Department of Human Services
Bureau of Human Service Licensing

June 22, 2022

[redacted], COO
[redacted]

RE: PAULA TEACHER & ASSOCIATES
206 SAGERVILLE ROAD
HARRISON CITY, PA, 15636
LICENSE/COC#: 44816

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/23/2022 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: *PAULA TEACHER & ASSOCIATES* **License #:** *44816* **License Expiration:** *08/23/2022*

Address: *206 SAGERVILLE ROAD, HARRISON CITY, PA 15636*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *PAULA TEACHER AND ASSOCIATES INC*

Address: *6149 SALTSBURG ROAD, SUITE 4, VERONA, PA, 15147*

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

Certificate(s) of Occupancy

Type: *R-4* **Date:** *09/21/2016* **Issued By:** *Township of Penn*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *12* **Waking Staff:** *9*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *05/23/2022*

Inspection Dates and Department Representative

05/23/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *10* **Residents Served:** *10*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *7*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *2* **Have Physical Disability:** *1*

Inspections / Reviews

05/23/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/09/2022*

Inspections / Reviews *(continued)*

06/06/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/10/2022*

06/14/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/20/2022*

06/22/2022 - 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

At 12:10 p.m., numerous resident records and resident information were unlocked, unattended and accessible it the staff office, to include the resident records for residents #1 and #2, as well as nursing notes for resident #3.

Plan of Correction ***Accept***

On May 24, 2022 all staff were educated on the confidentiality of Resident Records, keeping conference door locked, and the use of resident records. A sign was placed on the inside of the conference door as a reminder to protect confidentiality. Daily checks by Administrator will be conducted to ensure compliance of regulation. This began May 24. At 1:00 pm during inspection, the office door was closed and locked when not occupied.
Documentation of locked files shall be recorded on Regulation Safety checklist.
Responsible Person: Administrator
Completion Date: *05/24/2022*

Document Submission ***Implemented***

On May 24, 2022 all staff were educated on the confidentiality of Resident Records, keeping conference door locked, and the use of resident records. A sign was placed on the inside of the conference door as a reminder to protect confidentiality. Daily checks by Administrator will be conducted to ensure compliance of regulation. This began May 24. At 1:00 pm during inspection, the office door was closed and locked when not occupied.
Documentation of locked files shall be recorded on Regulation Safety checklist.
Responsible Person: Administrator

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

The influenza poster was not posted in a conspicuous and public place in the home in accordance with the Influenza Awareness Act of July, 2016.

Plan of Correction ***Accept***

Due to recent painting of the interior of the facility, the poster had not yet been re-hung. The influenza posters were immediately replaced in both residential wings of the home and bathrooms.
Beginning June 8, 2022 Administrator shall conduct monthly walk throughs of the facility and document checks on Regulations Safety sheet.
Completion Date: *06/07/2022*

Document Submission ***Implemented***

Due to recent painting of the interior of the facility, the poster had not yet been re-hung. The influenza posters

18 - Compliance With Laws (continued)

were immediately replaced in both residential wings of the home and bathrooms.
Beginning June 8, 2022 Administrator shall conduct monthly walk throughs of the facility and document checks on Regulations Safety sheet.

42l - Personal Clothing

1. Requirements

2600.
42.l. A resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

For approximately the past 2 months, nearly all of resident #3's personal clothing has been locked in the staff office. Resident #3 only has access to minimal items of personal clothing in his bedroom, to include 2 shirts, a few pair of underwear and socks.

Plan of Correction ***Accept***

Staff immediately moved resident's clothing back into his room on 5/23/2022. Following the license visit, all staff were reminded of the requirement of 2600.42.1. All Staff will review Resident Rights by June 12, 2022.
Corrective actions will be monitored to ensure the deficiency does not reoccur: Beginning June 11, 2022, Administrator, Program Coordinator, or Admin Assistant will conduct random checks weekly for 3 months. If 100% compliance is achieved at that time, checks can be discontinued, unless a new resident moves in. Then checks will be conducted for that individual using same criteria.
Note: All other residents in the home have possession of their belongings in their room at the time of inspection.
Responsible Person: Program Coordinator
Completion Date: *06/06/2022*

Document Submission ***Implemented***

Staff immediately moved resident's clothing back into his room on 5/23/2022. Following the license visit, all staff were reminded of the requirement of 2600.42.1. All Staff will review Resident Rights by June 12, 2022.
Corrective actions will be monitored to ensure the deficiency does not reoccur: Beginning June 11, 2022, Administrator, Program Coordinator, or Admin Assistant will conduct random checks weekly for 3 months. If 100% compliance is achieved at that time, checks can be discontinued, unless a new resident moves in. Then checks will be conducted for that individual using same criteria.
Note: All other residents in the home have possession of their belongings in their room at the time of inspection.
Responsible Person: Program Coordinator

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

At 12:10 p.m., numerous materials with a manufacturer's labels indicating "If swallowed, get medical help or contact poison control center", were unlocked, unattended and accessible in the staff office, to include the following:
• A 3.63 liter can of [redacted] *white paint, approximately 3/4 full*

82c - Locking Poisonous Materials (continued)

• A 3.63 liter can of Sherwin William Cashmere white paint, approximately 1/4 full
• A 3.63 liter can of Emerald extra white paint, approximately 1/2 full

Not all the residents of the home, including resident #3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept***

Maintenance was called to remove all of paint. Maintenance removed the substances to a locked area in the attic. Beginning June 11, 2022, Weekly checks of the presence of poisonous materials by the shall be made and documented on Safety Form utilized by the Safety Committee, in addition to the PCH Regulations Safety Checklist. Staff was retrained on poisonous substances on June 7, 2022, and will be assisting in the weekly walk throughs., notifying Administrator of safety issues.
Responsible Person: Administrator
Completion Date: *06/07/2022*

Document Submission ***Implemented***

Maintenance was called to remove all of paint. Maintenance removed the substances to a locked area in the attic. Beginning June 11, 2022, Weekly checks of the presence of poisonous materials by the shall be made and documented on Safety Form utilized by the Safety Committee, in addition to the PCH Regulations Safety Checklist. Staff was retrained on poisonous substances on June 7, 2022, and will be assisting in the weekly walk throughs., notifying Administrator of safety issues.
Responsible Person: Administrator

103d - Storing Food Off Floor

1. Requirements

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

Description of Violation

At 10:23 a.m., 8 one-gallon jugs of water were stored on the floor in the closet near the living room.

Plan of Correction ***Accept***

The gallons of water are distilled, and used for one resident's c-pap machine. During inspection, staff did relocate the 8 gallons on the shelf above the floor in the storage closet. Weekly checks will be made to ensure that these remain off the floor.
See Safety checklist.

Completion Date: *05/23/2022*

Document Submission ***Implemented***

The gallons of water are distilled, and used for one resident's c-pap machine. During inspection, staff did relocate the 8 gallons on the shelf above the floor in the storage closet. Weekly checks will be made to ensure that these remain off the floor.
See Safety checklist.

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 10:20 a.m., no thermometer was present in the commercial kitchen freezer. A thermometer was added to the freezer; however, at 1:00 p.m., it measured 10 degrees Fahrenheit.

Plan of Correction ***Accept***

Upon investigation of the freezer temperature, staff was instructed to check the breaker, since this had been a problem 2 weeks prior when SmartCare was called out for emergency repair. The breaker was reset immediately and temperature lowered and maintained proper temp throughout the day. An electrician was called and scheduled to come to the facility the next day. The freezer was repaired and breaker updated the to accommodate the power required by the freezer. By June 11, 2022, staff will have been reeducated on checking the temperatures of the equipment. Twice per day checks have always been recorded of both freezer and refrigerator.
Administrator will be responsible for daily review of the documentation.
See attached.

See attached invoice.
Completion Date: *06/07/2022*

Document Submission ***Implemented***

Upon investigation of the freezer temperature, staff was instructed to check the breaker, since this had been a problem 2 weeks prior when SmartCare was called out for emergency repair. The breaker was reset immediately and temperature lowered and maintained proper temp throughout the day. An electrician was called and scheduled to come to the facility the next day. The freezer was repaired and breaker updated the to accommodate the power required by the freezer. By June 11, 2022, staff will have been reeducated on checking the temperatures of the equipment. Twice per day checks have always been recorded of both freezer and refrigerator.
Administrator will be responsible for daily review of the documentation.
See attached.

See attached invoice.

103g - Storing Food

1. Requirements

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

Description of Violation

At 10:22 a.m., an open and unsealed bag of Gultino pretzel sticks, which was approximately 3/4 full, was present on the shelf in the dry storage room.

103g - Storing Food *(continued)*

Plan of Correction ***Accept***

Cook immediately removed the pretzels from the open bag and placed them in a resealable plastic bag, labeled and dated. . Staff was re-educated on the proper storage of open containers of food. To identify other storage deficiency, a 100% audit of all dry storage was conducted on 6/7/2022 by kitchen supervisor. Effective June 13, 2022, overnight staff will conduct weekly audits of dry storage for a period of 6 months. Findings of audits will be presented to kitchen supervisor and cook, who will review findings monthly. If, at the end of 3 months 100% accuracy is achieved, audits will be discontinued.
Overnight staff will be responsible for weekly inspection of all food items in the kitchen and 2 pantries. Checklists will be posted in all of those areas for initials of staff.
Responsible person: Kitchen chef
Completion Date: *06/07/2022*

Document Submission ***Implemented***

Cook immediately removed the pretzels from the open bag and placed them in a resealable plastic bag, labeled and dated. . Staff was re-educated on the proper storage of open containers of food. To identify other storage deficiency, a 100% audit of all dry storage was conducted on 6/7/2022 by kitchen supervisor. Effective June 13, 2022, overnight staff will conduct weekly audits of dry storage for a period of 6 months. Findings of audits will be presented to kitchen supervisor and cook, who will review findings monthly. If, at the end of 3 months 100% accuracy is achieved, audits will be discontinued.
Overnight staff will be responsible for weekly inspection of all food items in the kitchen and 2 pantries. Checklists will be posted in all of those areas for initials of staff.
Responsible person: Kitchen chef

132a - Monthly Fire Drill

1. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

No fire drill was conducted in January, 2022.

Numerous staff persons were notified in advance of the fire drill that was held on 5/22/22 at 3:40 a.m.

Plan of Correction ***Directed***

The facilitator of the fire drill was retrained on the regulation of unannounced drills to staff and residents. Staff who refused to assist in the designated fire drill was written up and educated on the abilities of the overnight staff who conducts the drills.
All previous months there were fire drills performed; however due to the inclement weather in January, 2022, and for the safety of the residents, administrator did not perform one that month. Going forward, fire drills will be done early in the month and/or during safer weather conditions. All monthly fire drills are documented on the DHS Fire Drill Record, and will be continued monthly. There is no end date.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the fire drill records monthly to ensure an unannounced fire drill is held at least monthly. LM 6/14/22

132a - Monthly Fire Drill (continued)

Completion Date: *06/06/2022*

Document Submission ***Implemented***

The facilitator of the fire drill was retrained on the regulation of unannounced drills to staff and residents. Staff who refused to assist in the designated fire drill was written up and educated on the abilities of the overnight staff who conducts the drills.
All previous months there were fire drills performed; however due to the inclement weather in January, 2022, and for the safety of the residents, administrator did not perform one that month. Going forward, fire drills will be done early in the month and/or during safer weather conditions. All monthly fire drills are documented on the DHS Fire Drill Record, and will be continued monthly. There is no end date.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the fire drill records monthly to ensure an unannounced fire drill is held at least monthly. LM 6/14/22

132d - Evacuation

1. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

All residents were evacuated outside the building in 4 minutes, 56 seconds during the fire drill held on 5/22/22 at 3:40 a.m.; however, the maximum evacuation time indicated in writing by the fire safety expert on 9/24/21 is 4 minutes.

Plan of Correction ***Directed***

The individual with mobility needs will have a wheelchair in [redacted] room for fire drill use. Staff will be instructed to use the w/c to evacuate resident in a safe and expedited manner.
Verbal order by physician will be followed by a written order to keep in resident's file. This order will state that a w/c to be used in fire drills due to gait deficiency. Staff will be educated by June 11, 2022 on the fire drill procedure for this resident. Evacuation times will be recorded monthly and reviewed by the trainers. (DIRECTED: Documentation of the staff education shall be kept. LM 6/14/22).

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the home's fire drill records monthly to ensure all residents evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. If all residents are unable to evacuate within the time specified by the fire safety expert, another unannounced fire drill shall be conducted within 5 calendar days. Documentation of all fire drills shall be kept. LM 6/14/22

Completion Date: *06/06/2022*

132d - Evacuation *(continued)*

Document Submission ***Implemented***

The individual with mobility needs will have a wheelchair in [redacted] room for fire drill use. Staff will be instructed to use the w/c to evacuate resident in a safe and expedited manner.
Verbal order by physician will be followed by a written order to keep in resident's file. This order will state that a w/c to be used in fire drills due to gait deficiency. Staff will be educated by June 11, 2022 on the fire drill procedure for this resident. Evacuation times will be recorded monthly and reviewed by the trainers. (DIRECTED: Documentation of the staff education shall be kept. LM 6/14/22).

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the home's fire drill records monthly to ensure all residents evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. If all residents are unable to evacuate within the time specified by the fire safety expert, another unannounced fire drill shall be conducted within 5 calendar days. Documentation of all fire drills shall be kept. LM 6/14/22
On June 19, 2022 an unannounced fire drill was done. The evacuation time was 1 minute and 58 seconds. All residents evacuated. A wheel chair was used to assist resident in room #7.

162c - Menus Posted

1. Requirements

2600.
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 menu posted in a conspicuous and public place ended on 5/28/22.

Plan of Correction ***Accept***

Kitchen supervisor immediately printed a menu for the week following, date ending June 4, 2022, and posted it.
Effective June 6, 2022, the kitchen supervisor will audit posted menus for compliance weekly for 12 weeks, utilizing checklist. Kitchen supervisor will report audits to Administrator monthly.
If 100% compliance is reached at this time, audits will be discontinued.
Responsible Person: Administrator
Completion Date: *06/06/2022*

Document Submission ***Implemented***

Kitchen supervisor immediately printed a menu for the week following, date ending June 4, 2022, and posted it.
Effective June 6, 2022, the kitchen supervisor will audit posted menus for compliance weekly for 12 weeks, utilizing checklist. Kitchen supervisor will report audits to Administrator monthly.
If 100% compliance is reached at this time, audits will be discontinued.
Responsible Person: Administrator

185a - Implement Storage Procedures

1. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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.

Description of Violation

Resident #2's glucometer was not set to the current date and time.

Plan of Correction ***Accept***

*(**Violation states that it was room #2's glucometer. The reference was for room [redacted]) Resident#6 glucometer was calibrated at the time of monitoring. All staff were re-educated by LPN on glucometer usage and calibration on June 6. A medication cart audit on 6/6/2022 found no other deficiencies. Beginning June 11, 2022, Medication cart will be audited by facility LPN and documented on audit form. Facility LPN will report the findings to Program Coordinator and Administrator for any additional monitoring or adjustments. Additionally, any newly arrived medical equipment will be inspected by LPN.*

Completion Date: *06/06/2022*

Document Submission ***Implemented***

*(**Violation states that it was room #2's glucometer. The reference was for room [redacted]) Resident#6 glucometer was calibrated at the time of monitoring. All staff were re-educated by LPN on glucometer usage and calibration on June 6. A medication cart audit on 6/6/2022 found no other deficiencies. Beginning June 11, 2022, Medication cart will be audited by facility LPN and documented on audit form. Facility LPN will report the findings to Program Coordinator and Administrator for any additional monitoring or adjustments. Additionally, any newly arrived medical equipment will be inspected by LPN.*