pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: October 31, 2022

[redacted]
Washington Ops, LLC
[redacted]

RE: Hawthorne Woods AL
791 Locust Ave.
Washington, Pennsylvania 15301
License #: 454090

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on September 23, 2022, and September 26, 2022, of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because this is a new legal entity operating the residence.

In accordance with 55 Pa.Code § 2800.11(b) (relating to procedural requirements for licensure or approval of assisted living residences a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

Your NEW 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: *Hawthorne Woods Al* **License #:** *45409* **License Expiration:**

Address: *791 Locust Avenue , Washington, PA 15301*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *WASHINGTON OPS, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/11/2000* **Issued By:** *L & I*

Type: *C-2 LP* **Date:** *05/02/2000* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *95* **Waking Staff:** *71*

Inspection Information

Type: *Partial* **Notice:** *Announced* **BHA Docket #:**

Reason: *Change Legal Entity* **Exit Conference Date:** *09/26/2022*

Inspection Dates and Department Representative

09/23/2022 - On-Site: [redacted]

09/26/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 81 **Residents Served:** *70*

Special Care Unit

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

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *70*

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

Have Mobility Need: *25* **Have Physical Disability:** *1*

Inspections / Reviews

09/23/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/08/2022*

10/19/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/27/2022*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/29/2022*

10/27/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/27/2022*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/04/2022*

10/27/2022 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/27/2022*

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

60a Staffing/support plan needs

1. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

On 9/17/22, the home served 67 residents, including 25 with mobility needs, 6 of whom require the assistance of two staff persons to transfer and from 12:00 a.m. to 6:00 a.m., there were only two staff persons working in the home. This level of staffing is insufficient to meet the care and supervision needs of the residents in the event of an emergency.

POC Submission ***Accept (JK - 10/27/2022)***

The license (#45409) under which Hawthorne Woods Assisted Living is being cited is not the current provider's license number ("Community"), nor is the license associated with any Certificate of Licensure issued by the Department to a new provider. The Community as the licensed entity responsible for operations and regulatory compliance respectfully requests that any deficiencies cited be assigned to its license as current owner/operator/licensee.

The Community acknowledges the need for and importance of having adequate staff available to care for and assist residents in the event of an emergency. On September 26, 2022 during the exit interview, the licensing representative asserted that as a whole the community is well above regulatory staffing requirements to evacuate in an emergency. However, the licensing representative identified, based on a sampling of 18 shifts over 6 days that for one nightshift there were only two staff scheduled to work.
Upon investigation, the Community Director ("Director") identified that the Community had inadvertently posted an incomplete schedule. The schedule posted had two staff on 3rd shift on the referenced date. The "Director's" copy of the schedule had three staff on 3rd shift on the referenced date. As is the process, the staff member included on the Director's schedule as the third staff member to work the night shift referenced the posted schedule where they were not scheduled to work.
To avert the potential for future staffing discrepancies, the Director will ensure that the Community maintains only one staffing schedule that the Director has approved for use. The staffing schedule approved for use will be titled "Community Staffing Schedule" to indicate its exclusive use by staff to reference their schedules, and to update for call offs and other schedule changes. Managers and lead Resident Assistants (RA) will receive training from the Director on how to identify that the approved schedule is in use/reference and to report to the Director or designee if an unapproved schedule is identified as in circulation. As is the current process, the Lead RA on each shift verifies that the staff scheduled have clocked in and are ready to work. The Lead RA is to notify the Assistant Community Director or designee during normal business hours or manager on call after normal business hours of any schedule changes, such as a call off. This education was completed on or before 10/4/2022 by the Director. For any gaps in staffing, the Assistant Community Director during normal business hours or the manager on call after normal business hours will follow the current staff scheduling process in which the manager calls staff who are not scheduled to work to ask if they will fill the shift. If no caregiver staff are available to fill the shift, a manager will work the shift to ensure residents have the staff necessary to provide needed resident care services and evacuate residents in an emergency.
The Director will monitor the posted schedule at least twice weekly to verify that only the approved Community Staffing Schedule is in circulation and staff scheduled meet staffing requirements based on resident needs. The Director will monitor shifts and hours worked by staff at least twice weekly to evaluate the effectiveness of covering schedule changes for both planned and unplanned staffing needs. Monitoring will begin 10/21/2022.
The Director reviewed the assessment and support plans for care needs to include but not limited to the number of

60a Staffing/support plan needs (continued)

residents, immobile residents, two person assists, and any changes to resident needs post exit interview and will continue these reviews at least weekly. As is the process, adjustments to staffing levels are made based on the needs of the residents as specified in the resident's assessment and support plan. Staffing levels are reviewed to evaluate that sufficient staff are scheduled to provide the assisted living services in compliance with applicable regulations and are adjusted accordingly based on the ongoing weekly reviews conducted by the Director or designee.
This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Plan Completion Date: *10/21/2022*

Implemented (JK - 10/27/2022)

85a Sanitary conditions

2. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/23/22, at approximately 11:00 a.m., there was a greyish blue extra large shower chair in the living room of unit #228. There was a brownish substance that appeared to be feces on the middle section of the chair measuring approximately 5" in diameter. The residence bathroom had a smaller shower chair in the shower stall However, the seat of the shower chair had a blackish substance over the nonslip surface of the chair.

POC Submission ***Accept (JK - 10/27/2022)***

The license (#45409) under which Hawthorne Woods Assisted Living is being cited is not the current provider's license number ("Community"), nor is the license associated with any Certificate of Licensure issued by the Department to a new provider. The Community as the licensed entity responsible for operations and regulatory compliance respectfully requests that any deficiencies cited be assigned to its license as current owner/operator/licensee.

Both of the shower chairs were cleaned by the assigned caregiver on September 23, 2022, by 2:30 pm prior to exit interview.
The Community Director ("Director") will provide retraining to care and housekeeping staff on the requirement for them to check durable medical equipment ("DME") for cleaning/sanitization needs when providing care services and cleaning apartments. This re-education began on 09/23/2022 and will be completed by 10/18/2022. The housekeepers will monitor DME cleaning/sanitization needs weekly on assigned cleaning days, and direct care staff will monitor when providing resident services. The housekeepers and direct care staff will clean/sanitize DME as warranted to support sanitation of devices in use.
The Director or designee will perform a sampling of 7 apartments weekly for 4 weeks to monitor staff maintaining the sanitation of DME in compliance with this regulation. Additional weekly checks will continue until consistent

85a Sanitary conditions (continued)

compliance with this regulation is verified. Sampling began week of 10/16/2022.
This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Plan Completion Date: *10/21/2022*

Implemented (JK - 10/27/2022)

91 Telephone Numbers

3. 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 9/23/22, there were no emergency phone numbers posted on or near the cordless telephone and base in bedroom #G70.

POC Submission ***Accept (JK - 10/27/2022)***

The license (#45409) under which Hawthorne Woods Assisted Living is being cited is not the current provider's license number ("Community"), nor is the license associated with any Certificate of Licensure issued by the Department to a new provider. The Community as the licensed entity responsible for operations and regulatory compliance respectfully requests that any deficiencies cited be assigned to its license as current owner/operator/licensee.
The Regulatory Compliance Guide allows for an omission with no violation if the Department determines the omission to be truly accidental or simply warranting technical assistance to correct. In this instance, the Community respectfully disagrees that the finding amounts to a violation, and instead asserts that the omission was accidental, warranting only minimal technical assistance to correct. At the time of inspection, the Community had more than 75 landline phones. The licensing representatives reviewed a sampling of phones and found only one that did not have the sticker. The Community verified phones not included in the sampling indeed had the emergency sticker adhered to or near phones. [redacted] for whom [redacted] phone did not have a sticker did not want a sticker placed on [redacted] phone or on the base but agreed to permit the Senior Living Counselor to place the sticker near the phone. The sticker was placed near the phone on September 23, 2022, at 1:15 pm prior to the exit interview. As the correction required minimal technical assistance to correct, the Community respectfully requests that this violation be removed.
In an effort to ensure compliance with this regulation, the Senior Living Counselor is responsible for ensuring that the emergency numbers are posted on or near phones for new move-ins. The Community Director ("Director") provided retraining to the Senior Living Counselor to ensure placement of the emergency numbers upon resident move-in which was completed 10/12/2022. The Director provided retraining to housekeepers on housekeeping's responsibility for verifying the emergency numbers are posted on or near phones post move-in. If a phone is identified to not have the emergency numbers posted, housekeepers will post the numbers on or near the applicable phone before

91 Telephone Numbers (continued)

moving to another apartment to clean. The Director provided retraining to housekeepers on this task by 10/12/2022. The Director or designee will perform a sampling of 7 apartments weekly for 4 weeks to monitor with this regulation. Additional weekly checks will continue until consistent compliance with this regulation is verified. Sampling began week of 10/16/2022.

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Plan Completion Date: *10/21/2022*

Implemented (JK - 10/27/2022)

95 Furniture & Equipment

4. Requirements

2800.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 9/23/22, the cover over the enabler on resident #1's bed was in disrepair. It appeared the threads on the left side of the cover were pulled apart. The top left side of the cover was not secured over the enabler and the seam holding the netting had pulled apart causing the netting to hang down below the enabler.

POC Submission ***Accept (JK - 10/27/2022)***

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The cover for the enabler bar (bed mobility device) was torn due to general wear and tear. The Community Director ("Director") had the cover repaired before 12:00 noon on September 23, 2022, by hand sewing the torn area. In addition, a new cover was purchased and applied to the enabler bar on September 23, 2022, prior to the exit interview.

The Director has completed a check of enable bars to ensure covers are in place and in good repair as of October 12, 2022.

The Director or designee will check enabler bar covers weekly for 4 weeks to monitor for needed repair/replacement to ensure compliance this regulation. Additional weekly checks will continue until consistent compliance with this regulation is verified and then move to monthly checks. Monitoring began the week of 10/16/2022.

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its

95 Furniture & Equipment (continued)

receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Plan Completion Date: *10/21/2022*

Implemented (JK - 10/27/2022)

121a Unobstructed egress

5. 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 9/23/22, the emergency exit door on the Garden level Garden Sunroom, required force to open. The door was hanging up on the bottom at the threshold, where there was a heavy concentration of dirt built up over the threshold preventing the door from easily opening.

POC Submission ***Accept (JK - 10/27/2022)***

The license (#45409) under which Hawthorne Woods Assisted Living is being cited is not the current provider's license number ("Community"), nor is the license associated with any Certificate of Licensure issued by the Department to a new provider. The Community as the licensed entity responsible for operations and regulatory compliance respectfully requests that any deficiencies cited be assigned to its license as current owner/operator/licensee.
The maintenance professional cleaned the threshold and checked the door for ease of release. This was completed on September 23, 2022, at 2:00 pm prior to the exit interview.
The maintenance professional or designee will visually monitor the exterior doors daily for obstructions. Daily monitoring to begin 10/24/2022. The Community Director ("Director") will provide training to the maintenance professional by 10/24/2022. The Director will train designee as they are assigned the task.
Additionally, the Community Director ("Director") trained maintenance on the task of checking exterior door thresholds for debris that obstructs egress on 9/23/2022. Upon completion of education on this date, the maintenance professional checked the exterior door thresholds. The thresholds were free of debris with unobstructed egress.
The Director or designee will check completion of this task weekly for 4 weeks to monitor compliance with this regulation. Weekly checks will continue until verification the task is consistently completed as assigned and in compliance with this regulation. Monitoring began week of 10/16/2022.
This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

121a Unobstructed egress (continued)

Licensee's Plan Completion Date: *10/24/2022*

Implemented (JK - 10/27/2022)