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

May 17, 2023

[redacted], CEO
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 03/22/2023, 03/31/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *03/31/2023*

Inspection Dates and Department Representative

03/22/2023 - On-Site: [redacted]

03/31/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire License* **Capacity**: *80* **Residents Served**: *37*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *37*

Diagnosed with Mental Illness: *5*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *37*

Have Physical Disability: *0*

Inspections / Reviews

03/22/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/19/2023*

04/19/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/11/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/25/2023*

Inspections / Reviews *(continued)*

04/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/11/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/05/2023*

05/17/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/11/2023*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The entire home is licensed a secured dementia care unit (SDCU). On [redacted] at approximately [redacted], resident #1 was found between the sets of interior front doors. Resident #1 exited the home to the outside and was unattended for approximately 15-30 minutes. However, the home did not report this incident to the Department until [redacted]

Plan of Correction ***Directed ([redacted] - 04/27/2023)***

Report was completed within the time frame required. However, the confirmation could not be located upon request. Therefore at the time of inspection the report was resent with proof of confirmation it was received. The reportable was properly submitted in our electronic medical records system within the regulatory time frame.
All reportable incidents will only be emailed to the department at ra-pwarlsouthwest@pa.gov. The report along with the confirmation email will be uploaded to the residents electronic medical file. Only to be formally submitted in the file by the Administrator to assure proper completion. Documentation will be kept.
All staff will be educated by Administrator about procedure for reportable incidents to include: What must be reported, when it must be reported and why incidents need to be reported to BHLS.
Education to occur by: 4/25/2023. Documentation will be kept.

Additions: The incident report will be submitted in tabulapro at the time of submission to BHLS. The confirmation will be uploaded to the electronic medical file within 72 hours of the incident.
Monitoring steps to prevent late submissions:
1. Education on reportable incidents to be reported to Administrator immediately.
2. DOW and or RCC to review daily staff reports and initial that all incidents are properly reported. (DIRECTED: The daily reviews conducted by the DOW and/or RCC shall begin on 5/1/23. [redacted] 4/27/23).
3. Administrator to check weekly starting 4/24/2023. Documentation will be kept.

Directed Completion Date: *05/01/2023*

Implemented [redacted] - 05/17/2023)

57c - 2 Hours/Day

2. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

The home is required to provide a minimum of 2 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs.

57c - 2 Hours/Day (continued)

On 3/11/23, there were 36 residents in the home, including 36 residents with mobility needs, requiring a total minimum of 72 hours of direct care hours. On this day, only 64 hours of direct care staffing were provided.

On 3/18/23, there were 37 residents in the home, including 37 residents with mobility needs, requiring a total minimum of 74 hours of direct care hours. On this day, only 65 hours of direct care staffing were provided.

On 3/19/23, there were 37 residents in the home, including 37 residents with mobility needs, requiring a total minimum of 74 hours of direct care hours. On this day, only 72 hours of direct care staffing were provided.

Plan of Correction ***Directed ([redacted] - 04/27/2023)***

The dates listed above did have adequate staff on site to tend to the needs of all residents. However, all staff was not listed on the nursing schedule specifically. All staff that work at the SDU are direct care trained and available to assist if and when needed. If all hours were accounted for the
totals would be as follows: 3/11 = 72hours (need 72) 3/18 = 75 hours (need 74) 3/19 = 82 (need 74)
POC:
Schedule is completed 2 weeks in advance by the Administrator.
HR Director to review every Monday for the following week using the staffing calculator (attached) to project any discrepancy based on fluctuating census and resident needs.
Administrator to audit weekly by reviewing and initially the resident care schedule.
Education to all staff by 4/25/2023 to include: staffing calculations and specific duties for staff members that are providing direct care per regulatory requirements. Documentation will be kept.

Additions: Weekly HR audits will start 4/24/2023
Staff call offs go directly to the community, Administrator to be notified by DOW/RCC of call off and plan to cover. Documentation will be kept.

DIRECTED: Beginning on 5/1/23: A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing is present in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. [redacted] 4/27/23

Directed Completion Date: *05/01/2023*

Implemented [redacted] - 05/17/2023)

57d - Waking Hours

3. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

The home is required to provide a minimum of 2 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs.

On 3/11/23, there were 36 residents in the home, including 36 residents with mobility needs, requiring a total minimum of 54 hours of direct care staffing during waking hours. On this day, only 49 hours of direct care staffing were provided during waking hours.

57d - Waking Hours (continued)

On 3/18/23, there were 37 residents in the home, including 37 residents with mobility needs, requiring a total minimum of 55.5 hours of direct care staffing during waking hours. On this day, only 50 hours of direct care staffing were provided during waking hours.

Plan of Correction ***Directed (- 04/27/2023)***

Schedule is completed 2 weeks in advance by the Administrator.
HR Director to review every Monday for the following week using the staffing calculator (attached) to project any discrepancy based on fluctuating census and resident needs.
Administrator to audit weekly by reviewing and initially the resident care schedule.
Education to all staff by 4/25/2023 to include: staffing calculations and specific duties for staff members that are providing direct care per regulatory requirements. Documentation will be kept.

Additions: Weekly HR audits will start 4/24/2023
Staff call offs go directly to the community, Administrator to be notified by DOW/RCC of call off and plan to cover. Documentation will be kept.

DIRECTED: Beginning on 5/1/23: A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing is present in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. 4/27/23

Directed Completion Date: *05/01/2023*

Implemented (- 05/17/2023)

187b - Date/Time of Medication Admin.

4. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 2/15/23, the following medications for resident #2 were discontinued; however, staff persons initialed resident #2's February 2023 medication administration record as administering the medications on the following dates and times:

- *-Take 1 tablet by mouth at bedtime: Documented as administered on and*
- *-Take 1 tablet by mouth daily: Documented as administered on and*

Plan of Correction ***Directed - 04/27/2023)***

Education for all current med techs by 4/25/2023 to include: Basic medication administration practices. (DIRECTED: Documentation of the staff education shall be kept. 4/27/23). Additional individual documented observations and MAR reviews for each med tech by Administrator who is a certified train the trainer. Ongoing observations/ MAR review Q 3 months to assure proper medications procedures are being followed. Documentation will be kept.

187b - Date/Time of Medication Admin. (continued)

Director of Wellness and Resident Care Coordinator are responsible to assure only CURRENT medications are in the med room and the medication cart as prescribed. When a resident is out of the community for more than 24 hours all medications/treatments will be pulled and kept in a secured location. Upon residents return to the community DOW/RCC will be responsible to assure all medications are correct in the MAR and in the community as ordered. MVMC is transitioning to a new EMAR system 4/24/2023 to allow for better communication with the pharmacy and administration oversight.
Administrator or designee to preform weekly audit (unspecified) random 4 residents to check for medication administration accuracy. This will
occur for 3 months, followed by monthly to show compliance. Documentation will be kept.

Additions:
All documentation will be kept
Documented observations and MAR reviews to start 4/24/2023 with the first round of completion by 5/5/2023. This will be done by Administrator (Train the Trainer). All med techs will be observed with MAR reviews Q3 months for one year and as needed.
Administrator will audit weekly starting 4/24/2023 for 3 months followed by monthly (Ongoing) to assure compliance.

Directed Completion Date: *05/05/2023*

Implemented ([redacted] - 05/17/2023)

231b - Medical Evaluation

5. 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 #2 was admitted to the home, which is licensed as a SDCU, on [redacted]; however, resident #2's medical evaluation was not completed until [redacted].

Resident #3 was admitted to the home, which is licensed as a SDCU, on [redacted]; however, resident #3's medical evaluation, dated [redacted], does not indicate the need for resident #3 to be served in the SDCU.

Plan of Correction ***Accept [redacted] - 04/27/2023)***

Education to Director of Marketing/Admissions and Director of Wellness: All residents must have a (DME) documentation of medical evaluation prior to move in - within 60 days. No exceptions. If there is an issue getting the appropriate documents the Administrator must be notified immediately. By 4/25/2023 DME training with all executive staff to assure proper understanding of the need for this documentation and how it is to be completed and updated. Documentation will be kept
All current resident DME's will be checked for accuracy and updated as necessary by Administrator and or designee

231b - Medical Evaluation (continued)

no later than: 5/2/2023. Documentation will be kept.
All DME's will be reviewed and signed off by the Administrator. Documentation will be kept. Administrator to submit in electronic medical record system upon approved completion.
Weekly, Administrator will review 4 residents for periodic review for compliance and completion. Documentation will be kept.

Additions: Resident CTB on [redacted] after licensing inspection report received. However, DME for significant change occurred on [redacted] which shows resident has a need to be served in the SDCU.
Administrator audits will start 4/24/2023.

Licensee's Proposed Overall Completion Date: *05/05/2023*

Implemented [redacted] - 05/17/2023)

233d - Electronic/Magnetic System

6. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The door leading into the kitchen is locked with a magnetic locking system. Staff person A, the home's administrator, indicated the door handle must be pulled upwards approximately 90 degrees to lock and secure the door once closed. There is an additional door inside the kitchen, which leads directly to the outside, that is not locked with an electronic or magnetic system. On [redacted] at approximately [redacted] resident #1 was found between the sets of interior front doors. Resident #1 exited the home to the outside and was unattended for approximately 15-30 minutes and it is believed resident #1 exited the home through the unlocked kitchen doors.

Plan of Correction ***Directed ([redacted] - 04/27/2023)***

Immediate: Upon review of the door at the time of the incident, the door was secured. The lock was adjusted and tightened and found to be in proper working order.
At the time of inspection it was found the door handle was loose and needed to be pulled up upon closing to assure it is secured. Further intervention taken to secure door to include a "auto shut" door latch. Maintenance Director to check door periodically to assure in working order.
Education: All staff educated on the importance of assuring this door is secured at all times for resident security and safety. Instruction for the main dining room doors to be closed and locked after 8pm. Documentation will be kept. Added to weekly environmental audit to be formally checked weekly and reported to Administrator as necessary. Documentation will be kept.

Additions: The door was adjusted on 2/13/2023 by the director of maintenance.
Auto shut hinge - which makes the door shut automatically (Unless propped open)
Staff education: immediate upon door adjustment and re-education to occur by 5/5/2023. (DIRECTED: Documentation of the education shall be kept. [redacted] 4/27/23).
All doors of the community will be checked the ensure properly secured by Director of Maintenance and Maintenance Assistant by 5/5/2023.

233d - Electronic/Magnetic System (continued)

Weekly audits to start 4/24/2023 that will include checking all doors for 3 months followed by ongoing monthly audits. Documentation will be kept.

Directed Completion Date: *05/05/2023*

Implemented (- 05/17/2023)

234a - Admission Support Plan

7. 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.

Description of Violation

Resident #2 was admitted to the home, which is licensed as a SDCU, on ; however, resident #2's initial support plan was not completed until

Resident #3 was admitted to the home, which is licensed as a SDCU, on ; however, resident #3's initial support plan was not completed until

Plan of Correction ***Accept - 04/27/2023)***

Education to Director of Wellness and Resident Care Coordinator by Administrator to include: time frames for finalized support plans. Policy and procedure review by 4/25/2023. Documentation will be kept
Day 1 - Director of Wellness or Resident Care Coordinator will start support plan upon move in.
Weekly, Administrator will review 4 residents for periodic review for compliance and completion. Documentation will be kept.
Day 2 - Discussion with family and coordination of care plan meeting set (care plan meeting to occur within 5 days of move in)
Day 3 - Finalized - Administrator review and formal submission in electronic medical record system.
All current resident RASP's will be checked for accuracy and updated as necessary by Administrator and or designee no later than: 5/2/2023. Documentation will be kept.

Additions: Weekly audits to begin 4/24/2023

Licensee's Proposed Overall Completion Date: *05/05/2023*

Implemented - 05/17/2023)

234b - Support Plan Needs Elements

8. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

234b Support Plan Needs Elements *(continued)*

Description of Violation

Resident #3 was admitted to the home, which is licensed as a SDCU, on [redacted] Resident #3's progress note from the day of admission, dated [redacted] indicates resident #3 is a "high fall risk". Additionally, resident #3 has fallen in the home on numerous occasions, including on [redacted] and [redacted]; however, resident #3's support plan, dated [redacted], does not address resident #3's fall risk or the plan to meet resident #3's risk of falling.

Plan of Correction ***Accept ([redacted] - 04/27/2023)***

Immediate: Resident #3 RASP updated to include fall risk and significant change as he was admitted to hospice.
Educations: Administrator to educate staff on the importance of keeping RASP up to date timely to reflect resident changes. All resident care staff to understand the importance of keeping support plans up to date and accurate. Documentation will be kept.
Intervention: Weekly IDT (Inner Disciplinary Team)meetings to occur to review all residents and adjust support plans as needed to reflect live changes to resident needs. RASP addendums to be added to each support plan to Documentation to be kept.
Weekly, Administrator will review 4 residents for periodic review for compliance and completion. Documentation will be kept.

Additions: Education completed 4/24/2023
DOW/RCC are responsible to update RASPS RASPS are kept for staff review in a designated location at the nurses station. Changes will be made and staff aware after IDT if not in between if and when changes need to occur.
Weekly administrator audits to start: 4/24/2023.

Licensee's Proposed Overall Completion Date: *05/05/2023*

Implemented ([redacted] - 05/17/2023)