pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TAPESTRY MOON LLC**
(LEGAL ENTITY)

To operate **TAPESTRY SENIOR LIVING MOON TOWNSHIP**
(NAME OF FACILITY OR AGENCY)

Located at **550 CHERRINGTON PARKWAY, CORAOPOLIS, PA 15108**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

To provide **Assisted Living-Special Care**
(TYPE OF SERVICE(S) TO BE PROVIDED)

The total number of persons which may be cared for at one time may not exceed **104** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 71

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 9, 2019** until **March 9, 2020**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450091**

Robert E. Robinson
ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 7/19

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Hand delivered: September 9, 2019

Ms. Teresa Pawlina
President
Tapestry Companies, LLC
2001 Killebrew Drive, Suite 100
Minneapolis, Minnesota 55425

RE: Tapestry Senior Living Moon Township
550 Cherrington Parkway
Coraopolis, Pennsylvania 15108
License #: 450091

Dear Ms. Pawlina:

As a result of the Department's Bureau of Human Services Licensing inspection on August 8, 2019, of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because the home is new and not yet serving four or more residents.

In accordance with 55 Pa.Code § 2800.11(b) (relating to procedural requirements for licensure or approval of assisted living residences) a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

During the inspection, citations on the enclosed violation report were found. All citations specified on the 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.

Your PROVISIONAL license is enclosed, based on substantial but not complete compliance with 55 Pa.Code Ch. 2800.

Ms. Tereasa Pawlina

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

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 applicant responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosures
License
Violation Report

Violation Report

Facility Information

Name: *Tapestry Senior Living Moon Township* License Number: *45009*
Address: *550 Cherrington Parkway, Coraopolis, PA 15108*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Anne Giehl* Phone: *412-480-4904* Email: *anne.giehl@tapestrysenior.com*

Legal Entity

Name: *Tapestry Companies, LLC*
Address: *2001 Killebrew Drive, Suite 100, Minneapolis, MN, 55425*

RECEIVED

8/22/2019

Western Region Field Office
Bureau of Human Services Licensing

Certificate(s) of Occupancy

Type: *I-1* Date: Issued By:

Staffing Hours

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

Inspection

Type: *Initial* BHA Docket #: Notice: *Announced*
Reason: *New*

Inspection Dates and Department Representative

08/08/2019 - On-Site: Amy Duncan, Trish Bartlett

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* Residents Served: *0*

Special Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *71* Residents Served: *0*

Hospice

Current Residents: *0*

Number of Residents Who:

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

18 Other laws, regs, ordins.

Requirements

2800.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Clean Indoor Air Act, enacted 9/11/08, requires public places to post signs where smoking is regulated by this act. The residence does not permit smoking; however, the sign posted on the left pillar at the main entrance indicates, "No smoking on this side, only in designated areas."

The influenza poster is not posted in a public and conspicuous place in the residence in accordance with the Influenza Awareness Act, enacted in July, 2016.

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires that carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. The residence has a gas stove in the 1st floor main kitchen and 2 gas fireplaces in the 1st floor lobby; however, no carbon monoxide detectors are present in close proximity to the stove and fireplaces.

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.)

See Attachment

See Page 2A of 18

Legal Entity Representative

Signature

TERESA PAWLINA, Authorized Signer. 8/21/2019

Printed Name and Title Date

President/Principle.

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

The above plan of correction is approved as of 9/6/19 (Date)

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

Plan of correction implementation status as of 9/6/19 (Date)

- ✓ Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

2800.18

1.Tapestry failed to post adequate signage at all entrances to notify the public that smoking is not prohibited on the property. 1. Environmental services purchased and posted (8/9/19) more signs on all entrances/exits and near outdoor sitting areas. (See attached)

2. Inspectors did not find postings in a conspicuous place of influenza/Flu Poster. the Executive Director immediately created a bulletin board and posted signage in the main lobby as well as the elevator. Business Office Director will be updated weekly, monthly, and annually as required to keep residents informed and will be kept on file. (See attached)

3. Tapestry has natural gas kitchen appliance, gas fireplace, main laundry room, and a boiler room without proof of required carbon monoxide monitoring. To ensure compliance monitoring alarms were purchased for each of the above areas by the Environmental Services Director. The alarms have auto alarms and are tied into the mobile devices of the Executive Director, Environmental Services Director and front desk computer, which is monitored 24 hours a day. If Tapestry is notified by the alarm company immediate action will be taken and fire department will be notified by Executive Director/designee and alarm monitoring company. In conjunction with the monthly fire drills Environmental Services will test the alarms to ensure they are in working order. A log kept in the maintenance office. The Executive Director/ designee will review daily during morning standup with Environmental Service directory and staff. (See attached)

8/21/2019

41c Rights poster

Requirements

2800.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the residence.

Description of Violation

The Department's poster of the resident's rights is not posted in a conspicuous and public place in the residence.

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.)

Inspectors did not find postings in a conspicuous place of resident's rights. The Executive Director immediately created a bulletin board and posted signage in the main lobby as well as the elevators. Business Office Director will be updated weekly, monthly, and annually as required to keep residents informed and will be kept on file. In addition, each resident receives a copy of resident rights upon move in to residence. (See attached)

Legal Entity Representative

Signature

TERESA PARLIKA Authorized Signer 8/21/2019
Printed Name and Title Date
CEO/PRESIDENT, Affiliate

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

The above plan of correction is approved as of 9/6/19 (Date)

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

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- Partially Implemented - Inadequate Progress
- Not Implemented

42s Privacy - self/possessions

Requirements

2800.
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

No door is present on the common restroom across from living unit #215.

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.)

It was found that no door was present in the common restroom across from unit #215. The contracting company Builders Hardware and Specialty was contacted on 8/1/19 for necessary parts to properly install restroom door. Expected date for necessary parts to be delivered will be 8/26/19. Once parts are received door hinge will be replaced no later than 8/30/19. The restroom will be out of service and the unit will not be opened prior to repair. (See attached)

Immediately: A designated staff person shall inspect all bathrooms to ensure a door is present and operable to afford privacy while in use. 8/23/19

Legal Entity Representative

Signature

TERESA PAWLINA, Authorized Signer
Printed Name and Title CCO PRESIDENT, Date 8/21/2019

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- Not Implemented

85d Trash cans – kitchen/bath

Requirements

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

No lids are present on the trash cans located in the common bathrooms on the 1st, 2nd, 3rd and 4th floors.

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.)

Trash cans in public bathrooms were found to be non-compliant due to missing lids. To prevent against rodent/insect infestation, the Dietary Director immediately purchased 13 commercial trashcans with flip lids (as described by inspector Bartlett) and placed them in each bathroom. These will be maintained for cleanliness and replaces as required. (See attached)

Immediately then monthly thereafter: A designated staff person shall inspect all kitchens and bathrooms to ensure a trash can with a lid is present to prevent the penetration of insects and rodents. 8/23/19 FM

Legal Entity Representative

Signature

TERESA PAWLUK Authorized Signature 8/21/2019
Printed Name and Title Date
CEO, President, Principal

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

85e Trash outside

Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

The door to the trash compactor does not completely close and latch, and remains open approximately 9".

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.)

It was found that the trash compactor did not completely close/latch. Environmental Service Director contacted Valley Waste services and a new compactor was installed on 8/16/19. Environmental Service Director is to be notified by staff verbally and via TELS maintenance system for immediate repair and or replacement intervention. (See attached)

Immediately: A designated staff person shall inspect the outdoor grounds at least monthly to ensure all trash outside the home is kept in covered receptacles, and that the door to the home's trash compactor is closed. FM 8/23/19

Legal Entity Representative

Signature | TERES Paulina Authorize Signer, CEO, President, Secretary | 8/21/2019
Printed Name and Title | Date

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

95 Furniture & Equipment

Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

A modem is hanging approximately 3' from the ceiling by a blue cable in the middle of the hallway in front of living unit #441.

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.)

Inspectors observed modem handing out of the ceiling in hallway near unit #441. Environmental Services Director immediately repaired modem and secured for proper placement. Hallways were inspected to ensure cleanliness and absence of hazards. Staff will notify Environmental Service Director of future hazards, who will ensure a safe environment with immediate replacement or repair. (See attached).

Legal Entity Representative

Signature

TERESA PAWLINA, Authorized Sign 8/21/2019
Printed Name and Title Date

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Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

96a First aid kit

Requirements

2800.

96.a. The residence 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. The residence shall have an automatic external defibrillation device located in each building on the premises.

Description of Violation

The first aid kits located at the nurse's stations on the 1st, 2nd, 3rd and 4th floors do not include a thermometer, a breathing shield or eye coverings.

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.)

While inspectors found first aids kits adequate in supply and location, they found the required components of thermometer, breathing shields and eye coverings were not located in the kit. Executive Director immediately purchased safety googles on 8/15/19 as well as thermometers purchased on 8/21/19. All items have been added to the first aid kit located on the 1st, 2nd, 3rd, and 4th floor. The Resident Services Director will ensure all first aids kits are properly stocked and stored on a monthly basis. Clinical staff have been educatedif any items have been used from kit is to be reported to the Resident Service Coordinator/ designee for repurchasing and stocking. (See attached)

Legal Entity Representative

Signature

TERESA PAULINA Authorized Signer 8/21/2019
Printed Name and Title President, ECS Date

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- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

101j1 Bed/Fire retardant mattress

Requirements

2800.

101.j. Each resident shall have the following in the living unit:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. An exception will be permitted for residents who wish to provide their own mattresses.

Description of Violation

Staff person A informed potential residents they are required to provide their own mattresses in the living units.

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.)

When interviewed by inspector, staff person A incorrectly stated that residents were responsible for own mattress. Education was completed by administration and nursing informing staff that mattresses will be provided if needed. Facility currently has mattresses immediately available for use. The Executive Director / designee will purchase additional mattresses as needed based on need. Staff person A has been in-serviced and is present on provided sign-in sheet. Housekeeping will maintain an inventory of items needed. Administration and nursing will communicate via verbally and TELS system when additional items are needed. (See attached).

Within 5 days of receipt of the plan of correction: All staff shall be educated that all items specified in 2600.101j(1) through 2600.101j(7) shall be provided to all residents upon request, without charge. Documentation of the education shall be kept. 8/23/19

Legal Entity Representative

Signature

Teresa Paulina Authorized Signer

Printed Name and Title

8/21/2019

Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

101j3 Bed linens/pillows/blankets

Requirements

2800.
101.j. Each resident shall have the following in the living unit:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

Staff person A informed potential residents they are required to provide their own bed linens, pillows and blankets in the living unit.

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.)

When interviewed by inspector staff person A incorrectly stated that residents were responsible for bed linens, pillows and blankets. Education was completed by administration and nursing informing staff that all bedding will be provided if needed. Facility currently has adequate supply for use. The Executive Director/ designee will purchase additional items as needed based on need. Staff person A has been in-serviced and is present on provided sign-in sheet. Housekeeping will maintain an inventory of items needed. Administration and nursing will communicate via verbally and TELS system when additional items are needed. (See attached).

Within 5 days of receipt of the plan of correction: All staff shall be educated that all items specified in 2600.101j(1) through 2600.101j(7) shall be provided to all residents upon request, without charge. Documentation of the education shall be kept. 8/23/19

Legal Entity Representative

Signature

Printed Name and Title

Date

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- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

102f Towel/washcloth/soap

Requirements

2800.
102.f. An individual towel, washcloth and soap shall be provided for each resident unless the resident provides his own supplies of these items.

Description of Violation

Staff person A informed potential residents they are required to provide their own towels and washcloths.

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.)

When interviewed by inspector, staff person A incorrectly stated that residents were responsible for individual towel, washcloth and soap. Education was completed by administration and nursing informing staff that all toiletries will be provided if needed. Facility currently has adequate supply for use. The Executive Director/ designee will purchase additional items as needed based on need. Staff person A has been in-serviced and is present on provided sign-in sheet. Housekeeping will maintain an inventory of items needed. Administration and nursing will communicate via verbally and TELS system when additional items are needed. (See attached).

Legal Entity Representative

Signature | Printed Name and Title | Date

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

123a Exit doors

Requirements

2800.
123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

The exit doors located in the special care units on the 1st, 2nd, 3rd and 4th floors, all require a card to be swiped in order to open the doors.

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.)

See Page 12A of 18

Legal Entity Representative

Signature

TERESA PAWLINA Authorized Signer 8/23/2019
Printed Name and Title PRESIDENT, CCO, Principle
Date

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

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

Plan of correction implementation status as of 9/6/19 (Date)

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

2800.123.A

1. A new key card system will be implemented for the control access doors. The company that will be installing the system is our current system Silversphere. The contract has been signed and the parts have been ordered (see attached).

2. Installation of the system will begin on September 3rd, 2019. Silversphere has provided a schedule of the immediate installation of the system for the 1st, 2nd, 3rd, 4th, and 5th floors. See attached map of all certain areas where the doors will be installed.

3. The completion of the installation will be Friday September 6th, 2019 and all systems will be tested by no later than Friday September 6th, 2019. Silversphere and the appropriate authority will submit certification letter of the appropriate function of the system.

4. The certification of the function will be submitted to Larry Mazza and Brent Sutherland immediately.

5. The doors will be secured using a numerical key pad. All staff will be educated on the new system by the Executive Director/ designee. All families who will have loved ones located on the memory care side will have education on how to access secured doors.

6. The access code will be posted in a picture/mural for immediate access, for individuals who wish to leave the neighborhood. The access code to the doors will be monitored and changed quarterly and/or as needed to ensure the safety our residents and staff.

7. Resident will not move in to the secured neighborhood until the installation of the key pad system for the door has been installed and tested.

Anne Gienl, Executive Director, 8/26/19
Anne Gienl Tapestry Moon

123b Emerg. procedures posted

Requirements

2800.
123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

The residence's emergency procedures are not posted in a conspicuous and public place in the residence.

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.)

Inspectors did not find appropriate placement of Emergency Procedure Manuals. Manuals were completed by Business Office Director and placed in multiple common areas such as main lobby, in front of the Senior Connection lobby, Environmental Service Office and outside the 5th floor elevator. In addition, all elevators have directors stating elevators are out of service and stairs are required. Business Office Director will monitor presence of manuals and replace/update as needed. (See attached)

Legal Entity Representative

Signature | Printed Name and Title | Date

Teresa Pavlina-Authorized Signer 8/21/2019

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Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

123d Mobility need – FS area

Requirements

2800.
123.d. If the residence serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

Description of Violation

The documentation from the residence's most recent fire safety inspection conducted by a fire safety expert, dated 8/14/19, indicates there are no fire-safe areas within the residence. However, the 2nd, 3rd and 4th floors, which are all above grade level, each contain a special care unit. The residence intends on serving residents with mobility needs on these floors.

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.)

Inspectors did not find the required formal letter for fire safe area designation on 2nd, 3rd, and 4th floor. These letters are important for the overall fire safety plan of the community. Moon Twp. Fire Chief John Scott initially provided letters for ground level evacuations locations on 8/14/19. An addendum specifying internal locations on the 2nd, 3rd, and 4th floor was provided on 8/21/19. (See attached)

The fire safety expert designated the following areas as fire-safe areas in a letter, dated 8/21/19:
* The Moon Senior Connection Meeting Area, The Allegheny Room Dining Area, and Mulligan's Square, located on ground level.
* The elevator lobby areas located on floors 1 through 5. 8/23/19

Legal Entity Representative

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

126a Furnace inspection

Requirements

2800.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The residence has no record of the last time the furnace was inspected.

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.)

Tapestry has roof top heating/ air conditioning unit for the common areas of the building. This roof top unit has the perceived function of a furnace but does not have an annual inspection certification as traditionally required. Upon much research by building contractor and architect, such certification does not commonly exist for our roof top heat/ AC unit. However, a letter of inspection by HVAC company Sentry Mechanical is attached. Environmental services call for annual inspection is now in the automatic work order/maintenance software TELS. (See Attached)

The home's furnaces were inspected on 8/8/19. FM 8/23/19

Legal Entity Representative

Signature | TERESA Paulina Authorized Signer Printed Name and Title | 8/21/2019 Date

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

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The above plan of correction was approved by	FM (Initials)	✓ Fully Implemented Partially Implemented - Adequate Progress Partially Implemented - Inadequate Progress Not Implemented	

126b Furnace cleaning

Requirements

2800.
126.b. Furnaces shall be cleaned according to the manufacturer's instructions. Documentation of the cleaning shall be kept.

Description of Violation

The residence does not have documentation of any furnace cleanings.

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.)

Inspector noted furnace has no record of furnace cleanings. Environmental Service Director contacted Sentry Mechanical who provided documentation of furnace cleaning. Environmental Service Director will maintain documentation of any and all future furnace cleanings according to manufacturer's instructions Environmental services call for cleaning is now in the automatic work order/maintenance software TELS. (See Attached).

The home's furnaces were inspected on 8/8/19. 8/23/19

Legal Entity Representative

Signature | TERESA PAWLINA, Authorized Signer | 9/21/2019
Printed Name and Title | Date

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

The above plan of correction is approved as of 9/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

131f Fire extinguisher inspection

Requirements

2800.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher located in the 1st floor laundry room has not been inspected by a fire safety expert since May, 2018.

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.)

Inspector noted 1st floor laundry room fire extinguisher was expired and therefore out of compliance. A new fire extinguisher was obtained and placed in 1st floor laundry room. Maintenance will complete monthly audits of all fire extinguishers and document said audits on extinguisher tags by the 5th of every month. (See attached).

Legal Entity Representative

Signature | Printed Name and Title | Date

TERESA Bowling Authorized Signer 8/21/2019

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The above plan of correction is approved as of 9/6/19 (Date)

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

Plan of correction implementation status as of 9/6/19 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

171b5 Transportation-first aid kit

Requirements

2800.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

Description of Violation

The first aid kit in the van used to transport residents does not include a thermometer, breathing shield or eye coverings.

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.)

While inspectors found first aids kits adequate in supply and location, they found the required components of thermometer, breathing shields and eye coverings were not located in the kit. Executive Director immediately purchased safety googles on 8/15/19 as well as thermometers purchased on 8/21/19. All items have been added to the first aid kit located in the bus. The Resident Services Director will ensure all first aids kits are properly stocked and stored on a monthly basis. Clinical staff have been educated if any items have been used from kit is to be reported to the Resident Service Coordinator/ designee for repurchasing and stocking. (See attached)

Legal Entity Representative

Signature | Printed Name and Title | Date

TERESA PAWLICKA Authorized Signer 8/21/2019

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The above plan of correction is approved as of 9/6/19 (Date)

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

Plan of correction implementation status as of 9/6/19 (Date)

- Fully Implemented
- ✓ Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented