pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: August 18, 2022

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

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

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on June 28, 2022, and the corrections you have made after our inspection, 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: *AHAVA MEMORY CARE RESIDENCE* **License #:** *44858* **License Expiration:** *10/11/2022*

Address: *200 JHF DRIVE, PITTSBURGH, PA 15217*

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

Administrator

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

Legal Entity

Name: *JEWISH HOME AND HOSPITAL FOR AGED AT PITTSBURGH*

Address: *200 JHF DRIVE, PITTSBURGH, PA, 15217*

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *52* **Waking Staff:** *39*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date:** *06/29/2022*

Inspection Dates and Department Representative

06/29/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served:** *26*

Special Care Unit

In Home: *Yes* **Area:** *ALL* **Capacity:** *30* **Residents Served:** *26*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *26*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *26*

Have Physical Disability: *0*

Inspections / Reviews

06/29/2022 - Full

Lead Inspector [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/21/2022*

07/21/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/25/2022*

07/28/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/05/2022*

07/29/2022 - Document Submission

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

25a Resident - residence contract

1. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1 was admitted to the home on [redacted]21. However, resident #1 does not have a resident-home contract in place.

Plan of Correction ***Accept***

Resident #1 is unable to sign the Contract due to physical limitations; this documented on the signature pages. Please see attached signature pages.. An audit of all Resident Contracts was completed by the Administrator. Any unsigned contracts will be reviewed with residents and signatures will be obtained by August 15.. Moving forward, all new Contracts will be reviewed by the Administrator to ensure proper signatures are obtained.

Completion Date: *07/19/2022*

Document Submission ***Implemented***

Resident #1 is unable to sign the Contract due to physical limitations; this documented on the signature pages. Please see attached signature pages.. An audit of all Resident Contracts was completed by the Administrator. Any unsigned contracts will be reviewed with residents and signatures will be obtained by August 15.. Moving forward, all new Contracts will be reviewed by the Administrator to ensure proper signatures are obtained.

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 6/29/22, at approximately 11:05 a.m., there was an unlocked, accessible, and unattended 4oz. tube of WeCare CalaSoothe Cream, with a label indicating: If swallowed get medical help or contact Poison Control Center. The cream was on a shelf under the paper towel holder in the common bathroom next to the sunroom.

Plan of Correction ***Accept***

The CalaSoothe cream was removed from the bathroom on the day of inspection. A complete check of common bathrooms and resident rooms was conducted by the Administrator on 6.30.2022 to ensure all poisonous substances were properly secured. Direct Care staff and Activities staff have been re-educated regarding the requirement to secure poisonous materials; please see attached Staff Training Documentation. For 1 week, beginning 7.18.2022, the Administrator/designee will conduct a daily audit of 3 resident rooms to ensure compliance is maintained. Beginning the week of July 25, 2022, the Administrator/designee will conduct a random audit of 3 rooms twice a week for four weeks. Beginning August 15, 2022, the Administrator/designee will conduct a random audit of 5 rooms weekly for four weeks. Beginning September 12, 2022, the Administrator/designee will conduct random audits of five rooms monthly. Documentation of the audits will be kept by the Administrator.

Completion Date: *07/25/2022*

Document Submission ***Implemented***

The CalaSoothe cream was removed from the bathroom on the day of inspection. A complete check of common

82c Locked poisons (continued)

bathrooms and resident rooms was conducted by the Administrator on 6.30.2022 to ensure all poisonous substances were properly secured. Direct Care staff and Activities staff have been re-educated regarding the requirement to secure poisonous materials; please see attached Staff Training Documentation. For 1 week, beginning 7.18.2022, the Administrator/designee will conduct a daily audit of 3 resident rooms to ensure compliance is maintained. Beginning the week of July 25, 2022, the Administrator/designee will conduct a random audit of 3 rooms twice a week for four weeks. Beginning August 15, 2022, the Administrator/designee will conduct a random audit of 5 rooms weekly for four weeks. Beginning September 12, 2022, the Administrator/designee will conduct random audits of five rooms monthly. Documentation of the audits will be kept by the Administrator.

see attached

92 Windows/screens

1. Requirements

2800.
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 6/29/22, the right window screen in bedroom #M02 is in disrepair. The left corner of the screen is frayed and pulled away from the frame, leaving an opening of approximately 6" and frayed across the bottom of the screen.

On 6/29/22, the right window screen in bedroom #M09 has two small holes measuring approximately 1" in diameter.

Plan of Correction ***Accept***

The screens in rooms M02 and M09 were replaced on the day of the inspection. An inspection of all screens in the facility was conducted by the Administrator on 7.6.2022. As of 7.18.2022, any screen that was found to be in disrepair has been replaced. Beginning the month of August , 2022, a random audit of 3 screens per month will be conducted by the Administrator/designee and any screen found to be in disrepair will be replaced/repaired. Documentation of the audits will be kept by the Administrator.

Completion Date: *07/18/2022*

Document Submission ***Implemented***

The screens in rooms M02 and M09 were replaced on the day of the inspection. An inspection of all screens in the facility was conducted by the Administrator on 7.6.2022. As of 7.18.2022, any screen that was found to be in disrepair has been replaced. Beginning the month of August , 2022, a random audit of 3 screens per month will be conducted by the Administrator/designee and any screen found to be in disrepair will be replaced/repaired. Documentation of the audits will be kept by the Administrator.

see attached

101j5 Bedside table/shelf

1. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
5. A bedside table or a shelf.

Description of Violation

On 6/29/22, resident #2's bedside table measures approximately 56" from the resident's bedside with a chair between

101j5 Bedside table/shelf (continued)

the bed and table.

Plan of Correction ***Accept***

Resident #2's bedside table was moved within reach of [redacted] bed on the day of inspection. A check of each resident room was completed by the Administrator on 6.30.2022 to ensure proper placement of bedside tables. Direct Care Staff have been re-educated regarding this requirement; Please see attached Staff Training Documentation. In order to ensue compliance is maintained, beginning July 18, 2022, the Administrator/designee will conduct a daily audit of three resident rooms. Beginning July 25, 2022, the Administrator/designee will audit 3 rooms twice a week for four weeks. Beginning August 15, 2022, the Administrator/designee will audit 5 rooms weekly for four weeks. Beginning September 12, 2022, the Administrator/designee will audit five rooms monthly. . Documentation of the audits will be kept by the Administrator.

Completion Date: *07/25/2022*

Document Submission ***Implemented***

Resident #2's bedside table was moved within reach of [redacted] bed on the day of inspection. A check of each resident room was completed by the Administrator on 6.30.2022 to ensure proper placement of bedside tables. Direct Care Staff have been re-educated regarding this requirement; Please see attached Staff Training Documentation. In order to ensue compliance is maintained, beginning July 18, 2022, the Administrator/designee will conduct a daily audit of three resident rooms. Beginning July 25, 2022, the Administrator/designee will audit 3 rooms twice a week for four weeks. Beginning August 15, 2022, the Administrator/designee will audit 5 rooms weekly for four weeks. Beginning September 12, 2022, the Administrator/designee will audit five rooms monthly. . Documentation of the audits will be kept by the Administrator.

See attached

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 6/29/22, at approximately 11:03 a.m., the emergency exit door from the activity room into the secured courtyard was unable to be opened. There was a yellow hose on the ground at the exterior side of the emergency exit door in the secured court yard, that obstructed the door.

Plan of Correction ***Accept***

The hose was removed from the front of the door at the time of the inspection. A hose reel has been installed to ensure proper placement of the hose. Please see attached photo. Direct Care Staff and Activities Staff have been educated regarding the requirement to return the hose to the hose reel after use as well as the regulation regarding unobstructed egress. Please see attached Staff Training Documentation. The Administrator/designee will check the hose daily for two weeks beginning 7.18.2022, and 3 times per week for one month beginning 8.1.2022 and once a week thereafter. Documentation of the audits will be kept by the Administrator.

Completion Date: *07/19/2022*

Document Submission ***Implemented***

The hose was removed from the front of the door at the time of the inspection. A hose reel has been installed to ensure proper placement of the hose. Please see attached photo. Direct Care Staff and Activities Staff have been educated regarding the requirement to return the hose to the hose reel after use as well as the regulation

121a Unobstructed egress (continued)

regarding unobstructed egress. Please see attached Staff Training Documentation. The Administrator/designee will check the hose daily for two weeks beginning 7.18.2022, and 3 times per week for one month beginning 8.1.2022 and once a week thereafter. Documentation of the audits will be kept by the Administrator.

see attached

231c1 Preadmit screening

1. Requirements

2800.
231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #1 was admitted to the secured memory care unit on [redacted]21; however, a written cognitive preadmission screening was not completed.

Plan of Correction ***Accept***

The Preadmission Screening for Resident #1 has been completed; please see attached. An audit of all resident records was completed on 7.21.2022 and any missing Preadmission Screenings were completed. Moving forward, preadmission screens will be completed by the Administrator/designee within 72 hours of admission. In order to ensure all required documentation is present, all new admission paperwork will be audited prior to the admission by the Administrator/designee.

Completion Date: *07/21/2022*

Document Submission ***Implemented***

The Preadmission Screening for Resident #1 has been completed; please see attached. An audit of all resident records was completed on 7.21.2022 and any missing Preadmission Screenings were completed. Moving forward, preadmission screens will be completed by the Administrator/designee within 72 hours of admission. In order to ensure all required documentation is present, all new admission paperwork will be audited prior to the admission by the Administrator/designee.

see attached

233c Key-locking devices

1. Requirements

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 6/29/22, there were no codes posted at the locking mechanisms keypads at the gates on the left and right side of the secured courtyard.

Plan of Correction ***Accept***

The codes were posted on these gates the day of the inspection. Please see attached photos. The Administrator/designee will audit the posting monthly to ensure the codes remain in place. Documentation of the audits will be kept by the Administrator.

Completion Date: *06/29/2022*

233c Key-locking devices *(continued)*

Document Submission ***Implemented***

The codes were posted on these gates the day of the inspection. Please see attached photos. The Administrator/designee will audit the posting monthly to ensure the codes remain in place. Documentation of the audits will be kept by the Administrator.

see attached