Department of Human Services
Bureau of Human Service Licensing

June 10, 2021

[redacted] ADMINISTRATOR
JEWISH HOME AND HOSPITAL FOR AGED AT PITTSBURGH
200 JHF DRIVE
PITTSBURGH, PA 15217

RE: AHAVA MEMORY CARE RESIDENCE
200 JHF DRIVE
PITTSBURGH, PA, 15217
LICENSE/COC#: 44858

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/07/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jason Williams

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *AHAVA MEMORY CARE RESIDENCE* **Licen e #**: *44858* **Licen e Expiration Date**: *10/11/2021*
Addre : *200 JHF DRIVE, PITTSBURGH, PA 15217*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *4125218299* **Email**: [redacted]

Legal Entity

Name: *JEWISH HOME AND HOSPITAL FOR AGED AT PITTSBURGH*
Address: *200 JHF DRIVE, PITTSBURGH, PA, 15217*
Phone: *4125218299* **Email**: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Incident* **Exit Conference Date**: *01/26/2021*

Inspection Dates and Department Representative

01/07/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served**: *22*

Special Care Unit

In Home: *Yes* **Area**: *First floor* **Capacity**: *30* **Residents Served**: *22*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *22*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *22* **Have Physical Disability**: *0*

Inspections / Reviews

01/07/2021 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/08/2021*

Inspections / Reviews *(continued)*

4/1/2021 - POC Submission

Lead Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow-Up Date:** *04/07/2021*

6/10/2021 Document Submi ion

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

15a Resident abuse report

1. Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 12/21/2021 at approximately 6:00 pm, resident #1, who is diagnosed with Alzheimer's dementia, was walking around the common area looking for [redacted] walker. Resident #1 was agitated and yelling, saying that staff do not care about [redacted] and do not care if [redacted] falls. Staff persons A and B assisted resident #1 to sit on a chair in the living room. Staff person A told the resident to quiet down or [redacted] would pour cold water on [redacted]. Then staff person A said "You need a time out", reclined the chair with resident #1 sitting in it and dragged it backwards down the hall to resident #1's room. While being dragged down the hall, resident #1 kept screaming "let me out" as [redacted] was unable to get up from the chair while it was reclined. Staff person A put the resident in [redacted] room, still in the reclined chair, and closed the door leaving resident #1 alone in [redacted] room. The residence did not immediately notify the Area Agency on Aging in accordance with the Older Adult Protective Services Act.

Plan of Correction **Accept**

All staff will be reeducated on proper reporting requirement and processes. Additionally, signage will be posted in the nursing office as to the proper reporting procedures and what constitutes a Reportable Incident.

The Agency nurse who failed to report this incident has been notified that [redacted] is not permitted to return to AHAVA.

Completion Date: *03/08/2021*

Document Submission **Implemented**

Staff was reeducated on Abuse and Abuse Reporting

15b Resident abuse-superv plan

1. Requirements

2800.

15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

15b Resident abuse-superv plan *(continued)*

Description of Violation

On 12/21/2021 at approximately 6:00 pm, resident #1, who is diagnosed with Alzheimer's dementia, was walking around the common area looking for [redacted] walker. Resident #1 was agitated and yelling, saying that staff do not care about [redacted] and do not care if [redacted] falls. Staff persons A and B assisted resident #1 to sit on a chair in the living room. Staff person A told the resident to quiet down or [redacted] would pour cold water on [redacted]. Then staff person A said "You need a time out", reclined the chair with resident #1 sitting in it and dragged it backwards down the hall to resident #1's room. While being dragged down the hall, resident #1 kept screaming "let me out" as [redacted] was unable to get up from the chair while it was reclined. Staff person A put the resident in [redacted] room, still in the reclined chair, and closed the door leaving resident #1 alone in [redacted] room. Staff person A continued to work on 1/21/2021 from 6:00 pm to 11:00 pm and was not was suspended until 1/22/2021.

Plan of Correction **Accept**

All staff will be reeducated on proper reporting requirement and processes. Additionally, signage will be posted in the nursing office as to the proper reporting procedures and what constitutes a Reportable Incident. Further, nursing supervisors will be educated on the importance of immediately suspending any employee suspected of abuse.

The Agency nurse who failed to report this incident has been notified that [redacted] is not permitted to return to AHAVA.

Completion Date: *03/08/2021*

Document Submission **Implemented**

Staff was reeducated on Abuse and Abuse Reporting

15d Resident abuse notification

1. Requirements

2800.

15.d. The residence shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

15d Resident abuse notification *(continued)*

Description of Violation

On 12/21/2021 at approximately 6:00 pm, resident #1, who is diagnosed with Alzheimer's dementia, was walking around the common area looking for [redacted] walker. Resident #1 was agitated and yelling, saying that staff do not care about [redacted] and do not care if [redacted] falls. Staff persons A and B assisted resident #1 to sit on a chair in the living room. Staff person A told the resident to quiet down or [redacted] would pour cold water on [redacted]. Then staff person A said "You need a time out", reclined the chair with resident #1 sitting in it and dragged it backwards down the hall to resident #1's room. While being dragged down the hall, resident #1 kept screaming "let me out" as [redacted] was unable to get up from the chair while it was reclined. Staff person A put the resident in [redacted] room, still in the reclined chair, and closed the door leaving resident #1 alone in [redacted] room. The residence did not immediately notify the resident's designated person of this report of suspected abuse.

Plan of Correction **Accept**

All staff will be reeducated on proper reporting requirement and processes. Additionally, signage will be posted in the nursing office as to the proper reporting procedures and what constitutes a Reportable Incident.

The abuser has been terminated and has not returned to AHAVA since [redacted] - the date that the incident was brought to the attention of the Administrator.

Completion Date: *03/08/2021*

Document Submission **Implemented**

Staff was reeducated on Abuse and Abuse Reporting

42b Abuse/Neglect

1. Requirements

2800.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 12/21/2021 at approximately 6:00 pm, resident #1, who is diagnosed with Alzheimer's dementia, was walking around the common area looking for [redacted] walker. Resident #1 was agitated and yelling, saying that that staff do not care about [redacted] and do not care if [redacted] falls. Staff persons A and B assisted resident #1 to sit on a chair in the living room. Staff person A told the resident to quiet down or [redacted] would pour cold water on [redacted]. Then staff person A said "You need a time out", reclined the chair with resident #1 sitting in it and dragged it backwards down the hall to resident #1's room. While being dragged down the hall, resident #1 kept screaming "let me out" as [redacted] was unable to get up from the chair while it was reclined. Staff person A put the resident in [redacted] room, still in the reclined chair, and closed the door leaving resident #1 alone in [redacted] room.

42b Abuse/Neglect *(continued)*

Plan of Correction **Accept**

All staff will be reeducated on what constitutes an abuse. Specifically, staff will be educated that "A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined n any way."

Completion Date: *03/08/2021*

Document Submission **Implemented**

Staff Person A was terminated. Staff was reeducated on Abuse and Abuse Reporting

202 Prohibitions

1. Requirements

2800.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2800.231 (relating to admission).

Description of Violation

On 12/21/2021 at approximately 6:00 pm, resident #1, who is diagnosed with Alzheimer's dementia, was walking around the common area looking for [redacted] walker. Resident #1 was agitated and yelling, saying that staff do not care about [redacted] and do not care if [redacted] falls. Staff persons A and B assisted resident #1 to sit on a chair in the living room. Staff person A told the resident to quiet down or [redacted] would pour cold water on [redacted]. Then staff person A said "You need a time out", reclined the chair with resident #1 sitting in it and dragged it backwards down the hall to resident #1's room. While being dragged down the hall, resident #1 kept screaming "let me out" as [redacted] was unable to get up from the chair while it was reclined. Staff person A put the resident in [redacted] room, still in the reclined chair, and closed the door leaving resident #1 alone in [redacted] room.

Plan of Correction **Accept**

All staff will be reeducated on what constitutes an abuse. Specifically, staff will be educated that "Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. "

Completion Date: *03/08/2021*

Document Submission **Implemented**

Staff Person A was terminated. Staff was reeducated on abuse and abuse reporting