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

December 8, 2023

[redacted]
NT ROSE HAVEN LLC
[redacted]

RE: ROSE HAVEN
132 HAVEN DRIVE
INDIANA, PA, 15701
LICENSE/COC#: 45429

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/29/2023 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: *ROSE HAVEN* **License #:** *45429* **License Expiration:** *03/24/2024*

Address: *132 HAVEN DRIVE, INDIANA, PA 15701*

County: *INDIANA* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *NT ROSE HAVEN LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/02/2007* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *26* **Waking Staff:** *20*

Inspection Information

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

Reason: *Renewal, Monitoring* **Exit Conference Date:** *06/29/2023*

Inspection Dates and Department Representative

06/29/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *43* **Residents Served:** *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: [redacted]

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *21*

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

Have Mobility Need: [redacted] **Have Physical Disability:** *0*

Inspections / Reviews

06/29/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/22/2023*

07/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/28/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/01/2023*

Inspections / Reviews *(continued)*

08/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/28/2023*

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

12/08/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/28/2023*

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

64c - Annual Training

1. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, completed only 1 hour of Department-approved training in training year1/1/22 through 12/31/22

Plan of Correction ***Accept [redacted] - 08/17/2023)***

Immediate Action: On 6/30/2023, the administrator, working with the community owner, clarified her individual calendar year to be May to April (subject to change) in line with the RCG definition of "The Training Year" as outlined in 2600.64(c). This placed her approved training as surveyed during this inspection as being in compliance with 2600.64(c).

Corrective Action: The administrator will identify at least 24 tentative CEU options for 2023/24 using all available sources on or before 7/31/2023 in order for at least 24 CEU's will be obtained by April 2024.

Preventative Action: Using a recap sheet specifying the administrator's current training calendar year as required in 2600.64(c)the administrator will keep a record an ongoing list of all CEU's obtained for the calendar year identified.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] - 12/07/2023)

82a - Poisonous Materials

2. Requirements

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

Description of Violation

There was an unlabeled [redacted], approximately [redacted] and an unlabeled [redacted], approximately [redacted] in the first floor housekeeping closet.

Plan of Correction ***Accept [redacted] 07/24/2023)***

Immediate Action: The spray bottles identified were discarded by the administrator the day of the inspection.
Corrective Action: An audit of all spray bottles was conducted by the administrator and was concluded on 7/17/2023 with no other incorrectly labeled spray bottles were found.
Preventative Action: The administrator, or designee, will check all spray bottles at least weekly for August 2023. Once four consecutive weeks of no problems are found these checks will become random. Problems found during the random checks will be investigated and any findings will be archived, as needed, with the community's next scheduled quality management minutes. All community staff will be retrained on the need for proper labeling of spray bottles at the next community staff meeting planned for 7/27/2023.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented [redacted] - 12/07/2023)

82a - Poisonous Materials *(continued)*

123c - Evacuation Diagrams

3. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home serves 21 residents. However, there was no emergency evacuation diagram posted in a conspicuous and public place in the basement floor.

Plan of Correction ***Accept [redacted] - 08/07/2023)***

Immediate Action: A new evacuation diagram was placed in the missing location following receipt of the LIS on 7/20/2023 by the administrator.

Corrective Action: All other areas of the community requiring an evacuation diagram were audited on 7/20/2023 by the administrator. No other diagrams were found missing.

Preventative Action: The administrator, or designee, working with the community fire safety inspector, or local fire department, will check all areas where evacuation diagrams are required during the annual fire safety inspection (completed July 20, 2023, by administrator and then to be completed by the administrator or designee annually in conjunction with the community annual fire safety inspection) to ensure that all such diagrams are in place including their proper orientation.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] 12/07/2023)

141a 1-10 Medical Evaluation Information

4. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1 uses a bed enabler. However, the resident's initial medical evaluation, dated [redacted], does not indicate an order for a bedside enabler or what need it would address.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Directed [redacted] - 08/17/2023)***

Immediate Action: Working with the resident and family the bed enabler for resident #1 was removed by community staff on 6/30/2023 and the resident will no longer be using the bed enabler.

Corrective Action: The administrator completed an audit of all resident apartments by 6/30/2023. It was confirmed that the bed enablers identified were properly installed, maintained properly and that appropriate documentation, including physician's order, was present in the resident's records. Community staff will be trained by the administrator, or designee, on proper inspection criteria for such devices including the need to alert the administrator, or designee, should a new bed enabler be found with a resident. This training will occur on or before 7/27/2023. Family and resident education will include a letter to be sent to all current residents by 8/15/2023 outlining the community policy and regulatory requirements for bed enablers.

Preventative Action: Staff will routinely monitor resident apartments for new devices including proper installation, corresponding physician orders. The administrator, or designee, will ensure that proper documentation is present in the resident records.

Directed: Staff will monitor resident apartments weekly, beginning no later than 9/1/23, for new devices including proper installation, corresponding physician orders. Documentation will be kept.[redacted] 8/18/21

All staff received training on July 27, 2023 during review of the POC to make sure to notify the administrator immediately if any type of durable medical equipment has been brought into any resident room so that it can be properly used by the resident with the script from the doctor and added to the resident RASP to be in compliance with the DHS 2600 regulations. The administrator or designee will educate the families upon admission to notify the administrator if or when they feel that the resident would need a bed enabler and the proper steps can be taken to ensure the use and safety of the bed enabler.

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 12/07/2023)

141b2 - Medical Evaluation Changes

5. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #2's annual medical evaluation, dated 1/6/23, indicates the resident cannot self-administer medications. However, the resident self-administers multiple medications which were stored in the resident's bedroom to include the following:

* [redacted]
* [redacted]
* [redacted]
* [redacted]

141b2 - Medical Evaluation Changes (continued)

Plan of Correction ***Directed [redacted] - 08/17/2023)***

Immediate Action: Based on this inspection the community administrator immediately initiated an investigation. The root cause of this was a lack of follow through from the prior administrator. It was previously identified that the resident desired, and had the ability, to be independent with her medications. It was therefore decided to request this change from [redacted] physician. The prior administrator did not complete this request as understood by the community staff prior to [redacted] retirement in May 2023. The current administrator immediately contacted the resident's physician and obtained an order for these medications to be self-administered.

Corrective Action: The community administrator, and designees, audited the other resident DME's, including the resident apartments. This audit was completed by 7/8/2023. No other such discrepancies were identified at this time.

Preventative Action: The community administrator, or designee(s), will audit resident apartments at least quarterly to ensure the DME is consistent with any self-medication orders.

Directed: Starting no later than 9/1/23 the community administrator, or designee(s), will audit resident apartments at least quarterly to ensure the DME is consistent with any self-medication orders. [redacted] ***8/18/23***

Directed Completion Date: *07/31/2023*

Implemented [redacted] ***- 12/07/2023)***

183e - Storing Medications

6. 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

There was a [redacted] in the north nurse's station first aid kit. However, the medication label indicated an expiration date of 11/2009.

Resident #2 is prescribed [redacted] with meals three times per day; however the [redacted] and used and does not indicate the date the medication expires or the date the medication was opened

Resident #3 is prescribed [redacted] at bedtime. However, the resident's [redacted] used [redacted] does not have the date the medication was opened nor a date the medication is to expire.

183e - Storing Medications (continued)

Plan of Correction ***Directed [redacted] - 08/17/2023)***

Plan of Correction Item 1
Immediate Action: The first aid kit was an old, unused one that was thought to have been discarded. This old, unused, kit, including the out of date product was discarded by community staff the day of this survey.

Corrective Action: The community will continue to use the sole, active, first aid kit which was part of this inspection. All items were inventoried and found to be in compliance with 2600.96(a-c.) This was done as part of this survey and included verification by the administrator and licensing representatives conducting said inspection.

Preventative Action: The administrator, or designee, will check the first aid kit at least quarterly to ensure that all items are in compliance with 2600.96 and 183(e.)

Plan of Correction Items 2 & 3
Immediate Action: The administrator directed the staff to immediately reorder, properly label and make available, the items identified for use with the resident. The incorrectly labeled items were discarded at the same time.

Corrective Action: The community initiated an audit of all such items to ensure that they were labeled with the date opened and date of expiration specific to the manufacturer directions. This audit was conducted on 6/30/2023 and no other such problems were identified at that time.

Preventative Action: The community administrator, or designee, will perform a cart audit at least monthly including checking that all open and expiration dates are in place accurately applied per manufacturer directions.

Directed: Starting no later than 9/1/23 the community administrator, or designee(s), will perform a cart audit at least monthly including checking that all open and expiration dates are in place accurately applied per manufacturer directions. [redacted] 8/18/23

During inspection, the Med Tech was asked to see the [redacted] for

Additional training for all Med Techs has been scheduled for the earliest available date of August 15, 2023, at 9:00AM with [redacted] for the entire day. Rose Haven will continue to keep [redacted] in the facility as much as possible to make sure that all the Med Techs have the proper training to be in compliance with 2600. regulations.

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 12/07/2023)

185a - Implement Storage Procedures

7. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #2 is prescribed [redacted] – Insert [redacted] on Monday, Wednesday and Friday. However, this medication was not available in the home.

Plan of Correction ***Directed [redacted] 08/17/2023)***

Immediate Action: Based on this inspection the community administrator immediately initiated an investigation. The medication was found in the resident apartment as part of this investigation. The root cause of this was a lack of follow through from the prior administrator in obtaining the self-medication order in a timely manner. It was previously identified that the resident desired, and had the ability, to be independent with her medications. It was therefore decided to request this change from her physician. The prior administrator did not complete this request as understood by the community staff prior to her retirement in May 2023. The current administrator immediately contacted the resident's physician and obtained an order for these medications to be self-administered.

Corrective Action: The community administrator, and designees, audited the other resident DME's, including the resident apartments. This audit was concluded by 7/8/2023 No other such discrepancies were identified at this time.

Preventative Action: The community administrator, or designee(s), will audit resident apartments at least quarterly to ensure the DME is consistent with any self-medication orders.

Directed: Starting no later than 9/1/23 the community administrator, or designee(s), will audit resident apartments at least quarterly to ensure the DME is consistent with any self-medication orders. [redacted] 8/18/23

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 12/07/2023)

8. 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

Resident #2 is prescribed [redacted] four times per day with meals and at bedtime. However, there were multiple incorrect [redacted] in the resident's June 2023 Medication Administration Record (MAR) to include:

** [redacted] – MAR indicates [redacted], however the [redacted] indicates [redacted]*
** [redacted] – MAR indicates [redacted], however the [redacted] indicates [redacted]*

185a - Implement Storage Procedures (continued)

[redacted] – MAR indicates [redacted] however the glucometer indicates [redacted]. *[redacted] –the [redacted] indicates a [redacted]., however there was no record of this [redacted]

Resident #3's [redacted] was not calibrated to the correct date and time.

The home policy includes a procedure where staff count the scheduled and narcotics medication at the change of shift. However, the documentation for resident #4's [redacted] indicates [redacted] are available, however [redacted] are available in the home in the South medication cart.

Plan of Correction ***Accept [redacted] - 08/17/2023)***

Plan of Correction Item 1
Immediate Action: The community administrator and staff amended the record to reflect the correct readings noted during the inspection. This amended record will be added to the resident record by on or by 8/1/2023.

Corrective Action: Med Techs were retrained by the administrator on, or by, 7/17/2023 specific to the proper recording of [redacted]

Preventative Action: The retraining indicated above on 7/17/2023 included checking the recorded readings against the [redacted] as part of the shift change procedure for med techs. Any discrepancies will be corrected using the [redacted] and noting the correction in the MAR.

Plan of Correction Item 2
Immediate Action: Under the supervision of the administrator, the community staff the [redacted] noted was immediately recalibrated to the correct date and time. This occurred on 6/29/2023.

Corrective Action: Med Techs were retrained by the administrator on 7/17/2023 regarding the procedure to confirm accurate calibration of each [redacted] prior to performing ordered [redacted] each shift.

Preventative Action: The retraining indicated above on 7/17/2023 included confirming that each [redacted] is correctly calibrated prior to their use each shift by the med tech. This process will be part of the routine med cart audits the community and pharmacy partners completes.

Plan of Correction Item 3
Immediate Action: Following the survey on 6/29/2023 the community administrator confirmed that the medication counts found were accurate according to the pharmacy partner delivery records. The [redacted] were also updated to reflect this correct count.

Corrective Action: The community will direct their med trainer, or designee, to retrain the med techs on the proper process to apply when performing the shift to shift narcotic counts including the steps to take should a discrepancy

185a - Implement Storage Procedures (continued)

of any kind be found. This training was concluded on 7/17/2023.

Preventative Action: The administrator, or designee, will audit the narcotic counts at least weekly during the month of August 2023. After the month of August, this audit will be conducted during the routine community and pharmacy partner cart audits. Discrepancies, if any, will be added to the next scheduled Quality Management meeting minutes.

Licensee's Proposed Overall Completion Date: *08/01/2023*

Implemented [redacted] - 12/07/2023)

187b - Date/Time of Medication Admin.

9. 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

Resident #2's June 2023 medication administration record (MAR) indicates that the medication was administered between 11:00 p.m. and 1:00 a.m. on the following dates: 6/2/23, 6/5/23, 6/7/23, 6/9/23, 6/12/23, 6/19/23,/6/21/23, 6/23/23, 6/26/23 and 6/28/23. However, according to staff interviews, this medication has not been available in the home since 6/1/23.

Plan of Correction ***Directed [redacted] - 08/17/2023)***

Immediate Action: The resident's record will be updated to reflect the incorrect administration documentations by 8/15/2023. This will be completed by the administrator or designee.

Corrective Action: Staff were retrained by the administrator, or designee, on or before 7/22/2023 on the proper documentation of medication administration including in those instances where the resident self-administers a medication.

Preventative Action: Community, and pharmacy partner cart audits, will include a review of self-administering resident records to ensure that the records reflect a self-medication order.

Directed: Beginning no later than 9/1/23 Community Administrator or designee will conduct med cart audits at least monthly with a review of self-administering resident records to ensure that the records reflect a self-medication order.[redacted] 8/18/23

Directed Completion Date: *08/15/2023*

Implemented [redacted] - 12/07/2023)

187d - Follow Prescriber's Orders

10. Requirements

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

Resident #2 is prescribed [redacted] – Insert [redacted] on Monday, Wednesday and Friday. However, this medication was not available in the home and according to staff interviews the medication has not been administered since 6/2/23.

Plan of Correction ***Directed [redacted] - 08/17/2023)***

Immediate Action: On 6/30/2023 the community staff conducted a search and did find the missing medication in the resident's apartment. An order for the resident to self-administer this medication was also obtained.

Corrective Action: On or by 7/22/2023, community staff were retrained by the administrator on the correct documentation method for medications including medications that are self-administered.

Preventative Action: As part of subsequent cart audits by both the community administrator, or designee, and the community's pharmacy partner records of self-medication will be compared with the resident records to ensure that correct documentation is being applied appropriate to the physician orders.

Directed: Beginning no later than 9/1/23 Community Administrator or designee will conduct med cart audits at least monthly with a review of self-administering resident records to ensure that the records reflect a self-medication order.[redacted] 8/18/23

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 12/07/2023)

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 uses a bed enabler. However, the resident's initial assessment and support plan, dated 9/22/22, does not indicate an assessment of this device or what need it would address.

Plan of Correction ***Directed [redacted] - 08/18/2023)***

Immediate Action: On 6/30/2023, working with the resident and family, the bed enabler for resident #1 was removed pending receipt of a physician's order.

Corrective Action: Under the direction of the administrator an audit of all resident apartments was conducted by the community staff. It was confirmed that the bed enablers identified were properly installed, maintained properly and that appropriate documentation was present in the resident's records including their RASP. Community staff will be trained by the administrator, or designee, on proper inspection criteria for such devices including the need to alert the administrator, or designee, should a new bed enabler be found with a resident during the community's next staff meeting scheduled for 7/27/2023. Family and resident education will include a letter to be sent to all current residents by 8/15/2023 outlining the community policy and regulatory requirements for bed enablers.

225a - Assessment 15 Days (continued)

Preventative Action: Staff will routinely monitor resident apartments for durable medical devices including proper installation, and, corresponding physician orders. The administrator, or designee, will ensure that proper documentation is present in the resident records.

Directed: Staff will monitor resident apartments weekly, beginning no later than 9/1/23, for new devices including proper installation, corresponding physician orders .The administrator, or designee, will ensure that proper documentation is present in the resident records. Documentation will be kept. [redacted] 8/18/21

Directed Completion Date: *08/15/2023*

Implemented [redacted] - 12/07/2023)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's annual assessment and support plan, dated 1/11/23, indicates the resident cannot self-administer medications. However, the resident self-administers multiple medications which were stored in the resident's bedroom to include the following:

*[redacted]

Plan of Correction ***Directed [redacted] - 08/18/2023)***

Immediate Action: Based on this inspection the community immediately initiated an investigation. The root cause of this was a lack of follow through from the prior administrator. It was previously identified that the resident desired, and had the ability, to be independent with [redacted] medications. It was therefore decided to request this change from [redacted] physician. The prior administrator did not complete this request as understood by the community staff prior to [redacted] retirement in May 2023. The current administrator immediately contacted the resident's physician and obtained an order for these medications to be self-administered.

Corrective Action: The community administrator, and designees, by 7/8/2023, audited the other resident DME's, including the resident apartments. No other such discrepancies were identified at that time.

Preventative Action: The community administrator, or designee(s), will audit resident apartments at least quarterly to ensure the DME is consistent with any self-medication orders.

Directed: Starting no later than 9/1/23 the community administrator, or designee(s), will audit resident apartments at least quarterly to ensure the DME is consistent with any self-medication orders.[redacted] 8/18/23

225c - Additional Assessment (continued)

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 12/07/2023)

251b - Record Entries Legible

13. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On 6/29/23 at approximately 2:15 p.m., an agent from the department requested a paper copy of the electronic administration history of [redacted] for resident #2. This electronic record indicated a late entry note from staff person B on [redacted] at approximately 10:30 a.m. indicating "the medication was administered timely, but the documentation of the administration was late". However, at 2:27pm a contracted agent for the home, with administrative electronic medication administrative credentials, remotely removed the note from the electronic record and provided a paper copy version of the record which was redacted and changed to indicate "input correct admin time of 8:30am" which created a duplicate administration on the same date for 8:00 a.m. and 8:30 a.m.

Plan of Correction ***Accept [redacted] - 08/18/2023)***

Immediate Action: While the community disagrees with this violation, the community immediately confirmed that the record did include full documentation of the amended portion. This was part of the survey activities with the licensing representatives the day of the survey.

Corrective Action: As of 6/30/2023 and pending review of the current medication administration record software that the community and their pharmacy partner uses, any amendments will include a note placed in the resident's record noting any such amendments. Such notes, if needed, will commence on or before 7/22/2023 by the administrator or designee.

Preventative Action: The community will work with their pharmacy partner and the software company to ensure that any amendments made are part of the resident's permanent record as required by 2600.251(b). The community administrator and contracted consultant will make such changes, as needed and as possible with either this software, or a different software, by 9/1/2023.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented [redacted] 12/07/2023)