pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: MARCH 15, 2023

[redacted]
Monarch Meadow LLC
490 Coolspring Street
Uniontown, Pennsylvania 15401

RE: Monarch Meadow
490 Coolspring Street
Uniontown, Pennsylvania 15401
License/COC #: 449441

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 8, 2022, September 9, 2022, September 13, 2022, and November 21, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 449 0) dated March 7, 2023 – March 7, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from March 15, 2023 to September 15, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *MONARCH MEADOW* **License #**: *44944* **License Expiration**: *03/07/2023*

Addre : *490 COOLSPRING STREET, UNIONTOWN, PA 15401*

County: *FAYETTE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MONARCH MEADOW LLC*

Address: *490 COOLSPRING STREET, UNIONTOWN, PA, 15401*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/20/1997* **Issued By**: *L&I*

Type: *Other* **Date**: *11/30/2020* **Issued By**: *North Union Twp.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *40* **Waking Staff**: *30*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *11/21/2022*

Inspection Dates and Department Representative

11/21/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

11/21/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/10/2022*

12/12/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/21/2022*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/16/2022*

12/16/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/21/2022*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/01/2023*

01/04/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/21/2022*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, whose first day of work was [redacted], did not receive training on any topics specified in 2600.65d(3), to include safe management techniques and personal hygiene. Also, direct care staff person A did not successfully complete and pass the Department-approved direct care training course and pass the competency test. Direct care staff person A provided unsupervised ADL services to numerous residents on numerous dates and times, to include the 10:30 PM to 7:00 AM shift from 11/6/22 through 11/9/22.

Plan of Correction ***Accept ([redacted] - 12/12/2022)***

Correction to above Description for Direct care staff person A- first day of work was on [redacted]. Hire date was [redacted], first day of work was 4[redacted].

Direct care staff person A did have initial direct care training on 4/2/2022. This education was documented on the facility form indicating this training and was in employee file. This documented form was provided via email to [redacted] on 12/2/2022.

WHY DID IT HAPPEN? The facility did not have a new hire training policy and procedures manual in place, nor a new hire checklist prior to exit interview on 9/13/2022. After exit interview on 9/13/2022, the facility developed a New Hire Policy and Procedures Manual, as well as a New Hire Checklist, and started to implement this. The New Hire Checklist, as well as the Policy and Procedures Manual was provided to the department in the POC dated 11/6/2022.

During this time, it was discovered that that direct care staff person A did not have the Department-approved direct care training course and had not passed the competency test. The administrator, as well as the office manager, was

65d - Initial Direct Care Training (continued)

perusing direct care staff person A to complete the Department-approved direct care training course. Due to staffing shortages, the administrator was unable to suspend Direct care staff person A until the department-approved direct care training course with passing competency test was obtained. Another inspection was conducted by DHS, and this was cited before direct care staff person A was able to complete the department-approved direct care course with passing competency test. Direct care staff person A also provided unsupervised ADL services to numerous residents - the employee may not provide unsupervised ADL services until completion of the following:
Training that includes a demonstration of job duties, followed by supervised practice. This happened due to a lack of having a checklist/sign off sheet, which is now the New Hire Checklist.

WHAT DID WE DO RIGHT NOW TO FIX THE PROBLEM? On 9/15/2022, all employee files were reviewed by administrator and office manager. Facility has implemented a new hire policy which is explained to all new hires on the day they are hired. This policy was implemented on 9/15/2022 and has been given to all new hires since mplementation on 9/15/2022. Direct care staff person A took the 6-hour department approved direct care course and competency test and completed it with a passing score on 11/30/2022.

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN? The facility has taken the following action: the facility has continued to implement the New Hire Policy and Procedure Manual and New Hire Checklist that was created on 9/15/2022 for every new employee hired at facility. In this checklist, that was provided to the department in the last POC dated 11/6/2022, the checklist is broken down into sections. The checklist details working unsupervised. The Direct Care Staff Person may not provide unsupervised ADL services until completion of training that includes a demonstration of job duties, followed by supervised practice. The facility has reviewed every staff chart to ensure all requirements are present. These charts were reviewed and signed off by the administrator and office manager. This was done on 9/15/2022 and again on 11/26/2022. On 11/26/2022, all management who hire staff were trained on the new hire policy and procedures, as well as the requirements regarding regulation 2600.65.

Licensee's Proposed Overall Completion Date: *12/10/2022*

Not Implemented [redacted] - 1/4/2023 *)*

132a - Monthly Fire Drill

2. Requirements

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

Description of Violation

An unannounced fire drill was not conducted in September, 2022.

Plan of Correction ***Accept*** [redacted] ***- 12/16/2022)***

WHY DID IT HAPPEN? The facility has not had a reminding system of checks and balances, including monthly fire drills.

WHAT DID WE DO RIGHT NOW TO FIX THE PROBLEM? Look for a reminding system to prevent occurrences from happening.

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN? After looking into this oversite and violation, the facility has determined that moving forward a reminding system is needed to prevent any oversites or violations similar to this to occur again in the future. On 12/5/2022, The facility started to utilize a part of the Senior Living Software,

132a - Monthly Fire Drill (continued)

(Tabula Pro), that we didn't use, which allows us to add alert reminders. These alert reminders will appear every time the administrator signs onto the Senior Living Software Program. The Senior Living Software Program (Tabula Pro) is used by administrator daily. This alert reminder, once attached to any task, will not go away until the task is completed. The alert reminders for fire drills have been added to every month. This was completed on 12/ 5/2022.
The facility has also created a monthly fire drill list on 12/5/2022. This list will be posted in the facility and will show the date every month the fire drill was completed, this list will only be documented after the unannounced fire drill has been completed. This list is not a posting telling when a drill is going to be done, it is posted to document when a drill was completed. The administrator is the only person who will know when a drill will happen. This list will be signed off and initialed by the administrator after the staff have completed the fire drill.
The facility has also implemented another reminding system called "Keep and Share". This program can be used on the computer or phone to receive emails and text message reminders when a task is due. Monthly fire drills have been added to all administrators' Keep and Share calendar.
A copy of the 2023 Calendar Year, which displays all planned reminders to date, and a copy of the monthly fire drill list, which is posted in the facility in the administrator office, and office manager's office, will be provided to the department in the next step of the POC.

Licensee's Proposed Overall Completion Date: *12/15/2022*

Not Implemented ([redacted] - 1/4/2023 ***)***

132c - Fire Drill Records

3. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 10/3/22 does not include the time of the fire drill, the amount of time it took for evacuation, the exit routes used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and if the fire alarm or smoke detector was operative.

Plan of Correction ***Directed*** [redacted] ***- 12/16/2022)***

WHY DID THE VIOLATION HAPPEN? The facility failed to get the fire chief to fill out the appropriate fire drill form, including the time of the fire drill, exit routes, number of residents in the home at the time of the fire drill, number of residents evacuated, the number of staff persons participating, problems encountered, and if the alarm or smoke detector was operative.

WHAT DID WE DO RIGHT NOW TO FIX THE PROBLEM? The PCH called the North Union Fire Chief to fill out the

132c - Fire Drill Records (continued)

department-specific fire drill record that the facility failed to have him complete on the date the unannounced fire drill (10/3/2022) was completed. On 12/7/2022, the Fire Chief of North Union stopped by PCH and completed the Department-approved form, along with signing the bottom of the form to confirm this was the correct information. This form will be given to the department in the next step of the POC. On 12/7/2022,

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN? The facility has started to utilize a couple of safeguards reminding systems. The first system is Senior Living Software (Tabula Pro) that the facility has been using for two years. In this software, it allows you to create a reminder calendar for weekly, bi-weekly, tri-weekly, monthly, annually, every two months, every three months, every six months, for all regulatory requirements. The facility also has started a program called, "Keep and Share". This program is similar but will send notifications to the administrator's phone and email when requirements are due. This reminder will continue until the task is completed and will send to administrator phone or email. The administrator has ensured that all appropriate department forms 2600.132 (c) [fire drill record]) is available and copies of this form are ready to use for monthly, unannounced fire drills. These forms have been put in back of the monthly fire drill binder in the administrator's office. Pictures of this binder, forms, and copies of new reminder calendars for 2023 calendar year will be provided to the department in the next step of the POC. A 2nd staff person [redacted] and co-owner) will review the fire drill record withing 48 hours of completion of the monthly fire drills to ensure the logs are completed in their entirety. (DIRECTED: The second review of monthly fire drill records shall begin on 1/1/23 [redacted]/16/22).

Directed Completion Date: *01/01/2023*

Not Implemented ([redacted] - 1/4/2023)

141b1 - Annual Medical Evaluation

4. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]

Resident #2's most recent medical evaluation was completed on [redacted]

Resident #3's most recent medical evaluation was completed on [redacted].

Resident #7's most recent medical evaluation, dated [redacted] indicates "see attached" under the medication addendum; however, the attached list is resident #7's May 2022 medication administration record (MAR).

Plan of Correction ***Accept[redacted] - 12/12/2022)***

WHY DID THE VIOLATION HAPPEN? The facility did not have a reminding system in place.

141b1 - Annual Medical Evaluation (continued)

WHAT DID WE DO RIGHT NOW TO FIX THE PROBLEM?
On 11/29/2022, all resident charts were reviewed. All DME's were updated, and medications were reviewed by RN and CRNP. New DME's were placed in charts to replace old DME's. Resident #1, #2, #3, #7 DMEs were updated, and medications were reviewed by RN and CRNP and finalized on 11/29/2022. A copy of these DME's will be provided to the department in the next step of the POC.

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN? The facility has started to utilize an alert reminding system on the Senior Living Software (Tabula Pro) used at the facility. All resident DME yearly due dates were added into the program, and attached to a reminder alert on 12/5/2022. Starting on the month a DME is due to update, the program will alert and continue every day of the month to alert management, until the DME is completed. This will ensure all management using the Senior Living Software (Tabula Pro) are aware a DME is due to be updated. The facility also added a new program to remind all management of regulatory due dates. This program is "Keep and Share". This program can be used on an App on a phone. It can send texts and emails to alert all management that a DME is due to update. These alerts will continue until the task is completed. The facility believes with the addition of both of these safeguards, it will prevent further violations of regulation 2600.141. To ensure all medications are added and all medications match date of DME, the facility is having the medical provider (CRNP) and RN to write all medications on DME. The day the DME is completed, both RN and CRNP will review the medications and sign off, ndicating the medications were reviewed. A copy of the 2023 reminder calendar showing all reminders for DMEs, fire drills, and RASPs will be provided to the department in the next step of the POC.

Licensee's Proposed Overall Completion Date: *12/10/2022*

Not Implemented [redacted] 1/4/2023 ***)***

185a - Implement Storage Procedures

5. Requirements

2600.
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

The glucometers for residents #4, #5 and #6 are not set to the current time.

On 11/18/22 at approximately 12:50 PM, resident #4's blood sugar was 347; however, resident #4's blood sugar was documented as 346 on resident #4's November 2022 MAR.

Resident #4's November 2022 MAR indicates a blood sugar reading of 91 on 11/18/22 at approximately 8:00 AM; however, this reading is not present on resident #4's glucometer.

Plan of Correction ***Accept*** [redacted] ***- 12/16/2022)***

WHY DID THE VIOLATION HAPPEN? The facility failed to emphasize in the medication administration training that the date and time on the glucometer needed to be accurate.
Staff were incorrectly documenting readings on the MAR and were not looking at the blood glucose machine.
On 11/22/2022, administrator and RN searched history on all glucometers for all residents at facility to see if they could find a reading of 91 on a glucometer. We were unable to find any reading of 91. Because of this, we believe that staff recorded a false blood sugar reading in order to pass to another screen on the electronic MAR.

185a - Implement Storage Procedures (continued)

WHAT DID WE DO RIGHT NOW TO FIX THE PROBLEM?
on 11/22/2022, all glucometers were checked for date and time. Residents #4, #5, and #6 glucometers date and time were all fixed and updated. The glucometer reading for resident #4 that was accidentally recorded on MAR on 11/18/2022 (reading of 347 was recorded as 346) was corrected on the MAR and noted why it was incorrect by the administrator on 11/22/2022.
On 11/22/2022, all staff who administer medications at the facility were educated on the importance of recording every glucometer reading exactly the same on the MAR as it is listed on the glucometer, and the importance of recording every glucometer reading that is taken on every resident in the facility's care a copy of this education will be put in all staff who administer medications employee file. On 11/22/2022, the facility started educating all staff who administer medications on the importance of not recording a false glucometer reading a copy of this education will be put in all staff who administer medications employee file.

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN? Since the exit interview, the administrator has ncorporated emphasizing in the medication administration training course that the date and time on the glucometer needs to be accurate. This was started to be incorporated into the medication training on 12-6-2022 and 12-9-2022, with staff who were trained by administrator in the medication administration course and will continue every future staff trained in the DHS approved medication administration course at facility. This is the first staff trained in the DHS approved medication administration course since exit interview on 11-21-22. A copy of all staff education and documentation for all education are kept in employee file at facility, it is also scanned onto the senior iving software (Tabula Pro) at facility for electronic storage. All staff at facility have an electronic employee file on the facilities senior living software (Tabula Pro). The administrator is the medication instructor for the facility. Although he understands staff cannot perform diabetic care before they receive the proper diabetic education training, he emphasizes in his training that this has been an issue in the past. He reviews the risks of sharing glucometers-no sharing glucometers, to ensure the correct date and time on each glucometer, and the importance of not recording false readings. When staff are able to do diabetic care, they must keep this in mind. It is Monarch Meadow's policy to train all potential staff in house on medication pass administration, even if they have a medication certificate present. The administrator has promoted a direct care medication administrator to be the Medication Room Supervisor on 11/23/2022 to oversee medications and all glucometers. This position audits all glucometer readings weekly against what is documented in the MAR and checks the time and date on all glucometers weekly. The medication room supervisor will note at the top of the audit page if the time and date were correct or if they needed changed at the time of audit. If the time or date was incorrect it will be corrected, and the administrator will be notified. The medication room supervisor will also be responsible for changing the time when daylight savings time occurs. The first audit was done on 11/24/2022 and was reviewed by administrator at that time. If discrepancy is found on any audit the administrator will follow the Monarch Meadow medication error policy. All readings (audits) that are taken to the administrator for review and are kept in administrators office, these readings (audits) will be kept for a period of six months. The readings will be disposed of according to facilities medical records policy. All medication administrators at Monarch Meadow will receive a six-month condensed education refresher on the risks of sharing glucometers-no sharing glucometers, to ensure the correct date and time on each glucometer, and the importance of not recording false readings. This will be documented on a staff training record and will be a recorded in each medication administrator's employee file and also scanned into Senior Living Software (Tabula Pro) at the facility. There will be a reminder alert added to facilities Senior Living Software (Tabula Pro) and also in the facilities new reminding system "Keep and Share". This will ensure that the refresher will be done for all medication administrator's every 6 months. A copy of the calendar will be provided to the department in the

185a - Implement Storage Procedures (continued)

next step of the POC. The facility has purchased over 100 post it notes on 11/24/22 to make available for staff doing medication administration at facility. These post it notes are to be used by staff to write down glucometer readings during medication administration, so staff do not forget before recording the glucometer reading EMAR. These post it notes are then shredded after med pass is over, there is a shredder in the medication room. The post it notes are kept n the med room for any medication administrator to get.

Licensee's Proposed Overall Completion Date: *12/16/2022*

Not Implemented [redacted] - 1/4/2023)

225c - Additional Assessment

6. Requirements

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

Description of Violation

Resident #3's most recent assessment was completed on [redacted]

Plan of Correction ***Accept*** [redacted] ***- 12/16/2022)***

WHY DID THE VIOLATION HAPPEN? The facility believes this oversight was caused from not having a reminder system in use. Note: facility has only been in operation 4 years.

WHAT DID WE DO RIGHT NOW TO FIX THE PROBLEM?
On 11/29/2022, resident #3 New annual RASP was completed, and updated to reflect any changes in past year according to regulation 2600.225 (c) (1). A copy of this RASP will be given to the department on the next level of the POC. On 11/22/2022, all resident charts were audited, including RASPs for every resident. Any RASP for any resident that was close to a time period of needing a review, was pulled to be updated.
The facility also researched for a reminder system.

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN?
The facility has started to use a reminder system on Senior Living Software (Tabula Pro). The facility has attached an alert reminder to every resident's RASP due date at the facility. This alert reminder will start notifiying all management who signs on the program on the first day of the month that the RASP is due, and will not stop alerting until the RASP is completed. The facility has also added a second reminding system called, "Keep and Share". This program has the ability to send emails and texts to every manager starting the month the RASP is due. The program will send these emails and texts until the RASP is completed. A copy of this program calendar, which includes all of the reminders will be provided in the next step of the POC.

Licensee's Proposed Overall Completion Date: *12/16/2022*

Implemented [redacted] - 1/4/2023)