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

May 2, 2024

, OWNER
PERSONAL CARE AT EVERGREEN INC

RE: PERSONAL CARE AT EVERGREEN
25 GLADE AVENUE
WAYNESBURG, PA, 15370
LICENSE/COC#: 40090

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/03/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PERSONAL CARE AT EVERGREEN* **License #**: *40090* **License Expiration**: *08/17/2024*

Address: *25 GLADE AVENUE, WAYNESBURG, PA 15370*

County: *GREENE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *PERSONAL CARE AT EVERGREEN INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/24/2003* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *46* **Waking Staff**: *35*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/03/2024*

Inspection Dates and Department Representative

04/03/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *44* **Residents Served**: *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *32*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *14* **Have Physical Disability**: *0*

Inspections / Reviews

04/03/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/29/2024*

05/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

Inspections / Reviews *(continued)*

05/02/2024 Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *05/02/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 9:50 a.m., the privacy coding for the licensing inspection conducted on 11/1/22 included resident #1's name.

At approximately 10:00 a.m., a white binder containing diet schedules, bowel documentation and narcotic count sheets for multiple residents, including residents #1 and #2, was unlocked, unattended and accessible on the second-floor medication cart.

Plan of Correction ***Accept █ - 05/02/2024)***

On 4/3/24 the privacy coding for the licensing inspection conducted on 11/1/22 was immediately removed.
On 4/3/24 the white binder containing the resident's information that was left unlocked, unattended and accessible on the second-floor medication cart was immediately locked up.
All staff were educated on regulation 17 on 4/16/24.
Executive Director will begin monitoring all areas of the building starting 4/29/24 daily, Monday through Friday, for two weeks and then weekly for one month ending on 6/7/24, to ensure resident records are kept confidential in regard to regulation 17.

Licensee's Proposed Overall Completion Date: *06/07/2024*

Implemented █ - 05/02/2024)

65f - Training Topics

2. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff person B, hired on 5/12/21 did not receive training in care for residents with dementia and cognitive impairments or medication self-administration for training year 2023.

Plan of Correction ***Accept (JD - 05/02/2024)***

Executive Director completed an employee file audit on all staff currently employed in the facility on 4/25/24.
All staff were educated on regulation 65.f. on 4/16/24.
Executive Director is developing a new staff training plan that will begin May of 2024 and run to May of 2025, to

65f Training Topics (continued)

have monthly education's scheduled with staff to ensure all training topics are covered under regulation 65.f. Please see attached.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/02/2024)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff person A, hired on did not receive training in emergency preparedness during training year 2023.

Staff person B, hired on did not receive training in emergency preparedness, during training year 2023.

Plan of Correction ***Accept - 05/02/2024)***

Executive Director completed an employee file audit on all staff currently employed in the facility on 4/25/24.
All staff were educated on regulation 65.g. on 4/16/24.
Executive Director is developing a new staff training plan that will begin May of 2024 and run to May of 2025, to have monthly education's scheduled with staff to ensure all training topics are covered under regulation 65.g. Please see attached.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented - 05/02/2024)

65i - Training Record

4. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff person B's training record does not include the date of training, who conducted the training or the amount of time of the training.

Plan of Correction ***Accept - 05/02/2024)***

Executive Director completed an employee file audit on all staff currently employed in the facility on 4/25/24.
All staff were educated on regulation 65.i. on 4/16/24.
Executive Director is developing a new staff training plan that will begin May of 2024 and run to May of 2025, to have monthly education's scheduled with staff to ensure all training topics are covered under regulation 65.i. to include date of training, who conducted the training and the amount of time the training took. Please see attached.

65i - Training Record *(continued)*

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/02/2024)

107c - Food/Water 3 Day Supply

5. Requirements

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 4/3/24, the home served 32 residents, requiring 96 gallons of emergency drinking water. However, the home had only 55 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction ***Accept (- 05/02/2024)***

the company that supplies our emergency water, delivered enough water to cover all resident's served in the home on 4/16.24.
Please see attached letter for contract we have with .
All staff were educated on regulation 107.c. on 4/16/24.
Cook will monitor the emergency water weekly for one month starting 4/29/24 and then monthly for three months after ending in August 2024 to ensure we maintain compliance for regulation 107.c.

Licensee's Proposed Overall Completion Date: *08/29/2024*

Implemented - 05/02/2024)

131a - Fire Extinguisher

6. Requirements

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

There was no fire extinguisher in the home's attic.

Plan of Correction ***Accept (- 05/02/2024)***

Fire extinguishers were immediately placed in the attic on 4/4/24.
All staff were educated on regulation 131.a. on 4/16/24.
Executive Director will check attic weekly starting 4/29/24 for one month and then monthly for two months after ending in July of 2024 to ensure we maintain compliance for regulation 131.a.

Licensee's Proposed Overall Completion Date: *07/29/2024*

Implemented - 05/02/2024)

132a - Monthly Fire Drill

7. Requirements

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

Description of Violation

An unannounced fire drills were not conducted during the months of July and August of 2023.

132a - Monthly Fire Drill *(continued)*

Plan of Correction ***Accept (█ - 05/02/2024)***

Executive Director immediately reached out to local fire department to obtain correct fire letter stating the homes evacuation time and safe areas. See attached.
All staff were educated on regulation 132.a. on 4/16/24.
Executive Director will monitor fire drills monthly starting May of 2024 for one year to ensure fire drills are conducted and facility is in compliance with regulation 132.a.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/02/2024)

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 approximately 12:57 p.m., there were 7 pills in an unlabeled pill cup in medication cart 3.

At approximately 1:05 p.m., there were 2 loose pills in the second drawer of medication cart 2.

Plan of Correction ***Accept █ 05/02/2024)***

Executive Director completed a whole house cart audit on 4/16/24 and 4/17/24 to ensure all carts stored all medications in an organized manner under proper conditions in regard to regulation 183.e.
All medication technicians were educated on regulation 183.e. on 04/16/2024.
Director of Resident Care will audit medication carts monthly starting 5/16/24, for two months and then quarterly after that to ensure all carts store all medications in an organized manner under proper conditions in regard to regulation 183.e.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented █ - 05/02/2024)

185a - Implement Storage Procedures

9. 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 #3's glucometer was not calibrated to the current date and time. Multiple staff interviews indicate they are unaware of how to calibrate resident glucometers.

Plan of Correction ***Accept (█ - 05/02/2024)***

All glucometers in the home were checked and calibrated appropriately to the current date and time on 4/16/24 and 4/17/24.
All medication technicians will be educated on how to calibrate resident glucometers appropriately by our facility train the trainer on 5/7/24. Director of Resident Care will audit medication carts monthly starting

185a - Implement Storage Procedures (continued)

5/16/24, for two months and then quarterly after that to ensure all resident glucometers are calibrated to the correct date and time to ensure compliance with regulation 185.a.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented - 05/02/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident #2 is ordered blood glucose checks twice daily at . However, on , the blood glucose checks were not completed.

Repeat Violation; 6/15/22 et al

Plan of Correction ***Accept (- 05/02/2024)***

Executive Director completed a whole house cart audit on 4/16/24 and 4/17/24 to ensure blood glucose checks are being completed on all shifts.
All medication technicians will be educated on blood glucose checks by the facility train the trainer on 5/7/24.
Director of Resident Care will audit medication carts monthly starting 5/16/24, for two months and then quarterly after that to ensure all blood glucose checks are being completed and the home is in compliance with regulation 187.d.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented - 05/02/2024)

223a - Description of Service

11. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home's current written description of services does not include financial management for residents; however, the home does provide financial management if needed.

Plan of Correction ***Accept (- 05/02/2024)***

The home was assisting resident #2 with financial management. Resident was discharged from an SSI home that was closing, the healthcare rep payee that was in place for resident #2 was terminated from facility.
Executive Director currently working with The Arc in Greene County on getting resident a new healthcare rep payee.
Application submitted to Brean Fuller 4/24/24.
Executive Director keeping financial records with resident #2 until healthcare rep payee is effective.

223a - Description of Service (continued)

Moving forward the home will not be assisting residents with financial management and if we accept SSI residents in the future, Executive Director will ensure a healthcare rep payee is in place prior to admitting resident.

Licensee's Proposed Overall Completion Date: *05/31/2024*

Implemented (- 05/02/2024)