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

August 16, 2023

[redacted], CEO
MELODY MANOR PCH LLC
413 NORTH MCKEAN STREET
KITTANNING, PA, 16201

RE: MELODY MANOR
413 NORTH MCKEAN STREET
KITTANNING, PA, 16201
LICENSE/COC#: 44676

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/25/2023, 04/26/2023 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: *MELODY MANOR* **Licen e #**: *44676* **Licen e Expiration**: *07/21/2023*

Address: *413 NORTH MCKEAN STREET, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MELODY MANOR PCH LLC*

Address: *413 NORTH MCKEAN STREET, KITTANNING, PA, 16201*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *09/28/1987* **I ued By**: *Dept L & I*

Type: *Other* **Date**: *12/29/1983* **I ued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/26/2023*

Inspection Dates and Department Representative

04/25/2023 On Site [redacted]

04/26/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *43* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *30*

Diagnosed with Mental Illness: *13* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

04/25/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/21/2023*

Inspections / Reviews *(continued)*

05/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/30/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/30/2023*

08/16/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/30/2023*

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

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 4/25/23, at approximately 10:30 a.m., there were no paper towels, mechanical air blower, or other sanitary method of hand drying in the single use common bathroom, located on the 2nd floor lighthouse of Melody house.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/25/23 DCS [redacted], stocked the 2nd floor lighthouse bathroom. [redacted] also stocked each remaining bathroom throughout the home. To ensure that this is not an issue again, on 5/1/23 administrator made a bathroom stock list available for all of the DCS.
On 5/22/23 Administrator did a re-training with DCS staff on this regulation. Starting 5/1/2023 Administrator or designee will do random walk-through's of the home to check for sanitary conditions, weekly.

Licensee's Proposed Overall Completion Date: *05/22/2023*

Implemented [redacted] - 08/16/2023)

87 - Lighting

2. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 4/25/23, at approximately 10:25 a.m., the light in the in the hallway beyond the emergency exit door, near room 11 on the second floor, was inoperable, posing a safety hazard to residents in the event of an emergency.
REPEAT VIOLATION: 10/24/22

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/25/23 our maintenance man replaced the lightbulb near the emergency exit door, near room 11. To ensure that this doesn't happen again, on 4/25/2023 Administration reminded maintenance of the importance of the maintenance checklist, and to check the lighting monthly.
All DCS will have a re-training on the importance of reporting any lighting issues throughout the home, at our next staff meeting. Staff meeting is scheduled for Wednesday June 14th at 2 pm.

Licensee's Proposed Overall Completion Date: *06/14/2023*

Implemented [redacted] - 08/16/2023)

88a - Surfaces

3. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

88a - Surfaces *(continued)*

Description of Violation

On 4/25/23, at approximately 10:45 a.m., wallpaper in the bedroom belonging to resident #1 and resident #2, was peeling in multiple sections of the wall, including a 16" x 16" section, between the bathroom and the door to the room.

On 4/25/23, at approximately 11:20 a.m., the threshold, between the main entrance hallway and the sitting room to the right, on Melody side was frayed is an 6 ft x 1 in section; posing a tripping hazard.

Plan of Correction [redacted] ***- 05/25/2023)***

On 4/25/23 our maintenance man fixed the peeling wall paper in resident #1 and resident # 2's bedroom, with wall paper adhesive. Brian also fixed the frayed carpet between the main entrance hallway and the sitting room to the right, with duct tape until the parts that we ordered, come in.
All DCS will have a training on the importance of reporting damaged surfaces, at our next staff meeting. The staff meeting is scheduled for Wednesday June 14th at 2pm.

Licensee's Proposed Overall Completion Date: *06/14/2023*

Implemented [redacted] ***- 08/16/2023)***

93a - Handrails

4. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 4/25/23, at approximately 11:15 a.m., the right handrail leading from the emergency exit door, down the ramp to the front street, between both Melody and Cooper, was not well-secured. This railing was attached to the ramp yet moved approximately 12 inches with any pressure applied to the railing; posing a fall risk in the event of use or an emergency.

Plan of Correction ***Accept*** [redacted] ***- 05/25/2023)***

On 4/25/2023 administrator informed all residents and staff, to avoid using the front ramp unless it was an emergency. It is not commonly used and all agreed to avoid use until it was fixed.
On 5/24/23, our handyman inspected the front ramp and has a plan to fix it on 5/25/2023.
Ramp work is in progress as of 5/25/23 at 8 am.
All DCS will have a training at our next staff meeting (6/14/2023) on the importance of reporting unsecured handrails to administration.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented [redacted] ***- 08/16/2023)***

96a - First Aid Kit

5. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

96a - First Aid Kit *(continued)*

Description of Violation

On 4/26/23, the home's first aid kit, in the medication room, did not include adhesive bandages, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/26/23 Administration put together a new first aid kit that was stocked with disposable gloves, antiseptic, bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.
Administrator will check the first aid kit monthly to ensure that anything that got used, is replaced.
DCS will have a training on the requirements for a PCH first aid kit, at our next staff meeting, which is scheduled for Wednesday June 14th at 2 PM.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented ([redacted] - 08/16/2023)

101r - Bedroom - shades/drapes/window covering

6. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 4/25/23, at approximately 10:45 a.m., the window behind resident #2 bed, did not drapes, shades, curtains, blinds or shutters to provide privacy to the residents residing in this bedroom.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/25/23 the maintenance man hung a new mini blind in resident #2's bedroom. DCS will check resident rooms daily to ensure any lost or broken window coverings are fixed or replaced.
All DCS will have a training on the importance of reporting window coverings that are not in good repair, at our next staff meeting, which is scheduled for June 14th at 2PM.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented ([redacted] - 08/16/2023)

102l - Shelves/Hooks

7. Requirements

2600.
102.l. Shelves or hooks for the resident's towel and clothing shall be provided.

Description of Violation

On 4/25/23, at approximately 10:40 a.m., the towel rack on the shared bathroom door, belonging to resident #1 and resident #2, is missing the right side bracket and bar; posing a hazard to the residents when exiting the bathroom.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/25/23 our maintenance man fixed the towel bar in resident #1 and resident # 2's bathroom.
DCS will check all resident bathrooms daily, to ensure no other safety risks are present.
All DCS will be trained on this regulation at our next staff meeting, scheduled for June 14th at 2 pm.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented ([redacted] - 08/16/2023)

121a - Unobstructed Egress

8. 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 4/25/23, at approximately 11:45 a.m., the exterior emergency exit route, near the men's room and the kitchen, was blocked by an air conditioning unit attached to the exterior wall of the home, approximately 4 ft in height over the sidewalk, leaving a gap of approximately 18 inches.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/25/23 administrative assistant called to have the air conditioning unit moved that was blocking the emergency exit. On 4/27/23 our handyman removed the air conditioning unit that was attached to the exterior wall of the home, near the men's basement and the kitchen. The handyman is scheduled to return and place the unit in another area that does not block an exit. He said the unit will be in place by the end of June 2023.

Licensee's Proposed Overall Completion Date: *05/22/2023*

Implemented [redacted] - 08/16/2023)

132c - Fire Drill Records

10. 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

On 4/25/23, the fire drill record indicated a drill was conducted on March 22, 2023 at 1:40; however, the record did not indicate if the drill was completed in the a.m. or p.m.
On 4/25/23, the fire drill record indicated a drill was conducted on April 12, 2023 at 1:30; however, the record did not indicate if the drill was completed in the a.m. or p.m.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4/25/2023 Administrator, corrected the fire drill log to show the fire drill on March 22, 2023 was conducted at 1:40 pm and the fire drill done on April 12, 2023 was completed at 1:30pm. She was able to recall both fire drills and they happened during the work day. Administrator now sees the importance of marking AM or PM on the fire drill og and will ensure it is marked this way each fire drill.

Licensee's Proposed Overall Completion Date: *05/24/2023*

Implemented [redacted] - 08/16/2023)

132e - Fire Drill Sleeping Hours

11. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

On 4/26/23, there was not a sleeping hours fire drill conducted once every 6 months. The most recent overnight fire drill was held on July 31, 2022 at 5:20 a.m.

Plan of Correction ***Accept [redacted] - 05/25/2023)***

Administrator will conduct an overnight fire drill before the end of May. She plans to conduct it on night shift on Friday May 26, 2023 between 3am and 4 am. Documentation will be kept.
Administrator also added notes to her desk calendar on 5/24/23 to remind herself of any needed fire drills. This includes the overnight one that will not have to be done again until October 2023.

Licensee's Proposed Overall Completion Date: *05/24/2023*

[redacted] - 08/16/2023)

187d - Follow Prescriber's Orders

12. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 4/26/23, at approximately 2:30 p.m., resident #3 medication was not available in the home for administration as prescribed, on multiple dates, to include the following:

[redacted]

On 4/26/23, at approximately 2:15 p.m., resident #4 medication was not available in the home for administration as prescribed, on multiple dates, to include the following:

[redacted]

187d - Follow Prescriber's Orders (continued)

REPEAT VIOLATION: 4/19/22 et al

Plan of Correction ***Accept [redacted] - 05/25/2023)***

DHS Med techs were re-educated by Administrator on 5-22-2023. Training included regulation 187d, following the directions of the prescriber. Documentation was kept. Administrator or Designee will begin reviewing medications and medication administration documentation on 5-30-2023 with documentation kept. During this check administrator or designee will observe med tech administering medication's, and confirm all medications are given as ordered by residents Physician. The audits will consist of Administrator or Designee auditing at least 5 Residents per week for one month, then monthly thereafter, to ensure the directions of the prescriber are being followed and all current prescribed medications are present in the Facility and available for administration. All medications for Residents #3 And #4 were obtained for the Facility on 4-27-2023.This violation will be discussed at the next quality management meeting by the end of June 2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 08/16/2023)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On 4/26/23, The assessment, dated [redacted], for resident #2, were blank in the following: bladder management, bowel management, ambulating, personal hygiene, managing health care, securing health care, turning and positioning in bed/chair, doing laundry, shopping, securing and using transportation, managing finances, using the telephone, making and keeping appointments, caring for personal possessions, writing correspondence, engaging in social and leisure activities, using a prosthetic device, obtaining clean season clothing, and supervision.

REPEAT VIOLATION: 7/7/22 et al, 4/19/22 et al

Plan of Correction ***Accept [redacted] - 05/25/2023)***

On 4-26-2023 Administrative Assistant accounted for all the blanks on Resident #2's assessment. Audits of all other resident files will begin on 5-30-2023 by Administrator or Designee. Documentation will be kept. Audits will consist of Administrator or Designee going through every RASP to check for blank spaces or too many N/A's. At least 8 audits per week will finish by 6-27-2023. This regulation will be addressed at the next quality management meeting by the end of June 2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 08/16/2023)