pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]

EMAILING DATE: April 25, 2023

[redacted]
142 Fairview Avenue
Confluence, Pennsylvania 15424

RE: Deneane's Personal Care Home
Certificate #: 321520

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living) review on December 8, 2022 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]

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *DENEANE'S PERSONAL CARE HOME* **License #:** *32152* **License Expiration:** *02/28/2023*

Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA 15424*

County: *SOMERSET* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *DENEANE SMITH*

Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA, 15424*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *02/08/1999* **Issued By:** *DL&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *18* **Waking Staff:** *14*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date:** *12/08/2022*

Inspection Dates and Department Representative

12/08/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **Residents Served:** *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older:** *15*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability:** *9*

Have Mobility Need: *0* **Have Physical Disability:** *1*

Inspections / Reviews

12/08/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/24/2022*

Inspections / Reviews *(continued)*

01/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/02/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/10/2023*

01/17/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/02/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/01/2023*

02/24/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/02/2023*

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

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

On 12/8/22, a copy of the most current license inspection summary (LIS) issued by the Department and a copy of this chapter were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept[redacted] 01/03/2023)***

On December 20, 2022 the current license and current license inspection summary were hung in the resident dining room by the
Administrator. Beginning January 2023, the Administrator will check monthly to ensure this poster continues to be hung in the resident dining room. Staff were asked to notify the administrator if they notice this
poster missing from the resident dining area.

Licensee's Proposed Overall Completion Date: *12/24/2022*

Implemented ([redacted] - 02/24/2023)

82a - Poisonous Materials

2. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 12/8/22, at approximately 9:10 am, an unlabeled spray bottle with a blue-purple colored liquid was observed on the kitchen counter to the right of the microwave. Staff Person A reported it was their homemade "Febreze."

Plan of Correction ***Directed [redacted] - 01/13/2023)***

The unlabeled spray bottle was immediately disposed of. Staff were educated and reminded that they could not have unlabeled materials and that all materials should remain in their original containers. All staff were educated the week of December 26th. There are only 5 staff members so they were each informed separately. Administrator will being in January 2023 to check all areas of the home to ensure that all materials are in their original, labeled containers.

Directed
Staff were educated by 1/3/23.

Directed Completion Date: *01/11/2023*

Implemented[redacted] 02/24/2023)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 12/8/22 at approximately 9:30 am, a foul, musty odor was detected in the basement. Standing water was

85a - Sanitary Conditions (continued)

observed under and around the washer and dryer, in a 3-4 foot puddle.

On 12/8/22, at approximately 9:20 am, Room #1, which houses 4 residents, had a strong urine odor.

Plan of Correction ***Accept[redacted] - 01/13/2023)***

The staff cleaned the entire basement floor area and removed the standing water in the basement 12/09/22. The standing water in the basement is a product of the Confluence Borough implementing a new sewage system requiring all residences within the borough to have grinder pumps added to their sewage systems. The home did not ever have standing water in the basement of the home until the grinder pump was installed. The home also was not aware this would happen until winter came along with an excess of rain. After meeting with a contractor, the Administrator was advised that a sump pump could be installed to prevent water from laying on the basement floor. The Administrator had a sump pump installed in the basement on 1/12/23. The sump pump is working and there is not any water in the basement.

The home cleaned and scrubbed the carpets in Room #1 on 12/09/22. Staff will continue to weekly scrub the carpet to ensure that their is not a odor of urine. Beginning January 2023 the Administrator will walk through the entire home weekly to check the entire home to ensure that there is not a presence of and odors, including urine.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented ([redacted] - 02/24/2023)

102i - Soap Dispenser

4. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 12/8/22, at approximately 9:15 am, there was no soap in the second floor shared bathroom.

Plan of Correction ***Accept[redacted] - 01/03/2023)***

Liquid Soap was put in the second floor bathroom on December 8, 2022 the day of inspection by the Administrator Assistant. All staff were reminded that liquid soap is required in all bathrooms at all times. Liquid soap needs to be filled as it gets low to ensure the bathrooms do not run out. The Administrator has been checking the bathrooms monthly to ensure that there is liquid soap, however, beginning January 2023, the Administrator will check bi-monthly to ensure staff are continuing to fill all liquid soap dispensers and it is available in all bathrooms.

Licensee's Proposed Overall Completion Date: *12/26/2022*

Implemented[redacted] - 02/24/2023)

102k - No Common Towel

5. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 12/8/22, at approximately 9:15 am, there were no paper towels or other sanitary means of hand drying available in the second floor shared bathroom.

102k - No Common Towel (continued)

Plan of Correction ***Accept (- 01/03/2023)***

There was a means of sanitary hand drying provided on the second floor bathroom through the use of a provided electric hand dryer. The hand dryer was there and in working order, however, a resident had unplugged it. On 12/8/22, the day of inspection, the provided electric hand dryer was plugged in by the Administrator Assistant. All staff & residents were reminded that the hand dryer is required at all times and cannot be unplugged. Beginning January 2023, the Administrator will check monthly to ensure the provided electric hand dryers remain plugged in.

Licensee's Proposed Overall Completion Date: *12/26/2022*

Implemented - 02/24/2023)

103e - Left Overs

6. 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

On 12/8/22 at approximately 9:05 am, an unlabeled, undated, gallon-sized plastic zip bag of barbequed chicken legs was found in the white refrigerator in the kitchen.

Plan of Correction ***Accept (- 01/13/2023)***

On 12/8/2022 the unlabeled, undated, gallon sized plastic ziploc bag of chicken legs was immediately removed from the refrigerator and disposed of by the Administrators Assistant. All staff were reminded that all food must be labeled, dated and covered. All staff were educated the week of December 26th. There are only 5 staff members so they were each informed separately. Beginning January 2023, the Administrator will check monthly to ensure all leftover food items are labeled, dated and covered.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented - 02/24/2023)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 12/8/22 at approximately 9:25 am, the emergency exit door on the 2nd floor, near the shared restroom, was locked from the inside. The lock on the door handle was engaged in the lock position. In an emergency, the door could not be immediately opened.

Plan of Correction ***Accept - 01/13/2023)***

On 12/8/22 the 2nd floor emergency exit door was unlocked by the Administrators Assistant. All residents who reside on the second floor of the home are completely capable of unlocking the door, therefore, it would be able to

121a - Unobstructed Egress (continued)

be immediately opened. Administrator spoke to the residents and staff and informed them of this regulation and that they would need to keep the door unlocked at all times. The residents expressed concerns with not feeling safe leaving the door unlocked on 12/07/22. The Administrator apologized for them feeling this way, however, educated them on the regulation. The Administrator will randomly check the door bi-monthly to ensure it remains unlocked at all times and continue to speak to the residents regarding this regulation beginning January 2023.

NOTE: This door CANNOT be locked from the outside, to prevent outsiders from getting in, yet allow residents to get out. The Administrator will replace the doorknob that has been on that door for the last 22 years with a doorknob that can be locked from the outside and opened from the inside by 01/31/23.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

171b5 - First Aid Kit

8. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in Staff Person A's car, used to transport residents, does not include protective eye covering or gloves.

Plan of Correction ***Accept[redacted] 01/13/2023)***

Protective Eye Coverings & Gloves were immediately put into the first aid kit in Staff Person's A car. The Administrator will check all first aid kits monthly to ensure it all required items are in all kits. Checks will begin January 2023.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

182b - Prescription Medication

9. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

182b - Prescription Medication *(continued)*

Description of Violation

The following staff have administered medications to the residents of the home in November and December, 2022. However, these staff have not completed the required medication administration training to qualify for administering medications:

Staff Person A
Staff Person B
Staff Person C
Staff Person D
Staff Person E

Plan of Correction ***Directed ([redacted] - 01/17/2023)***

All Staff persons including staff persons A, B, C, D, & E have been trained and passed the medication administration training. They do not have an updated MAR & Med Pass review. The Administrator is in the process of getting re-certified as a Medication Administration Train the Trainer as during Covid the Administrator could not attend a re-certification training. The Administrator will continue to complete MAR reviews and also a medication pass for all staff persons the week of 12/16/23 to ensure they are all completing MARS and Med Pass per the medication administration training. Administrator will set reminders on the calendar to ensure that all medication & MAR reviews are completed prior to the required date to remain compliant with this regulation. The Administrator will also set reminders on the calendar to ensure that staff trained as a Medication Administrator Train the Trainer are current. We will include Medication Administrator for the trainer as well as staff in our next Quality Management Meeting scheduled August 15, 2023.

Directed -
The Administrator will arrange for all staff to redo and complete the Med Tech training by 2/1/23. Any observations/MAR reviews will be completed by a currently certified med tech trainer.
If the Administrator is to recertify as a med tech trainer, the Administrator must first redo and complete training as a med tech, per regulation 190a. If the Administrator is not going to recertify, the Administrator must arrange for a certified trainer to complete the regular observations and MAR reviews on staff.

Directed Completion Date: *02/01/2023*

Implemented ([redacted] - 02/24/2023)

183b - Meds and Syringes Locked

10. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 12/8/22 at approximately 9:05 am, syringes of Lorazepam 2mg/ml concentrate ml intensol were unlocked, unattended, and accessible in the kitchen's white refrigerator, on the door's top shelf.

183b - Meds and Syringes Locked *(continued)*

Plan of Correction ***Accept [redacted] - 01/13/2023)***

On 12/28/2022 a lock box was placed in the refrigerator. All medication requiring refrigeration will be kept in this lock box, in the refrigerator, to ensure that there are not any medications in the home unlocked, unattended or accessible. Beginning January 2023 the Administrator will check all medications monthly while doing audits of the Med Cart to ensure all medications in the facility are locked and inaccessible. All staff were educated the week of December 26th. There are only 5 staff members so they were each informed separately. We will include this training in our next Quality Management Meeting, scheduled August 15, 2023.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

183d - Prescription Current

11. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #2's OTC medication, orange flavored Glucose Tablets, stored in the top drawer of the medication cart, had an expiration date of 09/20.

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident #2's Glucose Tablets were immediately disposed of by the Administrators Assistant. On 12/23/22 an audit was conducted of the Med Cart to ensure all medications within the cart are not expired by the Administrator. Staff were educated on being mindful and checking medication expiration dates the week of December 26th. There are only 5 staff members so they were each informed separately. We will include this training in our next Quality Management Meeting scheduled August 15, 2023. Beginning January 2023 the Administrator will check all medications expiration dates while performing monthly audits of the Med Cart to ensure all medications within the Med Cart are not expired.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

183e - Storing Medications

12. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 12/8/22 at approximately 2:30 pm, ½ of an oval pill was found in the 3rd drawer of the medication cart in the 3rd compartment from the left. The pill was found in the back right corner of the compartment and was off-white/beige color with the number
"2" etched on it.

183e - Storing Medications (continued)

On 12/8/22 at approximately 2:40 pm, ½ of a white round pill was found the 3rd drawer of the medication cart in the 1st compartment from the left. The pill was found in the back right corner of the compartment.

Plan of Correction ***Accept ([redacted] - 01/13/2023)***

The loose pills were immediately disposed of by the Administrator's Assistant. On 12/23/22 an audit was conducted of the Med Cart to ensure that all medications were stored in an organized manner and that there were not any loose pills within the Med Cart by the Administrator. Staff were educated on being mindful and to make sure that there are not any loose pills within the Med Cart the week of December 26th. There are only 5 staff members so they were each informed separately. We will include this training in our next Quality Management Meeting scheduled August 15, 2023. Beginning January 2023 Administrator will check the Med Cart by performing monthly audits ensure all medications within the Med Cart are stored in an organized manner.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

185a - Implement Storage Procedures

13. 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 following diabetic medical supplies were found in the top drawer of the medication cart:
- Prodigy No Coding Blood Glucose Test strips (50 count) had an expiration date of 7/4/2021.
- Prodigy No Coding Blood Glucose Test Strips (50 count) had an expiration date of 8/24/2022.
- Assure Platinum Blood Glucose Test Strips (50 count) had an expiration date of 10/2/2020.
- Free Style Lite Test Strips had an expiration date of 5/31/2022.

Plan of Correction ***Accept [redacted] - 01/13/2023)***

All expired diabetic medical supplies were immediately disposed of by the Administrators Assistant on 12/8/22. On 12/23/22 an audit was conducted of the Med Cart, by the Administrator to ensure all diabetic medical supplies within the cart are not expired. Staff were educated on being mindful and checking expiration dates the week of December 26th. There are only 5 staff members so they were each informed separately. We will include this training in our next Quality Management Meeting scheduled August 15, 2023. Beginning January 2023 the Administrator will check all diabetic medical supplies expiration dates while performing monthly audits of the Med Cart to ensure that they are not expired.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

185b - Medication Procedures

14. Requirements

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

Resident #3's oxycontin was observed in a locked drawer of the medication cart, but was not double-locked. Staff reported they couldn't get into the drawer with the narcotics box (which was double-locked) so narcotics were kept in a regular single-locked medication drawer.

The narcotic count log sheet for Resident #3's oxycontin was incorrect. In the medication cart, Resident #3 had 4 blister packs of oxycontin (2 for morning and 2 for the evening dose), containing 19, 19, 3 and 2, totaling 43. Resident #3's narcotic count log sheet stated the resident currently had 24 doses.

Plan of Correction ***Accept ([redacted] - 01/13/2023)***

The pharmacy was contacted and they sent a technician to fix the lock on the medication cart on 12/10/22, therefore, all narcotics are now double locked. Beginning January 2023 the Administrator will check the entire Med Cart while performing the monthly Med Cart audits to ensure all areas of the Med Cart are in proper working order and that staff are keeping all narcotics double locked.

The staff had made an error when receiving Resident #3's oxycontin. They somehow missed adding one of the cards containing 19 pills to the count. The home did have the correct amount of oxycontin for Resident #3, however the count log sheet was incorrect. The Administrator corrected the Resident #3's narcotic count log sheet on 12/10/22. Administrator educated staff on the importance of correct documentation the week of December 12th. There are only 5 staff members so they were each informed separately. Beginning January 2023, the Administrator will review all narcotic count log sheets within the facility monthly to ensure that all narcotics are counted correctly. We will include this training in our next Quality Management Meeting scheduled August 15, 2023.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented [redacted] - 02/24/2023)

187a - Medication Record

15. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #4 is prescribed an intramuscular injection of Sustenna once monthly, which is administered by home health agency staff, however, Resident's #4's medication administration record indicates that the medication was administered by Staff Person A. Both staff and Resident #4 report that Staff Person A does not administer the injection.

187a - Medication Record (continued)

Plan of Correction ***Accept (- 01/13/2023)***

On 12/09/22 the pharmacy was contacted and a code was added to the MAR key that day so that the staff could appropriately document when a medication is administered by home health agency staff. Staff were educated on this new code and the importance of MAR documentation the week of December 12th. There are only 5 staff members so they were each informed separately. Beginning January 2023 the Administrator will conduct monthly MAR checks to ensure that all medication administrations are documented correctly. We will include this training in our next Quality Management Meeting scheduled August 15, 2023.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented (- 02/24/2023)

190b - Insulin Injections

16. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

The following staff have completed blood sugar readings using a glucometer on Resident #4 on the following dates, however, none of these staff have successfully completed a Department-approved diabetes patient education program within the past 12 months:

Staff Person C completed blood sugar checks on:
November 6, 13 and 19, 2022.

Staff Person E completed blood sugar checks on :
November 3, 4, 5, 7, 10, 11, 12, 14, 17, 18, 25, 26, 28, and 29, 2022.

Plan of Correction ***Accept (01/13/2023)***

Unfortunately, since the beginning of Covid, we are having a very difficult time finding Diabetic Educators in our area. With discussing this matter with other homes and Administrators, I believe this is a common issue for many. The Administrator was able to provide a Department-approved diabetic education to all staff 01/09/2023. The Administrator will make a calendar reminder and to continue to find sources in the future so that all staff receive this training every 12 months as required. We will include this training in our next Quality Management Meeting scheduled August 15, 2023.

Licensee's Proposed Overall Completion Date: *01/11/2023*

Implemented - 02/24/2023)