Department of Human Services
Bureau of Human Service Licensing

October 21, 2022

[redacted]
MOUNTAIN VIEW MEMORY CARE LLC
[redacted]

RE: MOUNTAIN VIEW MEMORY CARE
711 ROUTE 119
GREENSBURG, PA, 15601
LICENSE/COC#: 45377

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/30/2022, 08/31/2022 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

October 4, 2022

[redacted]
MOUNTAIN VIEW MEMORY CARE LLC
[redacted]

RE: MOUNTAIN VIEW MEMORY CARE
711 ROUTE 119
GREENSBURG, PA, 15601
LICENSE/COC#: 45377

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 08/30/2022, 08/31/2022 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations 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: *MOUNTAIN VIEW MEMORY CARE* **License #:** *45377* **License Expiration:** *06/22/2023*

Address: *711 ROUTE 119, GREENSBURG, PA 15601*

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

Administrator

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

Legal Entity

Name: *MOUNTAIN VIEW MEMORY CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/13/2006* **Issued By:** *Hempfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *84* **Waking Staff:** *63*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date:** *08/31/2022*

Inspection Dates and Department Representative

08/30/2022 - On-Site: [redacted]

08/31/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served:** *42*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire Home* **Capacity:** *80* **Residents Served:** *42*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *42*

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

Have Mobility Need: *42* **Have Physical Disability:** *0*

Inspections / Reviews

08/30/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/23/2022*

Inspections / Reviews *(continued)*

10/04/2022 - POC Submission

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

10/21/2022 - Document Submission

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

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 A does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept***

Immediate:
• Obtained proof of education from DCS A.
• Audit of all DCS staff files by Director of Human Resources
o One missing and obtained.
Action plan:
• Education completed: The need for proof of education (High School Diploma) at time of hire for all DCS. Policy updated to include sign off by Administrator.
Implementation:
• Vice President of Operations to educate Director of Human Resources and Administrative Assistant on regulation.
• Administrator will review all new DCS hires for a period of 3 months and quarterly thereafter.
Timeline:
• Education completed: 9/14/2022
• Audit completed: 9/14/2022
• New DCS hires from: 9/1/2022 – 12/31/2022

Completion Date: *09/28/2022*

Document Submission ***Implemented***

Attached:
DCS - A Diploma
HR Audit
Staff Education
New Hire Checklist

85d - Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/30/22, the following trash can did not have a lid:

* *the bathroom in the main dining room.*
* *the bathroom at the beginning of hallway #200.*
* *the bathroom in the 200 wing common room.*
* *the bathroom in the 300 wing common/dining room.*

85d - Trash Receptacles (continued)

* the bathroom in the 500 wing common room.

Plan of Correction ***Accept***

Immediate:
• All areas noted to have trash cans with lids at the time of inspection.
• New trash cans researched and ordered for all areas (picture of trash receptacles of choice)
Action plan:
• Trash cans to be replaced with foot peddle trash cans in order to maintain compliance.
• Weekly walk through by Administrator or Designee to assure trash cans are properly placed and compliance is maintained to prevent the penetration of insects and rodents.
Implementation:
• Education to all staff
• Environmental Services team specifically educated to check and report if trash cans are missing lids or are in need of replacement. Work order to be placed if and when needed.
• Documented weekly walk throughs by Administrator or designee for 3 months starting 10/5/2022
Timeline:
• Trash cans set for delivery: 10/5/2022
• Education scheduled for 10/5/2022 (Monthly all staff)

Completion Date: *10/05/2022*

Document Submission ***Implemented***

Attached:
Trash Receptacle Audit
Picture New Trash Cans
Staff Education

85e - Trash Outside Home

1. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

The lid on the right side of the dumpster was open on 8/30/22 at approximately 2:05 pm.

Plan of Correction ***Accept***

Immediate:
• Dumpster lids closed immediately at time of inspection.
• Sign posted on outside dumpsters to remind all to keep the dumpster lid closed.
Action plan:
• Weekly walk through by Administrator or Designee to assure outside trash cans are properly closed and compliance is maintained to prevent the penetration of insects and rodents.
• All staff education on the importance of dumpster lids closed when not in use.
Implementation:
• Education to all staff

85e - Trash Outside Home (continued)

• Environmental Services team specifically educated to check and report to the Administrator if trash cans are not closed properly.
• Documented weekly walk throughs by Administrator or designee for 3 months starting 10/5/2022
Timeline:
• Trash cans set for delivery: 10/5/2022
• Education scheduled for 10/5/2022 (Monthly all staff)

Completion Date: *10/05/2022*

Document Submission ***Implemented***

Attachments:
Trash Receptacle Audit
Dumpster Pictures
Staff Education

92 - Windows

1. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 8/30/22 at approximately 2:45 pm, an area of the screen measuring approximately 10" x 8" was detached from the frame on the window in the right side of the common room, at the end of hallway #200.

Plan of Correction ***Accept***

Immediate:
• Screen replaced by the environmental services team
• All screens checked by environmental services (3 replaced)
Action plan:
• Weekly walk through by Administrator or Designee to assure all community screens are attached properly and without damage.
Implementation:
• Education to all staff
• Housekeeping team specifically educated by Administrator to observe and report when cleaning in the event screens are found out of placed or damaged.
• Documented weekly walk throughs by Administrator or designee for 3 months starting 10/5/2022
Timeline:
• Weekly walkthroughs to start 10/5/2022
• Education scheduled for 10/5/2022 (Monthly all staff)
Attachments:
• Education
• Picture of fixed screen

Completion Date: *10/05/2022*

92 - Windows *(continued)*

Document Submission ***Implemented***

Attachments:
Education
Picture of fixed screen
Walk Through Audit

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The door on the clothes closet in bedroom #305 was completely detached and leaning against the bedroom wall.

Plan of Correction ***Accept***

Immediate:
• Closet door removed from resident room and replaced.
• All closet doors checked by environmental services (2 replaced)
Action plan:
• Weekly walk through by Administrator or Designee to assure all closet doors are attached properly attached and without damage
Implementation:
• Education to all staff
• Housekeeping team specifically educated by Administrator to observe and report when cleaning in the event closet doors are found out of placed or damaged.
• Documented weekly walk throughs by Administrator or designee for 3 months starting 10/5/2022
Timeline:
• Weekly walkthroughs to start 10/5/2022
• Education scheduled for 10/5/2022 (Monthly all staff)

Completion Date: *10/05/2022*

Document Submission ***Implemented***

Attachments:
Education
Picture of fixed closet door
Walk Through Audit

101c - Bedroom Mobility Needs

1. Requirements

2600.

101c - Bedroom Mobility Needs *(continued)*

101.c. Each bedroom for one or more residents with a mobility need must have at least 100 square feet per resident, to allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space. A legal entity with a personal care home license for the home as of October 24, 2005, that has one or more bedrooms serving a resident with physical mobility needs as of October 24, 2005, shall be exempt from the requirements specified in this subsection for the bedroom. If a bedroom is exempt in accordance with this subsection, additional square footage may be required sufficient to accommodate the assistive devices of the resident with mobility needs.

Description of Violation

Two residents with physical mobility needs share bedroom #[redacted] A Broda chair, a Hoyer lift, and a Sit To Stand device are used in this room. The room measures 186 square feet, and 100 square feet per resident is required.

The home does not have a medical order from the attending physician that states the residents can maneuver without the necessity of the additional space.

Plan of Correction ***Accept***

Immediate:

• Resident moved to another room to meet the requirement due to mobility/equipment needs

• All residents reviewed for mobility/equipment needs

o 2 residents moved to accommodate mechanical lifts

Action plan:

• All noted equipment for residents will be documented with indication of equipment needs listed on face sheet and care plan.

• Residents that require extra equipment (specialized wheelchair, mechanical lift) will be assessed and assigned a room that meets the 100 square foot requirement.

Implementation:

• Resident Care Coordinator will be responsible to tracking equipment and use. Physician will be consulted in the event a resident is in need of special equipment. Documentation will be kept.

• Resident Care Coordinator will report to Director of Clinical Services any changes in equipment needs.

• Administrator or designee will do a weekly walk through to check equipment for each resident and make changes as needed to meet the requirement.

Timeline:

• Weekly walkthroughs to start 10/5/2022

• Education scheduled for 10/5/2022 (Monthly all staff)

Completion Date: *10/05/2022*

Document Submission ***Implemented***

Attachments:

Education

Bedroom Mobility Audit

Weekly Walk Through

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:

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

Description of Violation

Resident #1 is prescribed Lantus Solostar 100 u/ml pen, inject 50 units subcutaneously at bedtime. The pharmacy label on resident #1's indicates these instructions, however, also includes instructions for administration for the resident's Lispro 100 u/ml pen. The Lispro pen instructions are to inject subcutaneously 10 units 3 times daily before meals and sliding scale 3 times daily at meals and bedtime: 70 - 150=0 units; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 15 units; above 400 = 18 units and call MD.

Plan of Correction ***Accept***

Immediate:
• Change of Direction sticker added to label at the time of inspection
• New labels ordered from pharmacy
• Cart audit completed with a focus on labels matching MAR (4 stickers noted to be applied)
Action plan:
• Resident Care Coordinator will audit weekly to review that all pharmacy labels match the MAR.
• Director of Clinical Services will review monthly, specifically noting new orders for the month. Report to be pulled from EMAR system to show new orders.
• Pharmacy will preform routine quarterly audits with written reports for all issues noted.
Implementation:
• Education to all med techs: noting order changes and process to assure labels are matching MD orders and EMAR.
• Administrator will sign off monthly that audits are completed monthly.
• Resident Care Coordinator and Director of Clinical Services will report any discrepancies to the Administrator immediately for further intervention and education.
• Formal request to the pharmacy to send new labels for orders changed for all insulins and other treatments with ongoing changes.
• Vice President of Operations will oversee pharmacy and Administrator follow through.
Timeline:
• Weekly Audits started 9/14/2022
• Verbal education 9/14/2022
• Formal education 10/5/2022

Completion Date: *10/05/2022*

Document Submission ***Implemented***

Attachments:
Education
Weekly Audit
Example of redline report