pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: May 27, 2022

[redacted]
Tapestry Moon, LLC
[redacted]

RE: Tapestry Senior Living Moon Township
550 Cherrington Parkway
Coraopolis, PA 15108
License/COC#: 45009

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on December 21, 2021, December 22, 2021, April 14, 2022, and April 15, 2022, we have found the above facility to be in compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *TAPESTRY SENIOR LIVING MOON TOWNSHIP* **License #**: *45009* **License Expiration**: *02/11/2022*

Address: *550 CHERRINGTON PARKWAY, CORAOPOLIS, PA 15108*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *4125079915* **Email**: [redacted]

Legal Entity

Name: *TAPESTRY MOON LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *07/29/2019* **Issued By**: *Township of Moon*

Staffing Hours

Resident Support Staff: *14* **Total Daily Staff**: *130* **Waking Staff**: *98*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *12/22/2021*

Inspection Dates and Department Representative

12/21/2021 - On-Site: [redacted]

12/22/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *73*

Special Care Unit

In Home: *Yes* **Area**: *Units on 1, 2, 3, 4* **Capacity**: *71* **Residents Served**: *30*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *43* **Have Physical Disability**: *1*

Inspections / Reviews

12/21/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/05/2022*

02/04/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/10/2022*

02/10/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/14/2022*

02/11/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/15/2022*

05/02/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type:** **Follow-Up Date:**

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 12/21/21, the residence's current license was not posted in a conspicuous and public place in the residence.

Plan of Correction ***Accept***

1. The residence has posted the current license in the front lobby on 12/21/21.
2. The residence has also put a copy of the current license inspection summary issued by the Department with a copy of this chapter at the front desk labeled AL survey results which is a conspicuous and public place that visitors can access. This was also corrected on 12/21/21.
3. Business Office Director will audit monthly to ensure that a copy of the current license remains posted in the front lobby and also in the license inspection binder at the front desk.
4. Copy of audit will be kept.
5. Will implement a check list that will include the location of posted license.
Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

17 Record confidentiality

1. Requirements

2800.
17. Confidentiality of Records - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 12/21/21 at 11:29 a.m., the resident privacy coding document containing the names of numerous residents, to include residents #5 and #6, was attached to the licensing inspection summary, dated 1/2/20, and was posted in a black binder at the reception desk.

REPEAT VIOLATION: 5/28/2021; 11/9/2020, et.al.

Plan of Correction ***Directed***

1. On 12/21/21 the resident privacy coding document containing the name of numerous residents (resident #5 and #6) that was attached to the licensing inspection summary dated 1/2/2020 was removed from the black binder at the front desk.
2. Also, the binder was audited on 12/21/21 to ensure no other resident records with confidential information were in the binder.
3. The business office will audit each LIS before it is put into the binder at the front desk to ensure no confidential

17 Record confidentiality (continued)

information is posted in the binder.
4. The front desk staff was in serviced on 2800.17 record confidentiality to ensure the binders are maintained and compliant.
5. All staff education in-service will be completed by 3/1/22
6. Quarterly audits of Business Office files and Nursing Medical charts will be done to ensure all resident records are kept secure and confidential.
7. The initial audit will be completed by 3/1/22 and then quarterly moving forward.
8. Audits there after as information or violation reports will need to be added to ensure compliance.

DIRECTED: Within 5 calendar days of receipt of the plan of correction, then daily thereafter: A designated staff person shall inspect the residence to ensure all resident information is kept in an area that is locked. LM 2/11/22

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

51 Criminal background checks

1. Requirements

2800.
51. Criminal background checks
    a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
    b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

A Pennsylvania criminal background check has not completed for staff person A, who was hired on [redacted]/21.

A Pennsylvania criminal background check has not been completed for staff person B, who was hired on [redacted]/21.

A Pennsylvania criminal background check has not been completed for staff person C, who was hired on [redacted]21.

Plan of Correction ***Directed***

1. On 1/5/2022 all PA criminal background checks were re-ran on all current employees including staff persons A, B, C. Tapestry is contracted with USA Background Checks for all new hires to have a Background Checks ran through PA Police Checks (PATCH). This is in accordance with the Older Adult Protective services Act and 6 PA Code Chapter 15.
2. In addition, the hiring policies are in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's website.
3. Moving forward all new hires will have background checks ran through the PATCH systems.
4. Business Office Director was in serviced on 2800.51 criminal background checks.
5. Business Office Director will monitor monthly to ensure that all new hires have a criminal background check that has been processed, returned and are added as part of the employee file.

51 Criminal background checks (continued)

6. Copy of audits will be kept.

7. Check list will be implemented and placed in employee file that will cover all the requirements of regulation 2800.51.criminal background checks in addition to regulation 2800.65G initial direct care training. (DIRECTED: The new-hire checklist shall be implemented within 7 calendar days of receipt of the plan of correction. Copies of the completed new-hire checklist shall be kept in each staff person's record. LM 2/11/22)

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

65g Initial direct care training

1. Requirements

2800.

65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the residence.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. The signs and symptoms of infections and infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.
   - xvii. Behavioral management techniques.
   - xviii. Understanding of the resident's assessment and how to implement the resident's support plan.
   - xix. Person-centered care and aging in place.

Description of Violation

Direct care staff person B, hired on [redacted]21, has not successfully completed and passed the Department approved direct care training course and pass the competency test.

Plan of Correction ***Directed***

1. On 12/22/21 Direct Care Staff Person B, successfully completed and passed the Department approved direct care training course and passed the competency test. Moving forward all employees will complete 18 hours of training.

65g Initial direct care training (continued)

2. A demonstration of job duties, followed by supervised practice.
3. Successful completion and passing the Department approved direct care training course and passing the competency test.
4. All 18 direct care staff person training as listed in Reg 65g Tapestry uses Relias training program which includes the required training. Business Office Director and Executive Director will sign off on the new hires after completion of this training and before the new hire provides unsupervised assisted living services to the residents.
5. An audit of all direct care staff records will be completed by 3/1/22 to ensure that they have completed the DC competency test and it is part of their record.
6. Administrative staff will audit employee records by quarterly by ensure compliance.
7. Records of audits will be kept.
8. Check list will be implemented and placed in employee file that will cover all the requirements of regulation 2800.51.criminal background checks in addition to regulation 2800.65G initial direct care training. (DIRECTED: The new-hire checklist shall be implemented within 7 calendar days of receipt of the plan of correction. Copies of the completed new-hire checklist shall be kept in each staff person's record. LM 2/11/22)

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

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 12/21/21 at 12:47 p.m., a box of Polident denture tablets, with a manufacture's label indicating to call the Poison Control Center or Doctor if swallowed, was unlocked, unattended and accessible on the bathroom sink in bedroom #[redacted] of the special care unit. Not all the residents of the residence, including resident #1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Directed***

1. On 12/21/21 the box of Polydent denture tablets were removed from resident #1's room. All poisonous materials will be kept in a locked cabinet inaccessible to the residents.
2. The residence has purchased locks that will be installed on the kitchenette cabinets were all poisonous material for the resident will be secured and only accessed by a staff member. (DIRECTED: The locks shall be installed by 3/1/22. LM 2/11/22)
3. All staff inservices will be completed by 3/1/22 on reg 2800.82 c locked poisons. (DIRECTED: Documentation of staff inservice shall be kept. LM 2/11/22)
4. Environmental Services Director will monitor monthly as part of PM program to ensure that all cabinets in occupied resident rooms have functioning locks.

82c Locked poisons (continued)

5. Records of audits will be kept.

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

91 Telephone Numbers

1. 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

On 12/21/21, there were no emergency telephone numbers posted on or by the telephone in bedrooms #135 and #142.

On 12/22/21, there were no emergency telephone numbers posted on or by the telephone in bedroom #348.

Plan of Correction ***Accept***

1. On 12/22/21 Emergency telephone numbers including:
a. Nearest hospital
b. Police Department
c. Fire Department
d. Ambulance
e. Poison Control
f. Local Emergency Management
g. Assisted Living Complaint Hotline
Were posted by the telephones in rooms 135, 142, 348
2. An audit will be completed by 3/15/22 on all other occupied resident rooms to ensure that the telephone numbers list above was near every phone.
3. The Director of Environmental Services will audit all resident rooms upon move in and twice a year to ensure phone number are posted.

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

92 Windows/screens

1. Requirements

2800.

92 Windows/screens *(continued)*

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 12/21/21, there were no screens present on numerous operable windows, to include the windows in bedrooms #135, #142, #305, #316 and #344.

Plan of Correction ***Accept***

1. By 3/15/22 safety screws will be re-installed on the window latch to prevent windows from opening. The rooms that were effected were 135, 142, 305, 316, and 344.
2. By 3/15/22 all the other windows will be inspected to ensure that all safety screws are present and windows did not open. Record of audit will be kept.
3. Moving forward if the residence would decide that windows opening to the outside are needed, the residence will purchase screens for those windows individually as needed.
4. This will ensure that windows including windows in doors will be in good repair securely screened when doors and windows are open.
5. Maintenance staff in serviced on Reg 2800. 92 Window screens.

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

96a First aid kit

1. 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

On 12/22/21 at 4:34 p.m., the residence's first aid kit did not include a breathing shield.

Plan of Correction ***Directed***

1. By 3/15/22 breathing shields were purchased and added to the first aid kits. The residence now has a first aid kit that includes:
a. Nonporous disposable gloves
b. Antiseptic
c. Adhesive bandages
d. Gauze pads
e. Thermometer
f. Adhesive tape
g. Scissors
h. Breathing shield
i. Eye coverings
j. Tweezers

96a First aid kit (continued)

2. The residence will audit the first aid kit after every use to ensure all items listed above are present in the first aid kit.

3. A check list will be attached to the first aid kit. (DIRECTED: Within 7 calendar days of receipt of the plan of correction: All direct care staff persons shall be educated on the new first aid checklist and auditing requirements after each use of the first aid kit. Documentation of the education shall be kept. LM 2/11/22).

4. Audit of the first aid kit will be done quarterly and records will be kept.

5. DON, ADON to complete audit.

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

103f Fridge/Freezer Temps

1. Requirements

2800.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 12/21/21 at 11:20 a.m., the temperature in the walk-in kitchen freezer was 5 degrees Fahrenheit, and on 12/22/21 at 11:02 a.m., it was 4 degrees Fahrenheit.

Plan of Correction ***Accept***

1. By 3/15/22 repair company serviced and adjusted thermostat of the walk-in freezer. It now holds a temp of -1 degree

2. A daily log of fridge and freezer temps will be kept by the Dining Services staff.

3. Log will be monitored by Dining Services Director.

4. By 3/15/22 all dining staff will be inserviced on Reg 2800.103f fridge and freezer temps.

5. Inservice will be kept.

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

107c Food/water – 3 day supply

1. Requirements

2800.
107.c. The residence shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 12/21/21, the residence served 73 residents, requiring 219 gallons of emergency drinking water available for a 3-day supply; however, only 176 gallons of emergency drinking water were available on-site. The home has an agreement with Tri-State Waters; however, the letter from Tri-State Waters, dated 12/21/21, does not indicate how much water will be delivered or guarantee that the water will be delivered as a priority even in the event of a regional general emergency.

Plan of Correction ***Accept***

1. On 1/22/21 an order was placed and since has been received and is on hand to meet the regulation that the residence shall maintain at least a 3-day supply of non perishable food and drinking water for residents.
2. We serve 88 residents and have 312 gallons stored on site.
3. In addition to an agreement with Tri-State water to supply the residence with water in the event of an emergency
4. The Dining Services Director will monitor monthly to ensure that the residence has a 3 day supply of water for each resident in accordance with daily census.
5. Copies of the audit will be kept.
Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

141b1 Annual medical evaluation

1. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation, dated 11/6/21, does not include an assessment of the resident's ability to self-administer medications. This section of the form is blank.

Plan of Correction ***Accept***

1. On 12/22/21 the ADME for resident #1 was corrected by DON.
2. The box was checked and dated that the resident was notable to self-administer medications.
3. An audit of all resident charts will be completed by 3/15/22 to ensure that all residents medical evaluation is completed in entirety and also that all medical evaluations are done at least annually.
4. ADONs were in serviced on 2/3/22 on regulation 2800.141b annual medical evaluation by DON
5. Initial audits will be performed by clinical staff to be completed by 3/15/2022
6. Copies of audits will be kept
7. A tickler file will be implemented that will track monthly due dates for annual medical evaluations that are due. In the event of a significate change that date will become the new annual due date and moved in the file accordingly.
Completion Date: *03/15/2022*

141b1 Annual medical evaluation *(continued)*

Document Submission ***Implemented***

see attached

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.

Description of Violation

Resident #3 is prescribed Ondansetron HCL 4 mg tablet-Place 1 tablet under the tongue every 6 hours as needed; however, on 12/22/21, this medication was not available in the residence.

Plan of Correction ***Accept***

1. The residence will perform an initial cart audit on 2/2/22 to ensure that all needed medications are stored safely are accessible, secure ready for distribution and proper use of medications by the residence staff person.
2. Monthly cart audits will be performed moving forward.
3. Resident #3 prescribed Ondansetron was discontinued on 12/22/21.
4. The med techs and nursing staff was in serviced on 2800.185a storage procedures
5. Monthly monitoring will be completed by the clinical staff. copies of audits will be kept.
6. Med techs will be in-service on Reg 2800.185a storage procedures, medication procedures, ensuring medications are recorded timely.
7. In-services will be completed by 3/15/22 and records will be kept. 4. The med techs and nursing staff was in serviced on 2800.185a storage procedures.
Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

227e Self-administer medication

1. Requirements

2800.
227.e. The resident's final support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key-locking devices. Strategies that promote interactive communication on the part of and between direct care staff and individual residents shall also be included in the final support plan.

Description of Violation

On 11/26/21, resident #8's was prescribed Voltaren 1% topical gel-Apply to affected area 4 times a day as needed and that the resident can self-administer the medication and keep at bedside. However, resident #8's assessment and support plan, dated 8/6/21, indicates this resident cannot self-administer medications.

Plan of Correction ***Directed***

1. The residence will complete an audit of all self-administered medication orders and support plan/ADME for appropriate documentation to reflect resident's ability and need to self-administer. (DIRECTED: The resident record audit shall be completed within 10 calendar days of receipt of the plan of correction. LM 2/11/21)
2. ADON will be hosting in services on Reg 2800.227e self-administration of medications to ensure compliance.

227e Self-administer medication (continued)

3. Monthly monitoring will be completed by the clinical staff. Copies of audits will be kept.
4. In-services will be completed by 3/15/22, and records will be kept.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: Resident #8's assessment and support plan shall be updated to indicate current services needed relating to medication administration. LM 2/11/22)

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

231d No objection statement

1. Requirements

2800.
231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

Description of Violation

Resident #1 was admitted to the special care unit on [redacted]/19; however, there is no documentation present indicating the resident and the resident's designated person have agreed to the resident's admission to the special care unit.

REPEAT VIOLATION: 11/9/2020, et.al.

Plan of Correction ***Directed***

1. The residence has added on addendum to the resident record stating that the resident or potential resident and when appropriate the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.
2. Sales team will be in serviced on Reg 2800.231.d no objection statement. (DIRECTED: The staff education shall be completed within 7 calendar days of receipt of the plan of correction. Documentation of the education shall be kept. LM 2/11/22)
3. Sales team will initial audit by 3/15/2022 resident contracts to ensure compliance.
4. Record of audits will be kept.
5. Addendum/Verbiage was added to all old and new contracts to ensure compliance

DIRECTED: Within 5 calendar days of receipt of the plan of correction: Resident #1's record shall be updated with documentation indicating the resident and the resident's designated person have agreed to the resident's admission to the special care unit. Documentation shall be kept in resident #1's record. LM 2/11/22

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

233c Key-locking devices

1. Requirements

233c Key-locking devices *(continued)*

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

On 12/21/21, the current directions to operate the key-locking devices in the special care units were not present at the following emergency exit doors:

- *Mulligan Square-Level 1 exit*
- *Courtyard gate to east side front sidewalk*
- *Courtyard gate to east side parking lot*
- *Emergency exit stairwell A, across from bedroom #105*

REPEAT VIOLATION: 5/28/2021; 11/9/2020, et.al.

Plan of Correction ***Accept***

1. On 12/22/21 the current directions to operate the key locking device in the special care units were re-posted after changing of the code occurred for safety purposes.
2. The following emergency exit doors were now having the correct code posted at the following:
a. Mulligan Square
b. Courtyard Gate to east side front sidewalk
c. Courtyard gate to east side parking lot
d. Emergency Exit stairwell A across from room 105
3. The Environmental Services Director and both Maintenance Techs have been in service on 2/3/22 on Reg 233 c key locking devices.
4. In addition, this has been added to the TELs monthly maintenance PM program to be checked for ongoing compliance.
5. Documentation will be kept for the monthly audit in PM program
Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached

251c Standardized forms

1. Requirements

2800.
251.c. The residence shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #8's most recent assessment and support plan, dated 8/6/21, is not completed on the Department's current standardized form for Chapter 2800-Assisted Living Residences.

Plan of Correction ***Accept***

1. On 12/22/21 new ASP was completed for resident #8.
2. Assistant Resident Services Directors will review and ensure all required areas are filled out correctly.

251c Standardized forms (continued)

3. Audit of all existing AL resident charts will be done by 3/15/22 to ensure the proper AL forms are used.
4. Resident Services Director has reviewed Reg 2800.251c standardized form with ADONs to ensure ongoing compliance with regulation.

Completion Date: *03/15/2022*

Document Submission ***Implemented***

see attached