freezers and refrigerators weekly to ensure all food is in closed sealed containers. if any items are found not sealed or dated the items are thrown away immediately

162c - Menus Posted

1. **Requirements**

2600.

162c - Menus Posted *(continued)*

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menus for the current week of 9/5/21-9/11/21 and advance week of 9/12/21-9/18/21 were not posted.

Plan of Correction **Accept**

This has been corrected by dietary and the administrator. A new 2 week menus cycle has been posted in the dining room. The daily menu is also posted in the dining room. The menu will be posted for a 2 week time frame each Monday morning by the dietary department. The administrator will check daily to ensure that a 2 week menu has been posted. (please see the attached 2 week menu's)

Completion Date: *10/11/2021*

Document Submission **Implemented**

please see the attached menus

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

Resident #1 is prescribed [redacted], insert 1 suppository rectally every 4 hours as needed for mild pain/fever. However, this medication did not have a label.

Plan of Correction **Accept**

The pharmacy was contacted after the inspection and a new label was received for this medication. All staff have been educated on the requirements for labeling of OTC/CAM medications. The pharmacy will audit the medication cart quarterly and staff will audit daily while passing medications. If any medication does not have a proper label, the pharmacy will be contacted immediately to receive a proper label.

Completion Date: *10/08/2021*

Document Submission **Implemented**

the administrator contacts the pharmacy to audit the med carts quarterly and the staff audit daily while passing medications to ensure that all items are labeled

227g -Support Plan Signatures

1. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident #2's annual support plan, dated 7/6/21, was not signed by the resident and it did not indicate resident was unwilling or unable to sign.

Plan of Correction **Accept**

The resident was unable to sign the support plan. The administrator will audit all support plans immediately and make sure that all either have a signature or have the appropriate indication on if the resident was unwilling to sign or unable to sign. Ongoing the Administrator will review each support plan to make sure that there is either a signature or an appropriate indication if the resident was unwilling to sign or unable to sign

Completion Date: *10/11/2021*

Document Submission **Implemented**

this is part of the resident admission checklist now. please see attached med list

231b - Medical Evaluation

1. **Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] *however, the resident's medical evaluation, signed by the medical provider on* [redacted]*, does not include the date it was completed.*

Resident #2 was admitted to the SDCU on [redacted] *however, the resident's medical evaluation was completed on* [redacted]

Resident #3 was admitted to the SDCU on [redacted]*; however, the resident's medical evaluation was completed on* [redacted]

Plan of Correction **Accept**

Prior to any admission into the SDCU, a checklist will be completed that specifies the requirements for the medical evaluation and the time frame it is to be completed in. This check list will be on all new resident inquiries and resident records. All new admissions going forward will have the medical evaluation completed within 60 days prior to admission. The administrator will audit the medical records of the residents prior to admission going forward from this inspection to ensure the proper regulation is met. (please see attached copy of check list)

Completion Date: *10/08/2021*

Document Submission **Implemented**

this is now part of the resident checklist that is in place for all new admissions to ensure all required documents are completed in timely manner.

231c - Preadmission Screening

1. **Requirements**

2600.

231c - Preadmission Screening *(continued)*

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the SDCU on [redacted]. However, the resident's written cognitive preadmission screening was completed on [redacted].

Resident #3 was admitted to the SDCU on [redacted]. However, the resident's written cognitive preadmission screening was completed on 7[redacted]

Plan of Correction **Accept**

Prior to any admission into the SDCU, a checklist will be completed that specifies the requirements for the pre-admission screening and the time frame it is to be completed in. This check list will be on all new resident inquiries and resident records. All new admissions going forward will have the pre-admission screening completed within 72 hours of admission. The administrator will audit the medical records of the residents prior to admission going forward from this inspection to ensure the proper regulation is met. (Please see attached copy of check list)

Completion Date: *10/08/2021*

Document Submission **Implemented**

please see attached copy of checklist

231e - No Objection Statement

1. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the SDCU on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction **Accept**

A statement has been prepared for the resident's designated person to sign stating that they have no objection to the resident admission or transfer to the secured dementia unit. This statement will be included in a check list for all new admissions going forward. (please see attached statement)

Completion Date: *10/11/2021*

Document Submission **Implemented**

please see attached copy of statement for admission to SDCU

234a - Admission Support Plan

1. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

234a - Admission Support Plan *(continued)*

Description of Violation

Resident #1 was admitted to the SDCU on [redacted]. However, the resident's initial support plan was completed on [redacted].

Resident #3 was admitted to the SDCU on [redacted] However, the resident's initial support plan was completed on [redacted]

Resident #4 was admitted to the SDCU on [redacted]. However, the resident's initial support plan has not been completed.

Plan of Correction **Accept**

Prior to any admission into the SDCU, a checklist will be completed that specifies the requirements for the initial support plan and the time frame it is to be completed in. This check list will be on all new resident inquiries and resident records. All new admissions going forward will have the initial support plan completed within 72 hours of admission. The administrator will audit the medical records of the residents prior to admission going forward from this inspection to ensure the proper regulation is met. (Please see attached copy of check list)

Completion Date: *10/08/2021*

Document Submission **Implemented**

please see attached copy of checklist to be completed upon admission to SDCU