pennsylvania
DEPARTMENT OF HUMAN SERVICES

August 20, 2019

Mr. David Gritzer
Executive Director
Mars Holding, Inc.
191 Scharberry Lane
Mars, Pennsylvania 16046

RE: Rosecrest Assisted Living Residence
PO Box 1285
1000 Graham Way
Mars, Pennsylvania 16046
Certificate #: 444450

Dear Mr. Gritzer:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 3, 2019, of the above facility, the violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *ROSECREST ASSISTED LIVING RESIDENCE* License Number: *444450*
Address: *1000 GRAHAM WAY P O BOX 1285, MARS, PA 16046*
County: *BUTLER* Region: *WESTERN*

Administrator

Name: *Deborah Serafine* Phone: *7246873370* Email: *deborah.serafine@LUTHERANSENIORLIFE.ORG*

Legal Entity

Name: *MARS HOLDING INC*
Address: *191 SCHARBERRY LANE, PA, 16046*

Certificate(s) of Occupancy

Type: *I-2* Date: *04/11/2011* Issued By: *Mars Borough*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *58* Waking Staff: *44*

Inspection

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

Inspection Dates and Department Representative

05/03/2019 - On-Site: Belinda Graziano, Karen Georgoulis

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* Residents Served: *29*

Special Care Unit

In Home: *Yes* Area: *All* Capacity: *30* Residents Served: *29*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *29*
Diagnosed with Mental Illness: *4*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *29*
Have Physical Disability: *0*

23a ADL assistance

Requirements

2800.

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

Description of Violation

Resident #1's annual assessment, dated 7/23/18, indicates an updated note, dated 4/11/19, on personal hygiene to include "soap is locked up in (resident's) bathroom cabinet. (Resident) eats soap." However, at 3:16 p.m., a white bar of soap was in the resident's bathroom on the left side of the sink.

Repeat Violation: 8/2/18

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 2a of 10)

Legal Entity Representative

Signature	Printed Name and Title	Date
	Deborah Serafine, ALA	6/27/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 7/24/19 (Date)

The above plan of correction was approved by JW (Initials)

Plan of correction implementation status as of 7/24/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

RoseCrest Assisted Living

Plan of Correction

Annual Survey 5/3/2019

Regulation – 23a A residence shall provide each resident with assistance with ADL's as indicated in the resident's assessment and support plan.

Violation – Resident #1's annual assessment, dated 7/23/18, indicates an updated note, dated 4/11/19, on personal hygiene to include "soap is locked up in (resident's) bathroom cabinet. (Resident) eats soap." However, at 3:16pm, a white bar of soap was in the resident's bathroom on the left side of the sink.

Plan of Correction - As soon as the soap was noticed on the sink it was immediately locked up in the bathroom cabinet. All resident coordinators will be educated on the importance of following the care plans to ensure assistance with ADL's are being done accordingly. This particular resident has since been discharged, however, weekly audits will continue to be done on the rest of the residents to ensure that their soap is on their bathroom sink.

Deborah Serafini, ALA 6/27/19

81b Resident equip – good repair

Requirements

2800.

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

Resident #2's bed has an enabler bar attached to the top right side of the bed. The bar is loose and moves back and forth approximately 5 inches.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 3a of 10)

Legal Entity Representative

Signature

Deborah Serafin, ALA
Printed Name and Title

6/27/19
Date

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Plan of correction implementation status as of 7/24/19 (Date)

The above plan of correction was approved by (Initials)

- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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

Violation – Resident #2's bed has an enabler bar attached to the top right side of the bed. The bar is loose and moves back and forth approximately 5 inches.

Plan of Correction – Maintenance was called to check on this enabler bar and informed us that this is the way that the enabler bar is intended to function. It has the ability to be folded down during the day and then can be held up by putting a pin into it. This causes it to have some mobility when it is in the upward position. The son was notified that we can no longer use this enabler bar and he will be bringing in a new one that will be sturdier. Once the new enabler bar is in place we will have maintenance inspect it to ensure it is sturdy and in good working order. We will conduct monthly checks of all equipment to ensure that they are all in good working order and not in need of any repairs.

Deborah Serafin, ALA 6/27/19

91 Telephone Numbers

Requirements

2800.

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

Description of Violation

At 10:20 a.m., none of the emergency service telephone numbers were posted on or near the telephone in the computer area of Pebble Brook.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 4a of 10)

Legal Entity Representative

Signature

Deborah Serafine, ALA — Printed Name and Title

6/27/19 — Date

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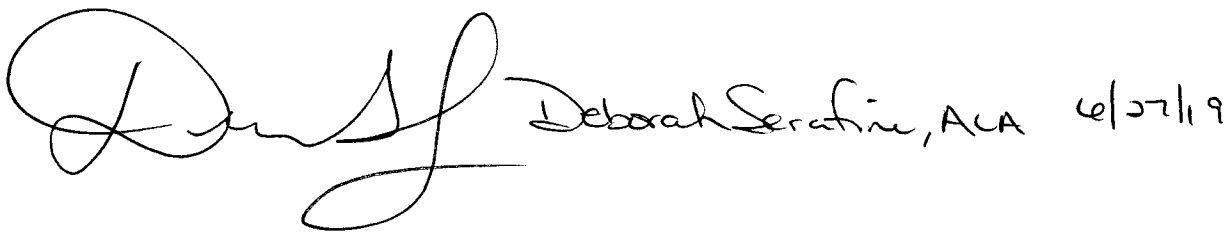
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Regulation – 91 Emergency Telephone Numbers – Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

Violation – At 10:20am, none of the emergency service telephone numbers were posted on or near the telephone in the computer are of PebbleBrook.

Plan of Correction – The emergency numbers were immediately posted once it was discovered that they were missing. Will educate resident coordinators on the importance of these numbers being posted and what to do if they notice that the numbers are missing from one of the phones in the facility. Monthly audits of all telephones that have an outside line will be done to ensure that none of them are missing. These audits were already started in May. Attached is a copy of May and June's audits.



95 Furniture & Equipment

Requirements

2400.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At 3:25p.m., the toilet was continuously running in resident bedroom 210.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 5a of 10)

Legal Entity Representative

Signature

Deborah Serafine, ALA

Printed Name and Title

6/27/19

Date

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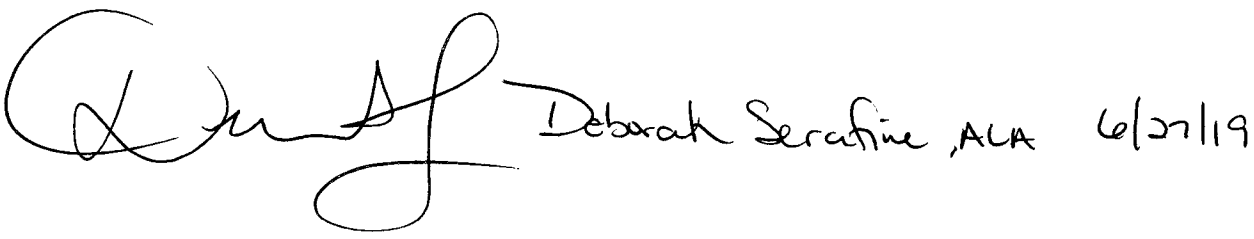
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Regulation – 95 Furniture and Equipment – Furniture and equipment must be in good repair, clean and free of hazards.

Violation – At 3:25pm the toilet was continuously running in resident bedroom 210.

Plan of Correction – Maintenance was called immediately as soon as we were notified that this toilet was running. They came up and fixed the toilet that day. We will continue to monitor all toilets on an on-going basis to ensure that the same thing does not happen again in the future.



101j7 Lighting/operable lamp

Requirements

2800.
101.j.7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident # 3 does not have access to a source of light that can be turned on/off at bedside. A lamp was present and plugged in; however, would not operate when turned on.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 6a of 10)

Legal Entity Representative

Signature | Deborah Serafine, ALA (Printed Name and Title) | 6/27/19 (Date)

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/24/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Regulation – 101.j.7 An operable lamp or other source of lighting that can be turned on at bedside.

Violation – Resident #3 does not have access to a source of light that can be turned on/off at bedside. A lamp was present and plugged in; however, would not operate when turned on.

Plan of Correction – The bulb was changed immediately and the lamp is now working properly. Will educate the staff on the importance of making sure that the lamps in the rooms are in working order and that if they need new bulbs that they notify the Administrator or the Health Care Coordinator. Will conduct monthly checks to make sure that all bedside lighting is operable. May and June audits are attached.

Deborah Serafini, ALA 6/27/19

132a Monthly fire drill

Requirements

2800.

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

Description of Violation

Multiple staff and resident interviews indicated that fire drills are sometimes announced ahead of time to the staff and residents on the day of the drill.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 7a of 10)

Legal Entity Representative

Signature

Deborah Serafine, ALA
Printed Name and Title

6/27/19
Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/24/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Regulation – 132a An unannounced fire drill shall be held at least once a month

Violation – Multiple staff and resident interviews indicated that fire drills are sometimes announced ahead of time to the staff and residents on the day of the drill.

Plan of Correction – The administrator immediately met with the Director of Facilities Maintenance and informed him that his staff was notifying RoseCrest staff of the evening fire drills. He spoke to his employee and assured me that this would not happen again in the future. Will educate staff on the importance of the fire drills being unannounced so that they are properly prepared in case of a true emergency. Monthly fire drills will continue to be held and will be unannounced.

Deborah Serafin, ACA 6/27/19

162c Menus - posted

Requirements

2800.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The residence's menu for 2 weeks were posted. However, the menu indicates Fall/Winter and it cannot be determined which week is current.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 8a of 10)

Legal Entity Representative

Signature

Deborah Serafine, ALA
Printed Name and Title

6/27/19
Date

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- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Regulation – 162c Menus stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Violation – The residence's menu for 2 weeks were posted. However, the menu indicates Fall/Winter and it cannot be determined which week is current.

Plan of Correction - The menus were updated immediately to say Spring/Summer instead of Fall/Winter and the dates were placed on the top of the menu to identify which week is current. The dietary manager will send up new menus each week so that we have the current week and the next week's menus posted with the correct dates. A photo of the new menus is attached.

Deborah Serafine, ACA 6/27/19

184a Labeling

Requirements

2800.

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

Description of Violation

Resident #3 is prescribed Breo Ellipta 100 mcg -25mcg dose powder for inhalation, inhale 1 puff by inhalation daily. However, the label record indicates Breo Ellipta 100 mcg -25mcg dose powder for inhalation, inhale 1 puff by inhalation daily. Rinse mouth after use

Also, resident #4 is prescribed Questran 4-gram powder for susp in packet, mix in thickened liquid twice daily for loose stool 1 hour before meals or 4 hours after. Give evening dose no earlier than 6pm and no later then 7pm; however, the label indicates Questran 4-gram powder for susp in packet, mix in thickened liquid twice daily for loose stool 1 hour before meals or 4 hours after.

Repeat Violation: 4/27/18 **at al**

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 9a of 10)

Legal Entity Representative

Signature

Deborah Sercaine, ALA
Printed Name and Title

6/27/19
Date

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Plan of correction implementation status as of 7/24/19 (Date)

The above plan of correction was approved by (Initials)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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

Violation – Resident #3 is prescribed Breo Ellipta 100mcg – 25 mcg dose powder for inhalation, inhale 1 puff by inhalation daily. However, the label record indicates Breo Ellipta 100mc -25mcg dose powder for inhalation, inhale 1 puff by inhalation daily. Rinse mouth after use.

Also, Resident #4 is prescribed Questron 4-gram powder for susp in packet, mix in thickened liquid twice daily for loose stool 1 hour before meals or 4 hours after. Give evening dose no earlier than 6pm and no later then 7pm; however, the label indicates Questron 4-gram powder for susp in packet, mix in thickened liquid twice daily for loose stool 1 hour before meals or 4 hours after.

Plan of Correction – The pharmacy was notified immediately and asked to not add or change anything on the labels that are not in the original physician's orders. Direction change stickers were applied to both of these medications that day. In the future, when receiving new medications, the LPN will check to ensure that the labels match the orders. Education will be done with the med techs to make sure that they are checking each label and order when they are administering medications. Monthly audits will be done by the LPN of the med carts to check to make sure that the labels are correct. May and June audits are attached.

Deborah Serafine, ALA 6/27/19

231c1 Preadmit screening

Requirements

2800.

231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #2 was admitted to the special care unit on 12/4/18. However, resident # 2's written cognitive preadmission screening was completed on 11/30/18.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached (page 10a of 10)

Legal Entity Representative

Signature

Deborah Serafine, ALA
Printed Name and Title

6/27/19
Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 7/24/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Regulation – 231.c.1.i A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Violation – Resident #2 was admitted to the special care unit on 12/4/18, however, resident #2's written cognitive preadmission screening was completed on 11/30/18.

Plan of Correction – All cognitive preadmission screenings were audited to ensure that they were in compliance. Moving forward, the administrator will be sure that all cognitive preadmission screenings are not done prior to the 72 hour period.

Attached is the staff education that will be held at the Monthly Staff Meeting on Friday, June 28, 2019.

Deborah Serafini, RLA 6/27/19