Department of Human Services
Bureau of Human Service Licensing

September 7, 2021

[redacted]
UPMC SENIOR COMMUNITIES
200 LOTHROP STREET
FORBES TOWER, SUITE 10055B
PITTSBURGH, PA 15213

RE: SENECA MANOR
5340 SALTSBURG ROAD
VERONA, PA, 15147
LICENSE/COC#: 44499

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/27/2021, 04/28/2021, 04/29/2021 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: *SENECA MANOR* **License #:** *44499* **License Expiration Date:** *05/13/2022*
Address: *5340 SALTSBURG ROAD, VERONA, PA 15147*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *4127986000* **Email:** [redacted]

Legal Entity

Name: *UPMC SENIOR COMMUNITIES*
Address: *200 LOTHROP STREET, FORBES TOWER, SUITE 10055B, PITTSBURGH, PA, 15213*
Phone: *4127986000* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *04/14/2010* **Issued By:** *Municipality of Penn Hills*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *98* **Waking Staff:** *74*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *04/29/2021*

Inspection Dates and Department Representative

04/27/2021 - On-Site: [redacted]
04/28/2021 - On-Site: [redacted]
04/29/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *65*

Special Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *65*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *33* **Have Physical Disability:** *0*

Inspections / Reviews

04/27/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/01/2021*

7/6/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/12/2021*

7/14/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/31/2021*

9/7/2021 - Document Submission

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

18 Other laws, regs, ordins.

1. 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

On 4/27/21, no influenza poster was posted in a public and conspicuous place in the residence in accordance the Influenza Awareness Act, enacted July 2016.

Plan of Correction **Accept**

We are disputing this violation. This Flu poster has been hung in this locked shadow box since last inspection. Staff was asked and no one stated they placed this poster in the locked shadow box after the inspector thought [redacted] didn't see it. The inspector stated that [redacted] had a picture. I believe that this poster was there, just as it is seen in the attached picture, the entire time.

The poster was placed in the shadow box in the main entry hall on 4/27/21. Admin will check Monday's or the first day of the work week to ensure that the poster is available for all to view at all times.

Completion Date: *04/27/2021*

Document Submission **Implemented**

N/A

81b Resident equip – good repair

1. 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 #1's bilateral half bed rails do not have a cover over the rails, which have multiple openings measuring approximately 3-4" wide, which pose a risk of limb entanglement.

Resident #1 left bedrail is loose and moves approximately 2" in each direction and is not secure to the resident's bed.

Resident #3's bed enabler is loose and moves approximately 2" in each direction and is not secure to the resident's bed.

REPEAT VIOLATION: 3/12/2020

81b Resident equip – good repair *(continued)*

Plan of Correction **Accept**

Maintenance immediately placed cover on #1's bed rail as well as tightening it on 4/27/21. #3's bed enabler was tightened immediately also. Maintenance will check all bed enablers 1x/month during routine monthly maintenance checks.

All staff will be educated by July 8th on regulation 2800.81.b. The education will be evidenced by a sign in sheet. Staff education will also include how to initiate a work order for unsafe equipment.

All rails and enablers were checked immediately and secured and/ or covered by maintenance. Spreadsheet updated. Attached.

Completion Date: *04/28/2021*

Document Submission **Implemented**

N/A

82c Locked poisons

1. **Requirements**

2800.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

On 4/27/21 at 9:51 am, there was a 10 oz. can, approximately 1/4 full, of Claire Cinnamon Air Freshener and Deodorizer unlocked and unattended in the common dining room bathroom, with a manufacturer's label indicating, "first aid if swallowed immediately call poison control center/doctor. Do NOT induce vomiting." Not all residents of the residence, to include resident #8, are assessed capable of recognizing and using poisons safely.

Plan of Correction **Accept**

Deodorizer removed immediately and placed in a locked housekeeping room.
Sign placed on cupboard (attached) .
Staff educated regarding violation. Sign in sheet attached. Will continue to educate staff to be completed by July 8, 2021.
Housekeepers will check cupboard daily when cleaning bathroom.

Completion Date: *07/08/2021*

Document Submission **Implemented**

N/A

85a Sanitary conditions

1. **Requirements**

2800.

85.a. Sanitary conditions shall be maintained.

85a Sanitary conditions *(continued)*

Description of Violation

On 4/29/21 at 10:01 am, there was a used Foley catheter leg bag and catheter lines present in resident #4's shower.

Plan of Correction **Accept**

Used Foley equipment disposed of immediately and shower disinfected.
Resident educated on proper disposal of used foley catheter equipment. Resident acknowledged understanding, nurses note written.
Staff inservice scheduled for July 8th for all direct care staff. Content covered to include infection prevention, sanitary handling/disposing of supplies and skin care.

The nurse Aides will monitor daily, after care, to ensure that all used foley equipment is disposed of. Housekeepers to disinfect shower as needed or weekly during their weekly cleaning.

Completion Date: *06/30/2021*

Document Submission **Implemented**

N/A

89b Hot water temperature

1. **Requirements**

2800.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 4/29/21 1:09 pm, the hot water temperature at resident #6's bathroom sink was 122.5 degrees Fahrenheit.

On 4/29/21 at 9:48 am, the hot water temperature at resident #7's kitchenette sink was 122.7 degrees Fahrenheit, and at 1:04 pm the hot water temperature was 123.4 degrees Fahrenheit.

On 4/29/21 at 9:50 am and 1:06 pm, the hot water temperature at resident #7's bathroom sink was 122.5 degrees Fahrenheit.

89b Hot water temperature *(continued)*

Plan of Correction **Directed**

In consultation with the Manager of Building Maintenance for UPMC Senior Services it has been decided that a Symmons tempcontrol mixing valve, model 7-900 will be installed to regulate water temps. This will be installed by the end of August 2021. Water temps are checked randomly on a monthly basis during regular monthly maintenance checks.

Maintenance will check 4 rooms on each floor for water temperatures for their monthly checks. All taps will be checked in each apartment. Temps will be recorded.

For now Maintenance will check temperatures in 4 rooms on each floor daily concentrating on rooms closest to the tanks. The tanks are set at 120 degrees which is lowest temp for them. Temps will be recorded.

DIRECTED: Within 24 hours of receipt of the plan of correction: A designated staff person shall adjust the home's hot water temperatures to ensure hot water accessible to residents does not exceed 120 degrees Fahrenheit. Hot water temperatures shall be taken from at least 4 different hot water sources daily for one week then weekly thereafter until the Symmons tempcontrol mixing valve can be installed. Documentation of the hot water temperatures shall be kept. LM 7/14/21

Completion Date: *07/08/2021*

Document Submission **Implemented**

Maintenance set the hot water to 115 by placing new temp gauge on 7/14/21/ Temps were taken by Admin every day for the following week and and so on. (attached). Pictures of water regulation system is attached along with the temperature gauge.

105g Dryer lint removal

1. **Requirements**

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 4/27/21 at 10:00 am, an approximate 1" accumulation of lint was present in the lint trap of the dryer in the 1st floor laundry room.

Plan of Correction **Accept**

Lint removed immediately.
Housekeeping and Aides educated on the Regulation. Sign in sheet attached. Will continue to educate for staff to be completed by July 8, 2021
Housekeeping will check lint trap daily as they do their morning rounds.
New signage to remind users to empty lint . Attached.

Completion Date: *07/08/2021*

Document Submission **Implemented**

N/A

107b Emergency procedures

1. Requirements

2800.
107.b. The residence shall have written emergency procedures that include the following:
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.

Description of Violation

The residence's emergency disaster plan, dated 1/28/13, does not include the telephone numbers of state and local emergency management agencies.

Plan of Correction **Accept**

The contact telephone numbers were attached to the emergency medical plan on 4/28/21. Picture attached. They are in a permanent binder at the front desk. Admin will check quarterly to ensure nothing has been removed.

Completion Date: *04/28/2021*

Document Submission **Implemented**

N/A

121a Unobstructed egress

1. 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

On 4/27/21 at 9:40 am, an accumulation of salt and debris on the exterior of the right emergency exit door in the dining room prevented the door from immediately opening.

On 4/27/21 at 9:43 am, the double exit doors located in the dining room were obstructed with packaging tape and took 2 people to open the door.

On 4/27/21 at 12:00 pm, the main exit doors of the home were locked with a keypad. The residents of the home can only exit the residence by staff using their key fobs or the receptionist using the button at the receptionist desk to open the exit doors.

121a Unobstructed egress *(continued)*

Plan of Correction **Directed**

The salt door and taped door were both repaired on the day of inspection and move freely. Current pictures attached.

The front door was repaired on 4/29/21. The interior code reader has been disconnected and the motion sensor has been reactivated. This door for egress is never locked. Continues to work properly at this time. Work order attached.

Maintenance will check the viability of all 1st floor doors to the outside on a monthly basis during their monthly checks. They will correct or repair immediately if needed.

DIRECTED: Within 24 hours of receipt of the plan of correction: A designated staff person shall inspect all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed. LM 7/14/21

DIRECTED: Within 10 days of receipt of the plan of correction: All staff persons shall be educated that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed at all times. Documentation of the education shall be kept. LM 7/14/21

Completion Date: *06/30/2021*

Document Submission **Implemented**

Administrator checked all stairways, hallways, doorways, passageways and egress routes from the building on 7/15/21. No doors were locked or obstructed.

Education was completed on 7/20/21.

123b Emerg. procedures posted

1. **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

On 4/27/21 at 10:10 am, the residence's emergency management plan was not posted in a public and conspicuous place.

REPEAT VIOLATION: 3/12/2020

Plan of Correction **Accept**

The wrong copy of the Emergency Plan was placed in the permanent binder on the reception desk. New Plan Attached on 4/27/21. Administrator will check quarterly to ensure nothing has been removed. Copy attached.

Administrator will check the first work day of each month to ensure that the permanent binder is complete with all required documents.

Completion Date: *07/08/2021*

123b Emerg. procedures posted *(continued)*

Document Submission **Implemented**

N/A

131f Fire extinguisher inspection

1. 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 in the residence van has not been inspected by a fire safety expert since February 2020.

Plan of Correction **Accept**

A call was made to Fire Safety Group on 4/29. The fire extinguisher was checked and given a new label on 4/30. Picture attached.

Going forward the driver will be informed ahead of time so that we may avail the van for the fire inspection.

All fire extinguishers in the building were checked and tagged by FSE in February of 2021. Maintenance checks monthly to ensure that they are full and in working order Pic. attached. Standing order with "The Fire Safety Group" to inspect all extinguishers each February. picture attached.

Completion Date: *07/08/2021*

Document Submission **Implemented**

N/A

[redacted]

Violation Withdrawn LM 7/6/21

[redacted]

141b1 Annual medical evaluation

1. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #2's most recent medical evaluation, dated 8/24/20, was updated after the in-person evaluation, to include the date of the in-person evaluation and the date the medical evaluation form was completed; however, the initials of the staff person who made the update and the date the update was made is not present on the form.

Plan of Correction **Accept**

The resident support coordinator (RSC) was present during the appointment. The missing information was added by the RSC to reflect the date of the evaluation and the date the ADME was completed.

The RSC acknowledges the understanding that any information or updates made to the aforementioned forms are required to be dated and initialed.

All current ADME's were reviewed by the DRC for accuracy and completeness.

Moving forward all ADME's completed will be reviewed for correct dates by the DRC prior to filing in residents chart.

Completion Date: *07/08/2021*

Document Submission **Implemented**

N/A

162c Menus - posted

1. 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

On 4/27/21, there were no menus posted in a public and conspicuous place in the residence.

Plan of Correction **Accept**

Menus had been given to the residents in their rooms during Covid. Menus were placed in elevators immediately during inspection. Menus are now placed for 2 weeks in the elevators. They are changed for week 2 every Saturday evening by the receptionist. Administrator will check Mondays to ensure 2 weeks of menus are posted. Picture attached. Menus are also available at the reception desk.

Completion Date: *04/27/2021*

Document Submission **Implemented**

N/A

185a Storage procedures

1. 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.

185a Storage procedures *(continued)*

Description of Violation

On 4/9/21 at 4:01 pm, resident #1's blood glucose was 282; however, it was documented on the resident's April 2021 vital report as 272.

On 4/12/21 at 4:07 pm, resident #1's blood glucose was 129; however, it was documented on the resident's April 2021 vital report as 127.

On 4/4/21 at 8:43 am, resident #2's blood glucose was 196; however, it was documented on the resident's April 2021 vital report as 169.

On 4/4/21 at 12:20 pm, resident #2's blood glucose was 486; however, it was documented on the resident's April 2021 vital report as 346.

On 4/5/21 at 1:28 pm, resident #2's blood glucose was 145; however, the blood glucose reading was not documented on the resident's April 2021 vitals report.

On 4/21/21 at 12:52 pm resident #2's blood glucose was 298; however, it was documented on the resident's April 2021 vital report as 238.

On 4/17/21 4:40 pm, resident #6's blood glucose was 152; however, the blood glucose reading is documented as 154 on the resident's April 2021 medication administration record (MAR).

There was an unlabeled One Touch glucometer in the cabinet of the 3rd floor medication room.

Plan of Correction **Accept**

The unlabeled glucometer was discarded immediately. All med rooms were searched by the DRC for any unlabeled glucometers. All glucometers are labeled with resident room # and placed in the corresponding resident labeled container.

A daily diabetic log (see attachment) was implemented for each resident requiring blood glucose monitoring as prescribed. All staff will record results on the diabetic log as well as in the MAR. Any blood glucose checks done on an as needed basis or as a nursing measure will be recorded on the diabetic log. The DRC or designee will audit this log against the MAR and the glucometer weekly x3 months. If documentation accuracy is reached, audits will resume monthly.

A staff supervisory counseling was completed with all LPNs and MTs (see attached)

The DRC or designee will conduct a thorough sweep of medication rooms weekly for 3 months and then monthly to ensure all glucometers are labeled and in good working condition.

Completion Date: *07/08/2021*

Document Submission **Implemented**

N/A

187d Follow prescriber's orders

1. **Requirements**

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed Humalog Kwik Pen-100u/ml-Blood glucose monitor 3 times daily with subcutaneous coverage per sliding scale: 70-130=0 units; 131-180=2 units; 181-240=4 units; 241-300=6 units; 301-350=8 units; 351-400=10 units.
On 4/4/21 at 8:43 am, resident #2's blood glucose was 196 and should have received 4 units of insulin; however, the resident only received 2 units of insulin.

On 4/5/21 at 1:28 pm, resident #2's blood glucose was 145 and should have received 2 units of insulin; however, the resident received 0 units of insulin.

Resident #6 is prescribed Metoprolol Tartrate 50 mg-Take 1/2 tablet (25 mg) twice daily. The residence is using 50 mg tablets; however, the pills are not being evenly cut on the score line, so it is unable to be determined if the resident is receiving the proper dose of 25 mg.

Resident #6 is prescribed blood glucose checks 3 times daily before meals; however, the resident's blood glucose was not taken before supper on 4/27/21.

Plan of Correction **Accept**

A daily diabetic log (see attachment) was implemented for each resident requiring blood glucose monitoring as prescribed. All staff will record results and units administered (as applicable) on the diabetic log as well as in the MAR. The DRC or designee will audit this log against the MAR and the glucometer weekly x3 months. If documentation accuracy and proper administration is reached, audits will resume monthly.

A staff education was completed on 6/28/21 on proper administration of the Metoprolol Tartrate 50mg. Education was provided to staff on how to cut all pills using the score line.

A supervisory counseling was completed with all LPNs and MTs (see attached)
Med passers will exhibit appropriate knowledge by splitting pills in front of the DRC on 2 occasions to ensure proper procedure is followed.
Med passers will be checked randomly, on a monthly basis, going forward by DRC or designee.

Completion Date: *07/12/2021*

Document Submission **Implemented**

N/A

203 Bedside rails

1. **Requirements**

2800.

203 Bedside rails *(continued)*

203. Bedside Rails

b. Half-length rails are permitted only if the following conditions are met:

1. The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.
3. The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

Description of Violation

Half-length rails are used on resident #1's bed; however, resident # 1's most recent assessment and support plan, dated 10/26/20, does not address the medical symptoms necessitating the use of half-length rails, or the health and safety protection necessary in order to safely use half-length rails. Also, resident #6 or the resident's legal representative did not consent to the use of half-length rails after the risk, benefits and alternatives were explained.

Plan of Correction **Directed**

Information added to the current ASP immediately. The required information was care planned on the previous ASP but was not carried over onto the current ASP. The RSC will ensure all updates made on the current ASP are transcribed accurately onto the new/annual ASP.

The RN/DRC will review and sign the ASP's upon completion to ensure accuracy and thoroughness before filing in resident's chart.

Resident #6 does not have or use half-length rails nor is care planned to have rails. See attached pictures of Resident #6 bed.

All residents with half-length rails are now care planned appropriately and informed consent has been received. See attached informed consent form for the use of bed rails.

DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident assessments and support plans are updated when a resident uses bedside rails in accordance with 2800.203b(1). The system shall also include a process to obtain consent from the resident or legal representative in accordance with 2800.203b(3). All staff persons involved with the completion of resident assessments and support plans shall be educated on the new system. LM 7/14/21

Completion Date: *07/07/2021*

Document Submission **Implemented**

DRC and RSC developed a spreadsheet with a consent column on 7/16. They have also added the bedrail consent on 7/16/21 to the assessment packet to be signed if needed upon admission. Consents will be checked with ASP on a quarterly basis by RSC. (Spreadsheet attached.)

221c Post activity calendar

1. Requirements

2800.

221.c. The week's daily activity calendar shall be posted in advance in a conspicuous and public place in the residence. The residence shall provide verbal cueing and reminders of activities, their start times and locations within the residence.

Description of Violation

On 4/27/21, residence's activity calendar was not posted in a public and conspicuous place.

Plan of Correction **Accept**

The weekly activities were given to residents in their rooms during Covid. The monthly calendar was immediately placed in the elevators during the inspection. The Activity Director will resume placing the monthly calendar in elevators the 1st of the month. Copies are also available at the reception desk throughout the month. Picture attached.

Completion Date: *04/27/2021*

Document Submission **Implemented**

N/A

225b Assessment content

1. Requirements

2800.

225.b. The assessment must, at a minimum include the following:

4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

Description of Violation

Resident #2's most recent assessment, dated 8/14/20, does not include the resident's diagnosis of depression. The resident is currently prescribed Cymbalta for depression.

Plan of Correction **Accept**

The diagnosis of depression was added to Resident #2's ASP immediately. The RSC will ensure all updates made on the current ASP are transcribed accurately onto the new/annual ASP.

Moving forward, the DRC will check all ASP's upon completion to ensure all diagnoses are transcribed over and they reflect the resident's medical history accurately before it is filed in the chart.

Completion Date: *07/12/2021*

Document Submission **Implemented**

N/A

252 Records – content

1. Requirements

2800.

252. Content of Resident Records - Each resident's record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

252 Records – content *(continued)*

Description of Violation

Resident #1's most recent photograph is dated 11/22/17.

Plan of Correction **Accept**

Picture taken of resident #1 and placed in [redacted] record. All other pictures reviewed and all were taken after 11/30/20. All pictures of current residents scheduled to be taken again during 10/22 to remain in compliance. Pictures will be taken of new residents upon admission. #1 Picture attached.

Completion Date: *06/28/2021*

Document Submission **Implemented**

N/A