pennsylvania
DEPARTMENT OF HUMAN SERVICES

November 4, 2019

Ms. Mary Ann Foley
Chief Operating Offcer
Jewish Home and Hospital for the Aging at Pittsburgh
200 JHF Drive
Pittsburgh, Pennsylvania 15217

RE: Ahava Memory Care Residence
License #: 448580

Dear Ms. Foley:

As a result of the Department's Bureau of Human Services Licensing annual inspection on September 12, 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: *AHAVA MEMORY CARE RESIDENCE*
License Number: *44858*
Address: *200 JHF DRIVE,, PITTSBURGH, PA 15217*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Mindy Dean* Phone: *4125218299* Email: *MAFOLEY@JAAPGH.ORG*

Legal Entity

Name: *JEWISH HOME AND HOSPITAL FOR AGED AT PITTSBURGH*
Address: *200 JHF DRIVE, PITTSBURGH, PA, 15217*

Certificate(s) of Occupancy

Type: *I-2* Date: *03/09/2018* Issued By: *City of PGH*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *60* Waking Staff: *45*

Inspection

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

Inspection Dates and Department Representative

09/12/2019 - On-Site: Scott Klein, Vicki Siegert, Josh Hoover

Resident Demographic Data as of Inspection Dates

General Information

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

Special Care Unit

In Home: *Yes* Area: *Entire Home* Capacity: *30* Residents Served: *30*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *30*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30*
Have Physical Disability: *0*

65h 16 hrs annual training

Requirements

2800.

65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person A did not receive 16 hours of required annual training related to job duties during the training year 1/1/18 to 12/31/18.

Plan of Correction (POC)

Moving forward all Direct Care Staff will receive the required 16 hours of annual training related to their job duties along with the required 2 hours of additional Dementia Training. This will be provided by the Administrator, Director of Resident Services and the Director of Memory Care. Direct Care Staff Person A will be required to make up the 16 hours of annual training from the training year 1/1/18-12/31/18 and remain current for the remaining training years, throughout employment.

By 11/1/19: The administrator or designated staff person shall review all direct care staff training records to ensure all direct care staff persons have received 16 hours of annual training during the 1/1/18 to 12/31/19 training year. Any direct care staff persons who have not completed the required training hours shall make up the training hours by 12/31/19. Documentation of education shall be kept. 10/1/19

Legal Entity Representative

Mindy Dean — Mindy Dean AHRA — 9/24/19

Signature — Printed Name and Title — Date

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

The above plan of correction is approved as of 10/1/19 (Date)

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

Plan of correction implementation status as of 10/1/19 (Date)

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

65i Training topics

Requirements

2800.

65.i. 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, cognitive and neurological 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. Assisted living 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 residence.

Description of Violation

Direct care staff person A did not receive training in any of the required topics during the training year 1/1/18 to 12/31/18.

Plan of Correction (POC)

Moving forward all Direct Care Staff will receive the required 16 hours of annual training related to their job duties along with the required 2 hours of additional Dementia Training. This will be provided by the Administrator, Director of Resident Services and the Director of Memory Care. Direct Care Staff Person A will be required to make up the 16 hours of annual training from the training year 1/1/18-12/31/18 and remain current for the remaining training years, throughout employment.

By 11/1/19: The administrator or designated staff person shall review all staff training records for the 2018 and 2019 training years to ensure all of the required documentation is present in each staff persons training record. 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ALRA 9/24/19 — Printed Name and Title — Date

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- ☐ Not Implemented

65j Annual training content

Requirements

2800.

65.j. 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—10225.708).
5. Falls and accident prevention.

Description of Violation

Direct care staff person A did not receive training in any of the required training topics during the training year 1/1/18 to 12/31/18.

Plan of Correction (POC)

Moving forward all Direct Care Staff will receive the required 16 hours of annual training related to their job duties along with the required 2 hours of additional Dementia Training. This will be provided by the Administrator, Director of Resident Services and the Director of Memory Care. Direct Care Staff Person A will be required to make up the 16 hours of annual training from the training year 1/1/18-12/31/18 and remain current for the remaining training years, throughout employment.

~~By 11/1/19: The administrator or~~ designated staff person shall review all direct care ~~staff training records~~ to ensure all direct care staff persons have received the reguiired training topics during the 1/1/18 to 12/31/19 training year. Any direct care staff persons who have not completed the required training shall make up the training by 12/31/19. Documentation of education shall be kept. 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean AERA — Printed Name and Title

9/24/19 — Date

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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 approximately 2:00 p.m. the emergency telephone numbers to include the nearest hospital and fire Department are not posted on or near the phone in the home's private dining room.

Plan of Correction (POC)

A list of emergency numbers were placed on the phone in the private dining room by the Administrator. In the future all phone will be check on a regular basis to make sure all appropriate emergency numbers are in place.

Immediately: Checks of required telephone numbers shall be completed monthly. 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean AERA — Printed Name and Title

9/24/19 — Date

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- ☐ Not Implemented

101j7 Lighting/operable lamp

Requirements

2800.

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

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

Description of Violation

Resident #4 does not have access to a lamp or other source of light that can be turned on/off at bedside in resident room #2.

Plan of Correction (POC)

Moving forward all residents will have access to a lamp or other light source that can be turned on and off at bedside. During all new admissions, the administrator shall inspect the room to ensure compliance of this regulation. A pop light was installed by the administrator to the wall along the residents bed in Room #2 for Resident #4

A light was placed at the resident's bedside. 10/1/19

By 11/1/19: The administrator or designated staff person shall check all resident rooms monthly to ensure the requirements of regulation 2600.101(j)(1) are met. 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean AHRA — Printed Name and Title

9/24/19 — Date

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- ☐ Not Implemented

121a Unobstructed egress

Requirements

2800.

121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 10:40 a.m. the left door, of the double metal doors across from the sunroom bathroom leading to the courtyard, is obstructed from being opened by several items lying on the ground on the opposite side of the door to include a bunched up green outdoor carpet, a grey plastic storage bin measuring approximately 30 inches high by 16 inches long by 16 inches deep, a red and white folded umbrella, several sections of approximately 8 inch high white plastic fencing, and a rolled up blue padded mat with sections cut out.

Plan of Correction (POC)

All materials outside of the double metal doors across from the sunroom bathroom leading to the courtyard will be removed by housekeeping and maintenance, to allow the door to open without any obstructions. Moving forward, things will not be stored in this area.

Immediately: The administrator or designated staff persons shall check the home daily to ensure the requirements of regulation 2600.121(a) are met. 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ACRA 9/24/19 — Printed Name and Title / Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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 emergency preparedness procedures for the home and local municipality were not posted in a public and conspicuous place in the home.

Plan of Correction (POC)

A copy of the emergency preparedness procedure manual for AHAVA was printed and placed in a binder near the visitors log at the main entrance of the home by the Administrator

By 11/1/19: The administrator or designated person shall check the home monthly to ensure compliance with regulation 2600.123(b). 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ALRA — Printed Name and Title

9/24/19 — Date

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Plan of correction implementation status as of 10/1/9 (Date)

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

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

At approximately 12:05 p.m. the menus posted in main hall across from dining room were dated 9/2/19 through 9/8/19 and 9/9/19 through 9/15/19 which does not include the week in advance menu of 9/16/19 to 9/22/19.

Plan of Correction (POC)

Moving forward 2 weeks of menus will be posted by dietary.

The home posted the current and week in advance menu. 10/1/19

By 11/1/19: The administrator or designated staff person shall check the home every two weeks to ensure complaince with regulation 2600.162(c). 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ACRA 9/24/19 — Printed Name and Title / Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

185a Storage procedures

Requirements

2800.

185.a. The residence 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 #1 is prescribed LiquiTears 1.4% – instill 2 drops in both eyes, two times daily. The label indicates to discard 28 days after opening. However, there is no open date on the label, and the pharmacy filled the order on 7/28/19.

Plan of Correction (POC)

The LiquiTears 1.4% for Resident #1 was disposed of by the Director of Resident Services, and replaced with new, a 28 days expiration date was placed on the medicine. Moving forward all medications opened will be labeled with a 28 day expiration date by the Nursing Supervisor opening the new medication.

By 11/1/19: The administrator or designated staff person qualified to administer medications shall check all medications monthly to ensure no medications are used after the expiration or discard date, 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ALA — Printed Name and Title

9/24/19 — Date

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- ☐ Not Implemented

191 Resident right to refuse

Requirements

2800.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1 was admitted to the home on 1/30/18. The resident was not educated on the right to question and refuse medication if the resident believes there may be a medication error.

Resident #2 was admitted to the home on 7/2/18. The resident was not educated on the right to question and refuse medication if the resident believes there may be a medication error.

Resident #3 was admitted to the home on 7/8/19. The resident was not educated on the right to question and refuse medication if the resident believes there may be a medication error.

Repeat Violation - 9/25/18

Plan of Correction (POC)

A new contract was done for Resident #1, the right to refuse medication was included in the resident rights. Resident #2 along with his guardian were advised of his right to refuse medications, the guardian signed off on it and it was added to Resident #2 chart. Resident #3 was educated on the right to refuse medication, resident rights were signed by her daughter and added to her chart.

By 11/1/19: The administrator or designated staff person shall review all resident records to ensure all residents have been educated on their right to refuse medication in accordance with regulation 2600.191. 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ALRA — Printed Name and Title

9/24/19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

233c Key-locking devices

Requirements

2800.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The code or instructions to operate the keypad that opens the home's main entrance is not posted conspicuously near the device.

The code or instructions to override the magnetic locks on the exit to the courtyard across from the sunroom bathroom is not posted conspicuously near the door.

The code or instructions to override the magnetic locks on the courtyard gates are not posted conspicuously at either courtyard gate.

Plan of Correction (POC)

The code to operate the keypad at the home's main entrance was posted by the Administrator, this will remain posted at all times to remain compliant.

The code to operate the metal doors across from the sunroom bathroom was posted by the Administrator and will remain posted at all time to remain compliant.

The codes have not been posted at the gates in the courtyards, these doors are set to deactivate in the event of a fire/emergency.

By 11/1/19: The administrator or designated staff person shall check all keypad exits weekly to ensure complaince with regulation 2600.233(c). 10/1/19

Legal Entity Representative

Mindy Dean — Signature

Mindy Dean ACRA — Printed Name and Title

9/24/19 — Date

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- ☐ Not Implemented