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

August 17, 2023

[redacted], OWNER
THE GATHERING PLACE PERSONAL CARE LLC
[redacted]

RE: THE GATHERING PLACE PERSONAL CARE
390 MOUNTAIN ROAD
UNIONTOWN, PA, 15401
LICENSE/COC#: 45417

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/08/2023 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: *THE GATHERING PLACE PERSONAL CARE* **Licen e #**: *45417* **Licen e Expiration**: *12/13/2023*

Address: *390 MOUNTAIN ROAD, UNIONTOWN, PA 15401*

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

Administrator

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

Legal Entity

Name: *THE GATHERING PLACE PERSONAL CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *02/06/1995* **I ued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *14* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/08/2023*

Inspection Dates and Department Representative

03/08/2023 On [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served**: *10*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *9*

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

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

03/08/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/07/2023*

04/10/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/25/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/17/2023*

Inspections / Reviews *(continued)*

06/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/25/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/20/2023*

08/17/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/25/2023*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home admission contract completed [redacted] for resident #1 was not signed by the resident.

The resident-home admission contract completed [redacted] for resident #2 was not signed by the resident.

Plan of Correction ***Directed [redacted] - 06/13/2023)***

On 3/8/23, during the 3 month inspection, it was discovered that the resident contract was not signed by the resident. Because [redacted] was admitted by [redacted] daughter before [redacted] arrival, [redacted] signature was obtained and [redacted] was to be gotten upon admission. This step was missed once resident arrived. The immediate correction was that resident #1 signed [redacted] contract since [redacted] was alert and oriented to do so. This signature was obtained by the Administrator, [redacted]. In order to prevent this oversight from happening in the future, a checklist was created to cross-reference required signatures in all of the proper places and will be signed by the Administrator only after all signatures are obtained in all of the required places.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure each resident has a resident-home contract in place with the required signatures in accordance with Regulation 2600.25(b). 6/13/23 [redacted]

Directed Completion Date: *06/14/2023*

Implemented [redacted] - 08/17/2023)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff person A began working for the home on [redacted] 22. However, a criminal history background check was not requested until 3/8/23.

Plan of Correction ***Directed ([redacted] - 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that staff person A didn't have a criminal background check on file and wasn't requested until the date of inspection. Because the employee started with the company just as it opened with 2 residents, [redacted] background check was overlooked. To ensure that the check will be completed in a timely fashion, potential employees will fill out the Criminal Background Check form at the time they are filling out the application. The background check will be run the day the applicant accepts the position and will be aware that the job offer is contingent on the background check results. Also, an audit will be performed by either the Administrator or the Administrative Assistant one month after the employee works to ensure that all required paperwork is in the employee folder. A checklist with dates that items were acquired will be attached to employee folder.

51 - Criminal Background Check (continued)

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current staff records to ensure each staff person has a criminal history background check completed in accordance with Regulation 2600.51. 6/13/23

Directed Completion Date: *06/14/2023*

Implemented - 08/17/2023)

85a Sanitary Conditions

3. Requirements

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

Description of Violation

On /23 at a.m., resident #1's glucometer was used to measure resident #3's blood glucose level of

On 23 at approximately a.m., resident #3's glucometer was used to measure resident #1's blood glucose level of

Plan of Correction ***Accept (JK - 06/13/2023)***

On 3/8, 23, during our three month inspection, it was discovered that glucometers were being used between two different diabetic residents. One of the glucometers that was used belonged to a resident that passed away previously. The immediate correction of the error is that we disposed of the glucometer belonging to the deceased resident. I purchased a new one for the surviving resident at the expense of the facility on the same day so that when reading for bedtime was due, would have a new glucometer. I informed the resident and his family of the incident. I then informed the house physician of the incident. instructed us to dispose of and replace it at the homes expense, which I had proactively already done. To ensure that the error won't happen again, trays were purchased for the diabetic residents to keep their glucometers and insulin separated, and they will have the residents name on either the glucometer or the tray. Training will be provided with new staff to ensure they are only using the glucometer belonging to that specific resident. If a staff member uses a glucometer that doesn't belong to the correct resident, the staff member will be responsible for replacing both residents glucometers and will be required to attending the Diabetic Training class again, at their expense. The Administrator will do weekly glucometer checks to ensure that the readings on the glucometer match the readings that are being recorded for each resident. If an error is found, the employee that logged the readings for that day will be responsible for replacing the units. The first offense will be that the employee will replace the glucometers. The second offense will be suspension, and the third will be termination.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented (- 08/17/2023)

101r Bedroom shades/drapes/window covering

4. 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.

101r - Bedroom - shades/drapes/window covering *(continued)*

Description of Violation

At approximately 10:45 a.m., the only covering on the window in resident room #4 which looks into the hallway that leads to the laundry room was a swag curtain which does not cover the entire window and therefore does not ensure resident privacy.

Plan of Correction ***Accept [redacted] - 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that a window in room #4 did not have any ful cover drapes, only a swag. Because the room looked out into a hallway, a blind was not installed by the previous owner of the facility. After the findings, a window blind was installed the next day to provide privacy. At the resident's request, the blind will not be lowered but the option is there if he decides to lower it. To ensure that this policy is followed, a monthly walk through of the house will be performed by either the Administrator or the Administrative Assistant using the Physical Site Inspection page from the regulations. This will ensure that any other items that might be overlooked are corrected.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented [redacted] - 08/17/2023)

103f Refrigerator/Freezer Temps

5. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At approximately 10:40 a.m., there was no thermometer in the freezer section of the refrigerator/freezer in the home's laundry room.

Plan of Correction ***Accept [redacted] 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that there was no thermometer in the back freezer. The immediate corrective action is that one of the two that were in the front freezer were taken to the back freezer. To ensure that they are always present and accurate, monthly temperature checks will be performed by the Administrator or the Administrative Assistant and logged on a spreadsheet that will be found in the Temperature Log Book. This book will be located in the locked resident folder cabinet on the wall in the medication cart area.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented [redacted] - 08/17/2023)

132a - Monthly Fire Drill

6. Requirements

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

Description of Violation

The home did not conduct fire drills in January 2023 and February 2023.

Plan of Correction ***Accept [redacted] 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that fire drills were not performed in January and February. In order to ensure that drills are performed, the Administrator or the Administrative Assistant will

132a - Monthly Fire Drill (continued)

conduct the fire drill each month on different shifts. Communication between the two will happen during our weekly meeting to determine when the fire drill will be performed. To make sure they are being performed as required, the Administrator will review the Fire Drill Log when reviewing the other temperature logs. This will not be an announced drill at any time.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented ([redacted] - 08/17/2023)

183c - Refrigerated Meds Locked

7. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

At 10:30 a.m., the following unlocked, unattended, and accessible medications were in the unlocked refrigerator in the kitchen:

** 1 box of [redacted] pens with pharmacy label for resident #3*
** 1 box containing four [redacted] with pharmacy label for resident #3*
** 1 half-full bottle of [redacted]*
** 1 box of [redacted] eye drops with pharmacy label for resident #4*

Plan of Correction ***Directed ([redacted] - 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that there was medication in the refrigerator that was not locked up. The diabetic medications belonged to a resident that recently passed away. When doing a sweep on the house to remove the resident belongings, the refrigerator was missed. The immediate corrective action was that the medication was disposed of immediately and removed from the refrigerator. The Latanoprost drops were moved to a lock box and placed on the bottom shelf of the refrigerator. Training will be provided to all employees on how to handle the refrigerated medication and the proper storage of such. In the future, all refrigerated medication will be placed in the lock box on the bottom shelf and the only ones who will have access to the medication is the Med Tech or Nurse. At any given time, the Administrator or Administrative Assistant will do a sweep of the refrigerator to look for unlocked medication. If there are any, it will be determined who received the medication from the pharmacy and retraining will be provided to that employee.

Directed Completion Date: *06/14/2023*

Implemented [redacted] - 08/17/2023)

183e - Storing Medications

8. 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

At 2:15 p.m., there was a [redacted] pen with pharmacy label for resident #1 in a clear zip top bag with faded [open] date in marker that appears to be "2/3/23" as confirmed by staff person B. According to manufacturer's directions, the [redacted] pen is to be discarded 28 days after it is opened.

183e - Storing Medications (continued)

At 2:15 p.m. there was a [redacted] with pharmacy label for resident #1 in a clear zip top bag with date written in marker that was too faded to read. The medication was dispensed by the pharmacy on 2/2/23. According to manufacturer's directions, the [redacted] is to be discarded 28 days after it is opened.

Plan of Correction ***Directed ([redacted] 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that the date written on the pouch provided was faded and the wrong date may have been written on it. Because we couldn't be sure what the actual date was on the pouch, the immediate corrective action was that both pens were disposed of immediately and new pens replaced them. To be sure the error doesn't occur in the future, the pens are now labeled with a piece of tape and a sharpie, making them very legible, eliminating the change of using expired insulin. The date that the pen was put into circulation will be written on this tape and will be disposed of when they are expired. The staff will be trained to be aware of the dates and what to do when they are expired. It will also be noted on the calendar in Tabula Pro, the program that we use for resident information, as to when they need to be disposed of and replaced.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all medications monthly to ensure medications which require an open date are marked with the open date are not expired. 6/13/23 JK

Directed Completion Date: *06/14/2023*

Implemented ([redacted] - 08/17/2023)

187a - Medication Record

9. Requirements

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

Description of Violation

Resident #1 is ordered [redacted] Give 1 tablet by mouth one time a day. However, at 2:15 p.m., the entry for this medication on the resident's March 2023 medication administration record (MAR) indicated [redacted] take 1 tablet by mouth once a day.

Plan of Correction ***Accept ([redacted] 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that Resident #1 MAR was mislabeled. According to the order, [redacted] should have been taking [redacted] but the MAR had written [redacted]. We looked closer to [redacted] actual medication and [redacted] was actually taking the correct dose at the correct time, it was wrong on the MAR. The immediate corrective action is that I reached out to the pharmacy and informed them of the error. The Pharmacist Technician confirmed that he was taking the correct dosage. They reprinted the MAR to reflect the correct number and it was placed in the MAR book. To ensure this error doesn't happen in the future, the Administrator and the nursing supervisor will do a monthly MAR audits to confirm the medication matches the MARs provided from the pharmacy. f an error is found, the pharmacy will be notified immediately to remedy the situation.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented ([redacted] - 08/17/2023)

224a - Preadmission Screen Form

10. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted to the home on [redacted]. However, the preadmission screening for the resident is dated 2/5/23.

Plan of Correction ***Directed [redacted] - 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that the preadmission form was dated 3 days after the admission. To ensure that the preadmission screening form is completed correctly and in a timely fashion, it will be taken to the facility/residence of the potential resident and filled out at the time of the screening instead of waiting until the screener gets back to the facility. Training will be provided to the Administrative Assistant as to the proper timelines and state guidelines for when papers need to be filled out.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure each resident has a preadmission screening completed and the resident's needs can be met by the home. Documentation shall be kept in each resident record. 6/13/23 [redacted]

Directed Completion Date: *06/14/2023*

Implemented ([redacted] - 08/17/2023)

225a - Assessment 15 Days

11. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #1 was admitted to the home on [redacted]. However, an initial assessment has not been completed for this resident.

Resident #2 was admitted to the home on [redacted]. However, an initial assessment has not been completed for this resident.

Plan of Correction ***Directed [redacted] - 06/13/2023)***

On 3/8/23, during our three month inspection, it was discovered that the initial assessments were not filled out on two separate residents. The assessments were filled out, signed by the house physician, and were in the Tabula Pro program, but a hard copy was not printed for the actual folder. To ensure that this is remedied, a hard copy will be printed and placed in the residents folder once signed by the house physician, as well as this will be a line item included on the checklist that is created for new resident folders. This checklist will have everything state-required in a resident folder. The Administrator will go through the entire new resident folder to ensure that all items are present, signed, and dated before signing the checklist. If anything is missing, training will be provided to the Administrative Assistant pertaining to state requirements for resident folders.

225a - Assessment 15 Days (continued)

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure each resident has an assessment completed. Documentation shall be kept in each resident record. 6/13/23

Directed Completion Date: *06/14/2023*

Implemented (- 08/17/2023)

227a Support Plan 30 Days

12. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted to the home on . However, an initial support plan has not been completed for this resident.

Resident #2 was admitted to the home on However, an initial support plan has not been completed for this resident.

Plan of Correction ***Directed (- 06/13/2023)***

On 3/8/ 23, during our three month inspection, it was discovered that the support plans were not filled out on two separate residents. The immediate corrective action is that both were started and worked on and are now submitted. To ensure that this is remedied, this will be a line item included on the checklist that is created for new resident folders. This checklist will have everything state-required in a resident folder. The Administrator will go through the entire new resident folder to ensure that all items are present, signed, and dated before signing the checklist. This will also be remedied by utilizing the feature in our software program, Tabula Pro. The calendar on the dashboard will notify the Administrator of upcoming deadlines and required forms.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure each resident has a support plan completed. Documentation shall be kept in each resident record. 6/13/23

Directed Completion Date: *06/14/2023*

Implemented - 08/17/2023)