Department of Human Services
Bureau of Human Service Licensing

April 22, 2021

[redacted] PRESIDENT/COO
GRAINGER AID OPCO LLC
10960 FRANKSTOWN ROAD
PENN HILLS, PA 15235

RE: ALLEGHENY PLACE
10960 FRANKSTOWN ROAD
PENN HILLS, PA, 15235
LICENSE/COC#: 44489

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/12/2021, 01/13/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Larry Mazza

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: *ALLEGHENY PLACE* **Licen e #**: *44489* **Licen e Expiration Date**: *04/14/2021*
Addre : *10960 FRANKSTOWN ROAD, PENN HILLS, PA 15235*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *4122417080* **Email**: [redacted]

Legal Entity

Name: *GRAINGER AID OPCO LLC*
Address: *10960 FRANKSTOWN ROAD, PENN HILLS, PA, 15235*
Phone: *4122417080* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/02/1998* **Issued By**: *Labor and Industry*

Staffing Hours

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

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal,Complaint* **Exit Conference Date**: *01/13/2021*

Inspection Dates and Department Representative

01/12/2021 - On-Site: [redacted]
01/13/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* **Residents Served**: *28*

Secured Dementia Care Unit

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

Hospice

Current Re ident : *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *16* **Have Physical Disability**: *0*

Inspections / Reviews

01/12/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *04/08/2021*

4/16/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/19/2021*

4/22/2021 - Document Submission

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

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. All battery-operated carbon monoxide detectors must include the date of installation on the alarm, and all batteries must be changed at least annually.

The batteries in the carbon monoxide detector located outside of the kitchen were last changed on 4/5/19.

The carbon monoxide detectors outside of bedrooms [redacted] *and* [redacted] *do not include the date the batteries were installed.*

Plan of Correction **Accept**

Plan of Corrections
Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

2600.18
On 1/12/2021 Executive Director replaced and labeled the Carbon Monoxide Detector batteries located outside of the kitchen, bedroom [redacted] *and* [redacted]

On 2/04/2021 Executive Director completed an audit of carbon monoxide detectors to ensure batteries were changed at least annually and were labeled with date of change. Batteries changed and labeled as necessary. (see attachments A & B)
Maintenance Tech in-serviced on regulation "2600.18 Applicable health and safety laws" on 4/07/2021 by ED (See attachment C.)

Executive Director and/or designee will audit 5 carbon monoxide detectors weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure that batteries have been changed at least annually and labeled with the date changed. Audit results will be reviewed monthly in QI meetings and QI Committee will determine in continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's resident-contract, dated 7/30/20, is not signed by the resident.

Resident #3's resident-contract, dated 2/7/20, is not signed by the resident.

Plan of Correction **Accept**

Plan of Corrections

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2600.25b

On 1/13/2021 Executive Director acquired Resident #1's signature on the resident contract. Resident #3 is incapable of signing; this is reflected in their resident contract. (Attachments E&F)

On 04/09/2021, Executive Director conducted an audit of current resident's contracts to ensure resident's signatures are present. Corrections made as necessary. (Attachment G)

Community leadership team in-serviced on regulation "2600.25b Contract Signatures" on 04/09/2021 by Regional Director of Care Services (RDCS). (Attachment H)

ED and or designee to audit 5 resident contracts weekly for four weeks, biweekly for 4 weeks, then monthly for one month to ensure residents signatures are present. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. (Attachment I)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

101j7 - Lighting/Operable Lamp

1. 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.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

Resident #4's bedside lamp is approximately 3 feet from the resident's bed and cannot be turned on/off from bedside.

Plan of Correction **Accept**

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2600.101.j.7

On 1/12/2021 Executive Director moved resident #4's lamp within reaching distance from bedside. (Attachment J)

Current Staff to be in-serviced on regulation "2600.101.j.7 Lighting/Operable Lamp" at Staff meeting on 4/19/2021 by Executive Director.

Maintenance Tech and/or designee to audit for bedside lighting 0f 5 residents weekly for 4 weeks, biweekly for 4 weeks and then monthly for 1 month to ensure bedside lamp is within reach from bedside. Audit Results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. (Attachment K)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

141b1 - Annual Medical Evaluation

1. **Requirements**

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation, dated 4/6/20, does not include the resident's temperature. This section of the form is blank.

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction **Accept**

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2600.141.b.1
On 4/5/21 Care Service Manager updated Resident #2's medical evaluation to include temperature. (Attachment L)

On 4/5/21 Care Service Manager completed an audit of current resident's medical evaluations to ensure resident temperatures were notated. Corrections made as necessary. (Attachment M)

Community Leadership team Educated on regulation 2600.141.b.1 on 04/09/2021 by RDCS. (Attachment N)

ED and/or Designee to review 5 residents Medical Evaluations weekly for 4 weeks, bi-weekly for 4 weeks and monthly for one month to ensure that temperatures are noted as required. Audit Results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. (See Attached Audit A) Monitoring will be ongoing. (Attachment O).

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

144c1 - Smoking Area Guidelines

1. **Requirements**

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At 9:56 a.m., a blue cushion, which is not made of a fire-resistant material, was present on a chair in the home's designated smoking area.

144c1 - Smoking Area Guidelines *(continued)*

Plan of Correction **Accept**

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2600.144.c.1
On 1/12/2021 Executive Director removed non-fire-resistant cushion from the designated smoking area.

On 01/13/2021 Executive Director audited the designated smoking area to ensure only fire-resistant materials are present. No additional concerns noted. (Attachment P)

Current Staffed in-serviced on regulation "2600.144.c.1 Smoking area guidelines on 3/9/2021 (Attachment Q) by Executive Director
ED and/or Designee to audit designated smoking area 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 1 time per week for 4 weeks to ensure designated smoking area only has fire resistant materials present. Audit results will be reviewed monthly in QI meetings and QI Committee will determine if continued Auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. (Attachment R)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

162c - Menus Posted

1. Requirements

2600.
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 current menus posted in the home were dated from 11/30/20-12/6/20 and 12/28/20-1/3/21.

162c - Menus Posted *(continued)*

Plan of Correction **Accept**

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2600.162.c
On 1/12/2021 Executive Director posted current menus.

Chef educated on 1/14/2021 and assistant chef educated on 4/2/2021 on regulation 2600.162.c by Executive Director. (Attachment S)

Executive Director and/or designee to complete weekly audits of the menu board to ensure current menus are posted as required for 12 weeks. Audit results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing(Attachment T)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

[redacted]

[redacted]

Plan of Correction **Accept**

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Violation Withdrawn - LM 4/22/21

[redacted]

185a - Implement Storage Procedures

1. **Requirements**

2600.

185.a. The home 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 #4 is prescribed Bisacodyl 10 mg-Insert 1 suppository rectally daily as needed for constipation; however, the medication is not available in the home.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

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2600.185.a
Resident #4 s bisacodyl was discontinued by resident s MD on 01/20/2021

On 04/09/2021 Care Service Manager conducted audit of current residents ordered medications to ensure medications available in community. Results of audit revealed current ordered medications are available in the community. (Attachment U)

Current Med Techs to be in serviced by 04/19/2021 on regulation 2600.185a by the Care Service Manager.

Care Service Manager and/or designee will audit 5 resident s current medications orders to ensure ordered medications available at the community weekly for 4 weeks, then biweekly for 4 weeks, then monthly for one month. Audit Results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing (Attachment V)

Completion Date *04/19/2021*

Document Submission **Implemented**

See Attached

187b - Date/Time of Medication Admin.

1. **Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

187b - Date/Time of Medication Admin. *(continued)*

Description of Violation

Resident #1 is prescribed Xarelto 20 mg- Give 1 tablet by mouth 1 time a day; however, the initials of the staff person who administered the medication on 1/12/21 are not indicated on the resident's January 2021 medication administration record (MAR).

Resident #3 is prescribed Repaglinide 0.5 mg-Take 1 tablet by mouth 3 times a day; however, the initials of the staff persons who administered the medication on the following dates/times are not indicated on the resident's January 2021 MAR:

- *4:30 p.m. on 1/5/21*
- *11:30 am on 1/7/21 and 1/9/21*

Resident #3 is prescribed Vitamin D3 2,000u-Take 1 tablet by mouth 1 time a day; however, the initials of the staff person who administered the medication on 1/6/21 are not indicated on the resident's January 2021 MAR.

Resident #4 is prescribed Acetaminophen 325 mg-Give 2 tablets by mouth every 6 hours; however, the initials of the staff person who administered the medication at 12:00 p.m. on 1/12/21 are not indicated on the resident's January 2021 MAR.

Resident #4 is prescribed Simvastatin 40mg-Take 1 tablet by mouth one time a day at bedtime; however, the initials of the staff person who administered the medication at 8:30 pm on 1/12/21 are not indicated on the resident's January 2021 MAR.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction **Accept**

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2600.187.b

Care Service Manager completed Audit of current resident MAR's on 01/19/2021 to ensure medications administered and recorded as ordered. Results of audits reviewed with Residents MDs as necessary. (Attachment W)

Residents #1, #3, and #4's primary care provider notified on 4/12/21 by CSM of findings with no new orders received. Resident suffered no negative effects from findings.

Current Med-techs will be in-serviced on regulation 2600.187.b by CSM by 4/19/2021.

CSM and/or designee to audit 5 resident MARs weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure medications administered or recorded per MD orders. Audit Results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. (Attachment X)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

187d - Follow Prescriber's Orders

1. **Requirements**

2600.
187.d. The home shall follow the directions of the prescriber.

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

Resident #1 is prescribed Lispro Kwik insulin 100/ml-Inject subcutaneously before meals in accordance with the following sliding scale: 70-140=0 units; 141-180=2 units; 181-220=4 units; 221-250=6 units; 251-300=8 units; 301-340=10 units; 341-400=12 units; greater than 400=16 units and call MD.

On 1/6/21 at 11:30 a.m., resident #1's blood glucose was not checked, so it is unable to be determined if insulin should have been administered in accordance with the prescribed sliding scale.

On 1/3/21 at 4:23 p.m., resident #1's blood glucose was 146, which would have required 2 units of insulin to be administered; however, the resident did not receive any insulin.

On 1/10/21 at 5:23 a.m., resident #1's blood glucose was 225, which would have required 6 units of insulin to be administered; however, the resident did not receive any insulin.

Plan of Correction **Accept**

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2600.187d
Resident #1 was evaluated by their Primary Care Physician on 01/29/2021. Resident #1 suffered no negative effects from findings.

On 01/28/2021 Care Service Manager audited current resident's medication administration records who are receiving sliding scale insulin to ensure directions of the prescriber were followed. Any discrepancies identified will be reviewed with resident's MD as necessary. (Attachment Y)

Med Techs to be in serviced on regulation 2600.187d by 4/19/2021 by the Care Service Manager.

Care Service Manager and/or designee will audit 5 residents receiving sliding scale insulin to ensure prescribers directions are followed weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month. Audit Results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. (Attachment Z)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's most recent support plan, dated 8/13/20, is not signed by the resident and does it indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #3's most recent support plan, dated 2/21/20, is not signed by the resident nor does it indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction **Accept**

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2600.277. g
On 4/5/2021 Executive Director updated Resident #1 and Resident #3's resident support plans to include resident's inability to sign due to cognitive ability. (Attachment AA)

On 4/5/2021, Executive Director conducted an audit of current resident's support plans to ensure resident have signed support plan or support plan states residents unable to participate, declined to participate, refused to sign or was unable to sign. Updates made as necessary (Attachment BB)

Community Leadership Team educated on regulation 2600.227.g by RDCS on 04/9/2021. (Attachment CC)

Executive Director and/or designee to audit support plans weekly for 4 weeks, biweekly for 4 weeks then monthly for one month to ensure that signatures are captured or support plan states resident unable to participate, declined to participate, refused to sign or was unable to sign. Audit Results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. (Attachment DD)

Completion Date: *04/19/2021*

Document Submission **Implemented**

See Attached