Department of Human Services
Bureau of Human Service Licensing

June 8, 2022

[redacted], PRESIDENT/COO
[redacted]

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 05/10/2022, 05/11/2022, 05/12/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *ALLEGHENY PLACE* **License #:** *44489* **License Expiration:** *04/14/2023*

Address: *10960 FRANKSTOWN ROAD, PENN HILLS, PA 15235*

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

Administrator

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

Legal Entity

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *02/02/1998* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *38* **Waking Staff:** *29*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *05/12/2022*

Inspection Dates and Department Representative

05/10/2022 - On-Site: [redacted]
05/11/2022 - On-Site:
05/12/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* **Residents Served:** *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *25*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *13* **Have Physical Disability:** *0*

Inspections / Reviews

05/10/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/28/2022*

Inspections / Reviews *(continued)*

06/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/06/2022*

06/08/2022 - Document Submission

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

17 - Record Confidentiality

1. Requirements

2600.

17. 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 5/10/22, at approximately 10:15 a.m., there was a binder labeled "Get to Know You" containing documents with confidential information of current and previous residents, to include resident #1, #2, #3 and #4. The documents included residents name, date of birth, social security numbers, diagnosis, care needs, family contact information, doctor's names and so on, in a wall file holder under the coat hooks on left wall in the unlocked, unattended and accessible activity room.

Plan of Correction ***Accept***

- *During the inspection on 5/10/22, the Executive Director (ED) removed the "getting to Know You" binder from the activity room and placed it in a secured cabinet.*
- *On 5/10/22, while walking through the community with the inspector, all other confidential records were found to be secured.*
- *On 5/25/22, ED was re-educated by the Regional Director of Care Services (RDCS) on requirements set within regulation 2600.17 (Exhibit A - In-service)*
- *ED or designee will walk through the community weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure no confidential resident information is accessible (Exhibit B - Audit tool)*
- *Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion Date 8/19/2022*

Completion Date: *08/18/2022*

Document Submission ***Implemented***

- *During the inspection on 5/10/22, the Executive Director (ED) removed the "getting to Know You" binder from the activity room and placed it in a secured cabinet.*
- *On 5/10/22, while walking through the community with the inspector, all other confidential records were found to be secured.*
- *On 5/25/22, ED was re-educated by the Regional Director of Care Services (RDCS) on requirements set within regulation 2600.17 (Exhibit A - In-service)*
- *ED or designee will walk through the community weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure no confidential resident information is accessible (Exhibit B - Audit tool)*
- *Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion Date 8/19/2022*
- *See Attached*

60a - Staff/Support Plan

1. Requirements

2600.

60a - Staff/Support Plan *(continued)*

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home served 27 residents, which includes 12 residents with mobility needs, 5 of which require 2-person assistance with use of a mechanical device in transferring. On 4/25/22, from 6:00 a.m. to 8:05 a.m., there were only two direct care staff persons working in the home, which is not adequate to meet the needs of the residents in the event of an emergency.

The home served 25 residents, which includes 12 residents with mobility needs, 5 of which require 2-person assistance with use of a mechanical device in transferring. On 4/28/22, from 6:00 a.m. to 7:00 a.m., only one direct care staff person was working in the home, which is not adequate to meet the needs of the residents in the event of an emergency.

Plan of Correction ***Accept***

- *On 5/10/22, ED reviewed the current schedule to ensure each shift has adequate staffing to meet the needs of the residents as specified in their assessments and support plans. Staffing was found to be in compliance with this regulation.*
- *On 5/12/22, ED reviewed the upcoming schedule to ensure each shift has adequate staffing to meet the needs of residents as specified in their assessment and support plans. Staffing was found to be in compliance with this regulation.*
- *On 5/25/22, ED was re-educated by the Regional Director of Care Services (RDCS) on requirements set within regulation 2600.60a (Exhibit A - In-service)*
- *On 5/25/22, ED implemented a process where if a direct care staff calls off for the next shift, a direct care staff from the current shift must stay until the ED or CSM arrive at the community. On 5/31/22 the ED will educate direct care staff on this process (Exhibit C - In - Service)*
- *ED will compare the schedule to employee timecards weekly x 6 weeks and bi-weekly x 6 weeks to ensure staffing is adequate to meet the needs of the residents as specified in their assessments and support plans. (Exhibit D - Audit tool)*
- *Results of the audit will be discussed at the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/12/2022*

Completion Date: *08/12/2022*

Document Submission ***Implemented***

- *On 5/10/22, ED reviewed the current schedule to ensure each shift has adequate staffing to meet the needs of the residents as specified in their assessments and support plans. Staffing was found to be in compliance with this regulation.*
- *On 5/12/22, ED reviewed the upcoming schedule to ensure each shift has adequate staffing to meet the needs of residents as specified in their assessment and support plans. Staffing was found to be in compliance with this regulation.*
- *On 5/25/22, ED was re-educated by the Regional Director of Care Services (RDCS) on requirements set within regulation 2600.60a (Exhibit A - In-service)*
- *On 5/25/22, ED implemented a process where if a direct care staff calls off for the next shift, a direct care staff from the current shift must stay until the ED or CSM arrive at the community. On 5/31/22 the ED will educate direct care staff on this process (Exhibit C - In - Service)*
- *ED will compare the schedule to employee timecards weekly x 6 weeks and bi-weekly x 6 weeks to ensure staffing is adequate to meet the needs of the residents as specified in their assessments and support plans.*

60a - Staff/Support Plan (continued)

(Exhibit D - Audit tool)

- *Results of the audit will be discussed at the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/12/2022*
- *See Attached*

92 - Windows

1. Requirements

2600.
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 5/11/22 at approximately 9:20 a.m., there were no screens the windows in bedroom #107.

Plan of Correction ***Accept***

- *On 5/11/22 at 1:10 PM, Maintenance Tech (MT) re-inserted the screen into the window in the bedroom in room #107.*
- *On 5/11/22 MT checked all rooms to ensure each window had a screen. All windows in rooms were found to be in compliance with this regulation.*
- *On 5/11/22, ED re-educated MT on requirements set within regulation2600.92 (Exhibit E - In-service)*
- *On 5/13/22, ED educated resident who resides in room #107 and this resident's family member on the requirements set within regulation 2600.92*
- *MT will check 3 resident rooms weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure each window has a screen and is in compliance with this regulation (Exhibit F - Audit tool)*
- *Results of the audit will be discussed at the monthly QI meeting. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/19/22*

Completion Date: *08/19/2022*

Document Submission ***Implemented***

- *On 5/11/22 at 1:10 PM, Maintenance Tech (MT) re-inserted the screen into the window in the bedroom in room #107.*
- *On 5/11/22 MT checked all rooms to ensure each window had a screen. All windows in rooms were found to be in compliance with this regulation.*
- *On 5/11/22, ED re-educated MT on requirements set within regulation2600.92 (Exhibit E - In-service)*
- *On 5/13/22, ED educated resident who resides in room #107 and this resident's family member on the requirements set within regulation 2600.92*
- *MT will check 3 resident rooms weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to ensure each window has a screen and is in compliance with this regulation (Exhibit F - Audit tool)*
- *Results of the audit will be discussed at the monthly QI meeting. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/19/22*
- *See Attached*

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 5/10/22 at approximately 10:45a.m. there was an open, unsealed, and undated bag of Eggo Waffles (four remaining) on top of a box of Eggo Waffles in first single upright freezer.

On 5/10/22 at approximately 10:50 a.m., there was a large open, unsealed, and undated, unsealed 15lb. box of Stripped Pangasius Fillets in the double door freezer

Plan of Correction ***Accept***

- *On 5/10/22, Chef immediately discarded the open, unsealed and undated bag of Eggo waffles as well as the open, unsealed and undated box of Pangasius Filets.*
- *On 5/11/22, Chef conducted an audit of the items in the kitchen and no other items were found to be out of compliance with this regulation.*
- *On 5/18/22, ED re-educated chef on requirements set within regulation 2600.103.i (Exhibit G - In-Service)*
- *ED or designee will check food storage areas weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 to ensure all food is in compliance with this regulation (Exhibit H - Audit tool)*
- *The results of the audit will be discussed at the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/19/22*

Completion Date: *08/19/2022*

Document Submission ***Implemented***

- *On 5/10/22, Chef immediately discarded the open, unsealed and undated bag of Eggo waffles as well as the open, unsealed and undated box of Pangasius Filets.*
- *On 5/11/22, Chef conducted an audit of the items in the kitchen and no other items were found to be out of compliance with this regulation.*
- *On 5/18/22, ED re-educated chef on requirements set within regulation 2600.103.i (Exhibit G - In-Service)*
- *ED or designee will check food storage areas weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 to ensure all food is in compliance with this regulation (Exhibit H - Audit tool)*
- *The results of the audit will be discussed at the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/19/22*
- *See Attached*

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 #5 is prescribed [redacted] use per sliding scale and inject subcutaneously three times a day (7:30 a.m., 11:30 a.m., and 4:30 p.m.) Sliding Scale: <131=0 units; 131-180 = 4 units; 181-240=8 units; 241-300 = 10 units; 301-350=12 units; 351-400=16units; 401 + =20 units and notify MD.

185a - Implement Storage Procedures (continued)

On 5/1/22 at 4:30 p.m., the resident's May 2022 Medication Administration Record (MAR) indicates the resident had a blood glucose level of 141, that required 4 units of insulin. However, the blood glucose level was not indicated on either of the resident's glucometers, (Ultra Touch II or Freestyle Libre 14d).

Plan of Correction ***Accept***

- *Resident #5 did not suffer any ill effects from the discrepancy between blood glucose level on the MAR and glucometer.*
- *On 5/12/22 resident #5's physician was notified of the discrepancy between blood glucose level on the MAR and glucometer. No new orders were received.*
- *on 5/12/22 Care Services Manager (CSM) conducted an audit of residents with orders for blood glucose monitoring to ensure no discrepancies identified between blood glucose level documented on MAR and residents glucometer readings in past 14 days. No additional findings noted.*
- *On 6/07/22 CSM will educate staff certified to administer medications on requirements set within regulation 2600.185a (Exhibit I - In-service)*
- *CSM or designee will audit 2 residents' MAR's and compare the blood glucose readings in the glucometer to the readings listed in the MAR's weekly x 4, bi-weekly x4 and monthly x 1 to ensure compliance with this regulation (Exhibit J - Audit tool)*
- *Results of the audit will be discussed a the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/19/2022*

Completion Date: *08/19/2022*

Document Submission ***Implemented***

- *Resident #5 did not suffer any ill effects from the discrepancy between blood glucose level on the MAR and glucometer.*
- *On 5/12/22 resident #5's physician was notified of the discrepancy between blood glucose level on the MAR and glucometer. No new orders were received.*
- *on 5/12/22 Care Services Manager (CSM) conducted an audit of residents with orders for blood glucose monitoring to ensure no discrepancies identified between blood glucose level documented on MAR and residents glucometer readings in past 14 days. No additional findings noted.*
- *On 6/07/22 CSM will educate staff certified to administer medications on requirements set within regulation 2600.185a (Exhibit I - In-service)*
- *CSM or designee will audit 2 residents' MAR's and compare the blood glucose readings in the glucometer to the readings listed in the MAR's weekly x 4, bi-weekly x4 and monthly x 1 to ensure compliance with this regulation (Exhibit J - Audit tool)*
- *Results of the audit will be discussed a the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.*
- *Completion date 8/19/2022*
- *See Attached*

227i - Support Plan Accessible

1. Requirements

2600.

227i - Support Plan Accessible *(continued)*

227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 5/12/22, staff person A indicated all resident support plans and records are secured in his/her office and only accessible when staff person A or staff person B and administrator is present in the home. Staff interviews indicated resident's support plans are not printed and kept in an area that is always accessible to all staff.

Plan of Correction ***Accept***

- *On 5/13/22, CSM moved the support plan binder to an area which is secure but accessible to direct care staff. On 5/13/22, CSM notified direct care staff of new location for support plans.*
- *On 5/25/22, CSM was re-educated by ED on requirements set within regulation 2600.227.i (Exhibit K - In-service)*
- *CSM will review the location and contents of the support plan binder weekly x 4, bi-weekly x 4, and monthly x 1 to ensure the support plans are accessible by direct care staff at all times. Exhibit L - Audit tool)*
- *Results of the audit will be reviewed at the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three months of consecutive compliance.*
- *Completion date 8/19/2022*

Completion Date: *08/19/2022*

Document Submission ***Implemented***

- *On 5/13/22, CSM moved the support plan binder to an area which is secure but accessible to direct care staff. On 5/13/22, CSM notified direct care staff of new location for support plans.*
- *On 5/25/22, CSM was re-educated by ED on requirements set within regulation 2600.227.i (Exhibit K - In-service)*
- *CSM will review the location and contents of the support plan binder weekly x 4, bi-weekly x 4, and monthly x 1 to ensure the support plans are accessible by direct care staff at all times. Exhibit L - Audit tool)*
- *Results of the audit will be reviewed at the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three months of consecutive compliance.*
- *Completion date 8/19/2022*
- *See Attached*