pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: [redacted]

E-mailed on: 10/9/24

[redacted], ADMINISTRATOR
MOUNTAIN VIEW MEMORY CARE LLC
[redacted]

RE: MOUNTAIN VIEW MEMORY CARE
711 ROUTE 119
GREENSBURG, PA 15601
LICENSE/COC#: 45377

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on 2/13/24, of the above facility, we have determined that your submitted plan of correction is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *MOUNTAIN VIEW MEMORY CARE* **License #:** *45377* **License Expiration:** *06/22/2024*

Address: *711 ROUTE 119, GREENSBURG, PA 15601*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *MOUNTAIN VIEW MEMORY CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/13/2006* **Issued By:** *Hempfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *66* **Waking Staff:** *50*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *02/27/2024*

Inspection Dates and Department Representative

02/13/2024 - On-Site: [redacted]
02/15/2024 - Off-Site: [redacted]
02/22/2024 - Off-Site: [redacted]
02/27/2024 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served:** *33*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire Building* **Capacity:** *80* **Residents Served:** *33*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *33*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *33*
Have Physical Disability: *0*

Inspections / Reviews

02/13/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/29/2024*

04/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/07/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/23/2024*

04/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/07/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/07/2024*

10/09/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/07/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 2/12/24, at approximately 8:00 p.m., the personal care home received a phone call from a third-party person outside of the home indicating that there was video evidence of staff person A calling resident #1 a "[redacted]" and throwing the baby doll of resident #1. However, this allegation of abuse was not immediately reported to the local Area Agency on Aging.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

Upon Notification: This administrator reported to AAA on 02/13/24. The staff person involved was suspended on 02/13/24 and terminated on 02/14/24.
Action Plan: The administrator did Safe management Technique training on 3/7/23 which covered the topic of Abuse and neglect. AAA did abuse training for staff on 03/12/24 in regards to regulation 2600.15 a. (Relating to reporting suspected) abuse Documentation shall be kept.
Ongoing compliance: The administrator shall review all internal incidents daily Starting on 04/01/24 to ensure all reportable incidents are reported. All staff including the administrator will complete Abuse and neglect training on line by AAA by 04/30/24. (See attached web site link) This will provide a certificate which shall be kept in employee chart. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/02/2024* ***Not Implemented ([redacted] - 10/09/2024)***

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

On 2/12/24, at approximately 8:00 p.m., the personal care home received a phone call from a third-party person outside of the home indicating that there was video evidence of staff person A calling resident #1 a "[redacted]" and throwing the baby doll of resident #1. However, the home did not report this incident to the Department until 2/14/24.

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediate Action: The DHS was in the building 02/13/24 for a survey and the Administrator did go over the incident with them along with AAA. The DHS paper report was submitted on 2/14/24. Immediately upon notification of any Future incident the administrator or designee will gather the information and complete a reportable incident. (relating to suspected abuse) immediately. New check list implemented documentation shall be kept (new checklist attached)
Action Plan: Staff completed AAA training with [redacted] on 03/12/24. All staff including the Administrator

16c - Written Incident Report (continued)

will complete Abuse and neglect online training on the AAA website upon hire so they can identify what is (relating to abuse and reporting in a timely manner) Documentation shall be kept.
On going compliance: The Administrator will review all internal incidents Daily starting 04/01/24 to ensure all reportable incidents are reported to the Department with 24 hours. Reportable incidents will be reviewed monthly starting on 04/1/24 at the facility team meetings and quality management meetings forthgoing. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024* ***Not Implemented (- 10/09/2024)***

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan (RASP), dated , indicates that the resident requires a Hoyer lift and 2 staff persons for all transfers/mobility. On 2/12/24, at approximately 2:30 p.m., the resident did not receive this assistance as required. Staff person A transferred resident #1 from Broda chair to bed, and back to the Broda chair, without use of a Hoyer lift or the assistance of an additional staff person.

Plan of Correction ***Accept (- 04/30/2024)***

Immediate Action: The staff working on the floor on 02/13/24 was verbally educated by the administrator about the assistance with Residents that required two assist.
Action Plan: Staff Education was conducted on 03/07/24 by the Administrator in regards to 2 assist and Hoyer lifts. New Form created and implemented on 03/27/24 to have two staff people check off that they are doing each resident with two people. Documentation shall be kept (please see attached example)
Ongoing compliance: The administrator or Designee will review new two assist check form created starting 04/01/24. The administrator will review daily for a period of 3 months ending in July 01, 2024. New Hoyer lift training implementation upon hire created to ensure care staff are aware all residents that are Hoyer's are two assist. New Hire Hoyer Training implementation date 4/8/24. Hoyer training Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented (- 10/09/2024)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1's RASP, dated , indicates the resident is diagnosed with dementia and requires a Hoyer lift and 2 staff persons for all transfers/mobility. Staff interviews indicate resident #1 is very attached to baby dolls and carries one with all the time.

On 2/12/24, at approximately 2:30 p.m., staff person A entered resident #1's bedroom, transferred the resident from

42b - Abuse (continued)

[redacted] Broda chair to [redacted] bed, and back to the Broda chair, without use of a Hoyer lift or the assistance of an additional staff person. Staff person A then used a personal mobile phone to record resident #1 in [redacted] Broda chair and sent the recording to a third-party person outside of the home, who confirmed that staff person A stated in the recording that [redacted] had to '[redacted] The third-party person further confirmed that staff person A called resident #1 [redacted] and [redacted] "threw that (resident #1's) baby doll across the room."

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediate Action: Staff Person A was suspended on [redacted] and terminated on [redacted]
Action Plan. Staff education completed on Safe Management Techniques on 03/07/24 by the Administrator covering Abuse and Neglect. AAA [redacted] Conducted an Education for staff on Abuse and Neglect and reporting on 03/12/24. Staff Education on Home's social Media's policy on 03/07/24 by the administrator. Documentation shall be kept. See attached Social Media Policy, Staff Education
Ongoing Compliance: The administrator will review all incidents daily Starting on 04/01/24 to ensure proper care and reporting are being completed. Upon Hire starting 4/20/24 new employees will now complete online training with AAA (Pda-Ims.org) and sign off on MMC Social Media policy. This administrator will interview 3 employees Starting in April 23 2024 monthly x 12 months to ensure all incidents are being reported promptly and resident care, transfers, mobility needs are properly done. Social Media policy attached Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024* ***Not Implemented ([redacted] - 10/09/2024)***

42s - Privacy

5. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home's social networking policy indicates, "Do not post pictures of…any residents"…"do not identify any residents… by name or otherwise."…"any on-line conduct that, if it occurred at work [the personal care home], would be grounds for discipline, up to and including termination of employment."

On 2/12/24, at approximately 2:30 p.m., staff person A used a personal mobile phone to record resident #1 in [redacted] Broda chair in the resident's bedroom and sent the recording to a third-party person outside of the personal care home.

Repeat Violation: 6/6/22

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediately on [redacted] Staff person A was suspended and on [redacted] staff person A was terminated.
Action Plan: Staff Education completed on 03/07/24 by the Administrator/ Safe Management Techniques topic: Abuse and neglect and MVMC Social Media Policy . [redacted] from AAA did Abuse and Neglect Training on 03/12/24 on Abuse and Neglect . Documentation shall be kept.
Ongoing Compliance: The administrator will privately interview 3 residents per week for 1 month starting on 4/23/24, and then monthly for 3 months, to ensure their right to privacy is preserved. Documentation will be kept. All new hires will now have to sign off on social media Policy and complete AAA abuse and neglect training on line and receive a certificate for employee file starting on 4/01/24

Licensee's Proposed Overall Completion Date: *04/22/2024* ***Not Implemented ([redacted] - 10/09/2024)***

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

Description of Violation

Staff person B did not receive training in medication self-administration training during training year January 1, 2023 to December 31, 2023.

Plan of Correction ***Accept (- 04/16/2024)***

On 02/13/24 The Administrative Assistance did a complete audit off all files to ensure compliance with regulation 2600.65F. Documentation shall be Kept Staff Person B completed Training on 03/07/24. Documentation attached. Documentation shall be Kept.
Action Plan: Staff Meeting scheduled for 04/03/24 to review topic Medication-Self administration training. Documentation shall be kept.
Ongoing Compliance: The administrator created a 2024 Training Plan to keep in compliance with regulation 2600.65 F . See attached training plan. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented (- 10/09/2024)

81b - Resident Personal Equipment

7. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

There were two small oxygen tanks, unsecured in a rack or carrying cart, on the shelf in the 100 hallway storage closet.

Plan of Correction ***Accept (- 04/30/2024)***

Immediately on 02/13/24 the two small oxygen tanks were placed in a small rack and secured by the maintenance department worker. They were moved to our 400-hall storage area by the maintenance department worker. (See attached photo)
Action Plan: Staff Education conducted on 3/07/24 by the administrator in regards to storage and security of oxygen tanks. Documentation shall be kept.
Ongoing Compliance: The administrator added oxygen tanks to the maintenance daily round check list. Starting 04/02/24 Maintenance or designee will check to ensure all oxygen tanks are secure daily x 2 weeks then monthly x 2 months and will remain on check list for compliance. See attached check list Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented (- 10/09/2024)

88a - Surfaces

8. Requirements

2600.

88a - Surfaces *(continued)*

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

Description of Violation

The right-side door bracket, for the double doors leading into the dining area, was bent and the door was unable to be closed.

Plan of Correction ***Accept (- 04/30/2024)***

Immediately on 02/13/24 The Maintenance Director removed the bent bracket. The door was completely functional at that time.
Action Plan: Staff Education completed on 03/07/24 by the administrator in regards to Doors in good working order. Compliance with Regulation 2600.88 a. Door rounds added to daily check list. Documentation shall be kept.
Ongoing compliance. The administrator added door checks to the maintenance daily round check list. Starting 04/02/24 Maintenance or designee will check to ensure all doors are functioning daily x 2 weeks then monthly x 2 months and will remain on check list for compliance. See attached check list Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented (- 10/09/2024)

101j3 - Bed/Linens/Pillows/Blankets

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

There was no pillow in resident #2's bedroom.

Repeat Violation: 6/2/23

Plan of Correction ***Accept (- 04/30/2024)***

Upon notification of 02/13/24 that resident # 2 did not have a pillow Dr. wrote an order that it was ok for resident #2 not to have a pillow due to behaviors. Order attached. Documentation shall be kept.
Action Plan: Staff Education on 03/07/24 by the administrator in regards to regulation 2600.101 J 3. Documentation shall be kept.
Ongoing Compliance: The administrator or designee will inspect each bedroom weekly x 12 months starting on 4/23/24 to ensure each resident has a pillow, bed linens and blankets that are clean and in good repair, unless otherwise indicated by their prescriber. Documentation will be kept. The administrator updated Resident's #2 RASP on 03/12/24for ongoing compliance. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented (- 10/09/2024)

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

103g - Storing Food *(continued)*

Description of Violation

A bag of diced chicken and a bag of bacon was open and unsealed in the walk-in refrigerator.

The following food items were open and unsealed in the walk-in freezer:
Two plastic bags containing hash browns
One plastic bag containing green beans
One plastic bag containing mixed vegetables
One plastic bag containing French toast sticks
One plastic bag containing frozen pancakes

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediately: On 02/13/24 the kitchen staff sealed the has browns, green beans, mixed vegetables, French toast sticks and frozen pancakes.
Action Plan: The Administrator completed staff education on 4/3/24 in regards to regulation 2600.103 with Kitchen Staff. New Dietary Manger Hired for ongoing compliance to start 04/08/24. See Education handout attached. Documentation shall be kept.
Ongoing Compliance: The Dietary Manager or Designee will check Freezer area daily starting 04/2/24 x 2 weeks then weekly x 2 weeks then monthly x 2 months to ensure compliance with regulation 2600.103 g. Dietary Freezer check list Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024* ***Not Implemented ([redacted] - 10/09/2024)***

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

There was an approximate 1/8-inch accumulation of lint in the lint trap of dryer #2.

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediately on 02/13/24 The Laundry person cleaned the lint from the dryer.
Action Plan: The Administrator did staff educated on the importance of lint removal from dryer lint traps on 03/07/24. Staff re-education also scheduled for 04/03/24 by the administrator due to 2 new laundry hires. New check list implemented to ensure compliance of regulation 2600.105 g. Documentation shall be kept.
Ongoing Compliance: Staff check list implemented to do checks starting 04/02/23 daily x 2 weeks, then weekly x 2 weeks then monthly x 2 months to understand importance of regulation 2600.105 g. New Signage created and hung in laundry room on 04/02/24. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024* ***Not Implemented ([redacted] - 10/09/2024)***

107c - Food/Water 3 Day Supply

12. Requirements

107c - Food/Water 3 Day Supply *(continued)*

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 2/13/24, the home served 33 residents, requiring 99 gallons of emergency drinking water. However, the home had only 86 gallons. The home does not have a contract with a local bottled water supplier that includes a guarantee that the water will be delivered immediately upon request, 24-hours-per-day, and a guarantee that the water will be delivered as a priority even in the event of a regional general emergency.

Plan of Correction ***Accept (- 04/30/2024)***

Immediately: 02/13/24 MVMC had sufficient water supply in the building when surveyor was present. It was just not located all in the same area. We had 106 gallons on site. (The water was already on site) this was not a tag brought up at exit.
Action Plan: This administrator had maintenance clean out on designated area and place all food/water supply in one area . We actually have 109 gallons to date. (see attached picture)
Ongoing compliance: Maintenance will continue to observe Census with water supply to ensure MVMC continue compliance with regulation 2600.107 c. Documentation shall be kept. Staff check list implemented to do checks starting 04/02/23 daily x 2 weeks, then weekly x 2 weeks then monthly x 2 months to understand importance of regulation 2600.105 g. New Signage created and hung in laundry room on 04/02/24. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented (- 10/09/2024)

183d - Prescription Current

13. 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

Quetiapine 25mg- take by mouth ½ tablet (12.5mg) twice daily as needed, belonging to resident #3 was in the medication cart; however, the medication was discontinued.

Plan of Correction ***Accept (- 04/30/2024)***

Immediately on 02/13/24 staff removed the Quetiapine 25mg from the cart. Verbal Staff Education on 2/13/24 to the Med-tech by the administrator of the importance of removing medication when they are discontinued.
Action Plan: Pharmacy Med-cart Audit /staff med cart audit scheduled for 04/18/23 Documentation shall be kept. Staff Education on Medication Management and Self-Administration on 04/03/24 completed by the administrator. Documentation shall be kept.
Ongoing Compliance: The administrator or Designee will Audit the Medication carts Quarterly x 1 year starting 04/18/24 documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented (- 10/09/2024)

185a - Implement Storage Procedures

14. Requirements

185a - Implement Storage Procedures *(continued)*

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 blood glucose readings were recorded on resident #2's February 2024 medication administration record (MAR); however, they were not indicated on the resident's glucometer:
2/2/24 at 8:00 a.m., a reading of 100
2/7/24 at 12:.00 p.m., a reading of 368

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediately: Verbal staff education was given to the Medication Tech about proper documentation when recording glucose readings given by the administrator.
Action Plan: The administrator completed staff education on 4/3/24 to review how glucometers work and documentation of glucose readings. Documentation shall be kept.
Ongoing Compliance: The Administrator or designee will review the glucometers starting on 04/8/23 x 2 weeks then weekly x 2 weeks then monthly x 2 months to ensure compliance with regulation2600.185a

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented ([redacted] - 10/09/2024)

231c - Preadmission Screening

15. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit on [redacted] However, the resident's written cognitive preadmission screening, dated [redacted] was not signed by the person completing the screening. This section of the form was blank.

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediately: The administrator who is a LPN updated the cognitive preadmission screening. Documentation will be kept.
Action Plan: Staff Education in regards to Regulation 2600.231 C Preadmission Screening / filling out and compliance scheduled for 04/03/24 completed on by the administrator . Documentation shall be kept.
Ongoing compliance: The administrator or designee will complete a pre admission memory care checklist to ensure pre-admission screens are completed entirely. The administrator to complete the pre-screen and the Director of Wellness to review and file. The Director of Wellness will review all new pre-admission screens x 12 months starting on 4/23/24 using the pre-admission screen check list. Documentation shall be kept. LPN Supervisor did a chart Audit with the chart audit check form to check pre-admission screens . Chart audit completed on 04/01/24. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented ([redacted] - 10/09/2024)

234d - Support Plan Revision

16. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #2's support plan, dated [redacted] indicates the resident has moderate supervision needs, minimal exit seeking at this time, and does not indicate any self-harming behaviors. However, multiple staff interviews indicate resident #2 is often exit-seeking, has wandered outside to the home's courtyard and has self-harming behaviors to include attempting to suffocate [redacted] with clothing and a pillow in [redacted] bedroom.

Plan of Correction ***Accept ([redacted] - 04/30/2024)***

Immediately on 02/13/24 the LPN/Administrator updated [redacted] rasp to reflect increased behaviors and moderate supervision needs.
Action Plan: Staff Education completed on 4/3/24 by the administrator to notify LPN or administrator of changes in behavior or supervision
Ongoing Compliance: The Administrator or Wellness Director will review all residents condition to ensure no changes. This will be reviewed at monthly staff meeting to get staff's input. Review of all residents condition/ status of supervision needs will be monthly starting on 05/01/24 x 12 months. The Administrator or LPN will review all Rasp by 4/30/24 to ensure all resident and mobility and supervision is accurate. See attached Check list (Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented ([redacted] - 10/09/2024)