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

November 21, 2024

[REDACTED], PRESIDENT
KELLY S II PERSONAL CARE HOME INC
141 UNITY CEMETERY ROAD
LATROBE, PA, 15650

RE: KELLY'S II PERSONAL CARE HOME
141 UNITY CEMETERY ROAD
LATROBE, PA, 15650
LICENSE/COC#: 44840

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/14/2024 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,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *KELLY'S II PERSONAL CARE HOME* **License #**: *44840* **License Expiration**: *05/04/2025*

Address: *141 UNITY CEMETERY ROAD, LATROBE, PA 15650*

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

Administrator

Name: **Phone**: **Email**:

;

Legal Entity

Name: *KELLY S II PERSONAL CARE HOME INC*

Address: *141 UNITY CEMETERY ROAD, LATROBE, PA, 15650*

Phone:

Certificate(s) of Occupancy

Type: *R 3* **Date**: *03/05/2010* **Issued By**: *L&I*

Type: *C 2 LP* **Date**: *05/15/1992* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *9* **Waking Staff**: *7*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/14/2024*

Inspection Dates and Department Representative

08/14/2024 *On Site*:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *7*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *7*

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

08/14/2024 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *09/04/2024*

Inspections / Reviews *(continued)*

09/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *09/30/2024*

10/07/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/14/2024*

11/21/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/14/2024*

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

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted] is providing unsupervised ADL services. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept ([redacted] - 09/23/2024)***

Staff member A is no longer employed by Kelly's II PCH. On Wednesday 09/04/2024 administrator made changes to new hire requirements and documentation policy to reflect ALL staff members including CNA's, to complete and pass the department approved direct care training. Upon hiring all employees must complete and pass "DA Direct Care Staff Training" before beginning any training on the floor. Once employee provides certificate of passing of the competency test to management they then can start scheduled training on the floor. New hire checklist and 1/4(quarterly) check list have been modified to assure "Department-approved direct care training course" is complete before any other training is to begin. Administrator will sign off verifying both check list is correct. All current employees have passed "Department-approved direct care training course" as documented in 1/4 check for September 2024.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented [redacted] - 11/21/2024)

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

Direct care staff person B did not receive training in the following topics during training year January 1, 2023 to December 31, 2023:
Medication self-administration
Care for residents with dementia and cognitive impairments
Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
Personal care service needs of the resident
Safe management techniques

65f Training Topics (continued)

Direct care staff person C did not receive training in the following topics during training year January 1, 2023 to December 31, 2023:
Medication self administration
Care for residents with dementia and cognitive impairments
Personal care service needs of the resident
Safe management techniques

Plan of Correction ***Accept (- 09/23/2024)***

Upon learning that Administration may create annual training in services required for all staff members, the administrator changed the training requirement policy and procedures. Administration made 12 self training in service guides with competency test along with online videos. To provide better support and care to each resident. As of 09 01 2024 a new training plan has been created and implemented. All staff members will begin completing 3 mandatory in services monthly to assure 12 hours of training in services are met annually. Management will check in service tests Bi weekly and issue Certification of Completion for all passing staff members. Certification and documentation of 1 hour in service credit will be done at that time. Management/administrator will sign initials to verify credits documented, and also check at the end of the month, to assure all staff has completed mandatory monthly in class self training guides and tests. Administrator will again initial and date if all in services/tests are done for that said month.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented - 11/21/2024)

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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B did not receive training in the following topics during training year January 1, 2023 to December 31, 2023:
Emergency preparedness procedures and recognition and response to crises and emergency situations
Falls and accident prevention

Staff person C did not receive training in the following topics during training year January 1, 2023 to December 31, 2023:

65g Annual Training Content (continued)

Resident rights
The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102)
Falls and accident prevention

Plan of Correction ***Accept (- 10/07/2024)***

Upon learning that Administration may create annual training in services required for all staff members, the administrator changed the training requirement policy and procedures. Administration made 12 self training in service guides with competency test along with online videos. To provide better support and care to each resident. As of 09 01 2024 a new training plan has been created and implemented. All staff members will begin completing 3 mandatory in services monthly to assure 12 hours of training in services are met annually. Management will check in service tests Bi weekly and issue Certification of Completion for all passing staff members. Certification and documentation of 1 hour in service credit will be done at that time. Management/administrator will sign initials to verify credits documented, and also check at the end of the month, to assure all staff has completed mandatory monthly in class self training guides and tests. Administrator will again initial and date if all in services/tests are done for that said month. Both staff persons completed the missing 2023 trainings once new training plan was implemented. Staff person B completed emergency preparedness and recognition and response to crises and emergency situations, on 09/09/2024, Falls & Accident prevention on 09/24/2024. As for staff person C they completed Older Adult Protective Services Act on 09/09/2024. and Both Residents rights and Falls & Accident prevention were completed on 09/24/2024

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented - 11/21/2024)

66a - Staff Training Plan

4. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2024.

Plan of Correction ***Accept - 09/23/2024)***

On 09/01/2024 Management and administrator re created and implemented a 2024 annual staff training plan. As well as an annual staff training plan for 2025. 2024 training plan will include 3 mandatory in services per month, including the mandatory training topics in order to reach at least 12 hours of training in services for the year. Will be apart of the homes annual checklist to ensure all training hours and topics have been covered. Management will check in service tests Bi weekly and issue Certification of Completion for all passing staff members. Certification and documentation of 1 hour in service credit will be done at that time. Management/administrator will sign initials to verify credits documented, and also check at the end of the month, to assure all staff has completed mandatory monthly in class self training guides and tests. Administrator will again initial and date if all in services/tests are done for that said month.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented (- 11/21/2024)

82a - Poisonous Materials

5. Requirements

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

Description of Violation

There was a clear spray bottle filled with approximately 850ml of blue liquid under the kitchen sink that did not have the original label. Staff indicated it was cleaner mixed with water.

Plan of Correction ***Accept ██ - 09/23/2024)***

On 08/15/2024 administrator printed a label that correctly states what is in the "Blue liquid" is in the spray bottle, which says "Mr. Clean and Water" , and was stuck on the front of the spray bottle. Along with the original factory label for Mr. Clean that has been attached to the back of the bottle. Starting the week of 09/09/2024 as a part of the weekly checklist, administrator will check to ensure all poisonous materials are kept in the original, labeled container. A Staff in-service was given on 09/09/2024 to reflect the homes new policy going forward, that will not tolerate the use or making of any self made cleaners, with the use of poisonous materials. We will only be using pre-made bought cleaners with original labeled containers.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented ██ - 11/21/2024)

85e - Trash Outside Home

6. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

There was garbage and debris on the ground behind the home's dumpster to include multiple plastic food containers, discarded drinking cups, and paper/plastic items in various stages of decomposition.

Plan of Correction ***Accept (██ - 09/23/2024)***

On 09/02/2024 Administrator along with one other staff member cleaned up any garbage and debris on the ground and behind the homes dumpster. Beginning on the week of 09/09/2024 administrator and management created and implemented a twice a week cleaning schedule for garbage and debris behind the dumpster. This will be conducted twice a week (Monday/Friday) by any staff persons. This clean up will require staff to fill out a chart verifying if it was clean or needed to be cleaned on said day and fill in their initials and the date on the form. Once a week administrator will also look over the form to ensure its being filled out and cleaning is done, as well as checking outside to see if the dumpster area is free of garbage and debris.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented ██ - 11/21/2024)

88a - Surfaces

7. Requirements

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

Description of Violation

The vanity under the sinks in the large common bathroom is in disrepair. The door on the left-hand side has a

88a - Surfaces (continued)

broken hinge and is not secure. In addition, the white, painted plywood front has an approximate 2-inch crack and is lifting off approximately 1/4 inch from the vanity, with sharp edges, posing a skin tear hazard.

Plan of Correction ***Accept - 09/23/2024)***

on 08/16/2024 To prevent any future possible hazards administrator repaired and securely shut both doors underneath the vanity permanently. Administrator also made repairs to the vanity itself sealing and closing all cracks, that could pose a potential skin tare hazard. Starting the week of 09/09/2024 checking all floors, doors, ceilings, windows, and other surfaces to be clean, in good repair and free of hazards. Will be implemented on a weekly checklist that will be conducted by Administrator or management.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented - 11/21/2024)

91 - Telephone Numbers

8. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident #1's bedroom.

Plan of Correction ***Accept - 09/23/2024)***

On 09/06/2024 administrator printed out and posted Emergency Telephone numbers on Resident #1's phone. Beginning on the week of 09/09/2024 administrator or management will check all phones in the facility to ensure they all have emergency telephone numbers attached to the phone or close by. Also on 09/09/2024 administrator added a portion onto our existing new resident checklist that will state wether, or not the new resident has their own private telephone. And if so are the emergency telephone numbers posted or nearby .

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented (- 11/21/2024)

96a - First Aid Kit

9. Requirements

2600.

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

Description of Violation

The first aid kit in the laundry room does not include gauze pads, eye coverings, and tweezers.

Plan of Correction ***Accept - 09/23/2024)***

On 09/04/2024 a new 1st aid kit and protective eye covering was purchased by administrator and is pending delivery. Once delivered administrator will check the 1st aid kit to assure the required items below can be found in at-least one first aid kit in the facility.

Gloves, antiseptic, adhesive bandage, gauze pads, thermometer, adhesive tape, scissors, breathing shield(CPR), eye coverings, and tweezers.

96a - First Aid Kit (continued)

First aid kit quantity check has been added to weekly checklist conducted by administrator or management to assure all required items are accounted for. New kit and eye wear will be included on 1/4(quarterly) Sept 2024 checklist.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented (█ - 11/21/2024)

101j7 - Lighting/Operable Lamp

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #2 does not have access to a source of light that can be turned on/off at bedside. The lamp near the bed is not operable.

Plan of Correction ***Accept (█ - 09/23/2024)***

On 08/15/2024 administrator replaced the light bulb in resident #2's bedside lamp, and ensured it is indeed operable. On 09/09/2024 administrator purchased 8 LED light pucks to use as a separate effort, to always provide adequate lighting for residents at all times. And also serve as a backup light, incase their bedside lamp were to fail during the night time hours, or during power outages. Starting on 09/09/2024 administrator or management will check to ensure that ALL residents have operable bedside lamp or light source, as a part of the weekly checklist.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented █ - 11/21/2024)

132e - Fire Drill Sleeping Hours

11. Requirements

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

Description of Violation

The home has not had a documented fire drill conducted during sleeping hours since 9/26/23.

Repeat Violation: 9/6/23

Plan of Correction ***Accept (█ - 09/23/2024)***

On 09/09/2024 administrator created and implemented a secondary checklist for fire drills to ensure proper documentation. This list will be used in conjunction with the monthly fire drill record form the state provides. Furthermore it will be included with our quarterly checklist to assure the home is in compliance.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented (█ - 11/21/2024)

184a - Resident's Meds Labeled

12. Requirements

2600.

184a - Resident's Meds Labeled *(continued)*

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #1 is prescribed [redacted], take 1 capsule by mouth 3 times a week; however, the pharmacy label indicates take by mouth daily.

Resident #2 is prescribed [redacted], inject 6 units subcutaneously at lunch and dinner daily, and inject 4 times daily per sliding scale: [redacted], [redacted]. However, the pharmacy label indicates the sliding scale only.

Resident #3 is prescribed [redacted], take by mouth 1 tablet every morning, and take 1 tablet every 4 hours as needed. The home has two bottles of medications for this prescription; however, one bottle has a pharmacy label that indicates [redacted], take by mouth 1 tablet every morning, and the other bottle has a pharmacy label that indicates [redacted], take 2 tablets by mouth 4 times a day as needed.

Repeat Violation: 9/6/23

Plan of Correction ***Accept ([redacted] - 09/23/2024)***

On [redacted] Bridges hospice provided a new pharmacy label for resident #1 that states take 1 capsule by mouth every Mon-Wed-Friday (3 times a week).
For resident #2 Health-Direct pharmacy provided new labels for the [redacted] that correctly states the Sub-Q units at breakfast, lunch, and dinner daily and also SQ 4 times daily per sliding scale on 08/16/2024.
At time of inspection administrator placed a " Directions Changed See MAR" sticker on resident #3's Acetaminophen 650mg, and the Acetaminophen 325mg was discarded. As of 09/04/2024 manager and administrator are still trying to get proper pharmacy label that matches the medication order from Suncrest Hospice, and states Acetaminophen 650mg, take by mouth 1 tablet every morning, and take 1 tablet every 4 hours as needed for pain. A "Directions Changed See MAR" sticker has been applied to new bottles used while awaiting correct label.
On 09/09/2024 a retrain staff In-service was given to all Med aides on how to properly check prescribed medications/Over the counter medicines coming from pharmacy prior to placing in medication cart, the importance of both correct labeling, and assuring all 5 rights are correct for each medication. Starting on the week of 09/09/2024 Checking all residents medication labels will be a part of the weekly medication checklist as further explained in 184b.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented [redacted] 11/21/2024)

184b - Labeling OTC/CAM

13. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident’s name.

Description of Violation

A package of [redacted] caplets belonging to resident #4 was in the home's medication cart and was not labeled

184b - Labeling OTC/CAM (continued)

with the resident's name.

Plan of Correction ***Accept (- 09/23/2024)***

Resident #4's was labeled with the residents name by administrator on day of inspection (08/14/2024). Starting on 08/19/2024 administrator has implemented a comprehensive weekly medication checklist that will be conducted by administrator alongside one other Med-tech. That will ensure over the counter labels/pharmacy labels are correct and in order. Along with expiration dates, and Administrator will order any medications needed. On 09/09/2024 a retrain staff In-service was given to all Med aides on how to properly check prescribed medications/Over the counter medicines coming from pharmacy prior to placing in medication cart, the importance of both correct labeling, and assuring all 5 rights are correct for each medication.

Licensee's Proposed Overall Completion Date: *09/09/2024*

Implemented - 11/21/2024)