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

July 10, 2023

[redacted], PRESIDENT/COO
GRAINGER AID OPCO LLC
[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 06/08/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ALLEGHENY PLACE* **Licen e #**: *44489* **Licen e Expiration**: *04/14/2024*

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

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

Administrator

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

Legal Entity

Name: *GRAINGER AID OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *02/02/1998* **I ued By**: *Dept. of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *06/08/2023*

Inspection Dates and Department Representative

06/08/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* **Residents Served**: *19*

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**: *19*

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

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

06/08/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/30/2023*

07/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/10/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/11/2023*

Inspections / Reviews *(continued)*

07/10/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/10/2023*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

There was an allegation of verbal abuse against staff person A involving resident #1. On [redacted]/2023, at approximately [redacted] pm, while providing care to the resident, staff person A was alleged to have chastised resident #1 for not cooperating with incontinence care said they would throw resident on floor if the resident did not cooperate. This allegation was not reported to the local area agency on aging until [redacted]/2023 at approximately [redacted] pm.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

• On 5/31/23, after the Regional Executive Director (RED) was made aware of this situation and collected all the information necessary to report, RED verbally reported it to the Area Agency on Aging (AAA).
• On 5/31/23, RED provided staff member with oral warning for failing to report this situation immediately and re-training on resident abuse reporting in accordance with OAPSA. Documentation will be retained within the community. (Exhibit 1 - Inservice)
• On 6/1/23, RED conducted an audit of shift change log as well as conducted resident and staff interviews and no other violations of regulation 2600.15a were found.
• On 6/1/23, Regional Director of Care Services (RDCS) re-educated RED on requirements set within regulation 2600.15a. Documentation will be retained within the community. (Exhibit 2 – Inservice)
• By 6/23/23, RED re-educated current employees on resident abuse reporting in accordance with the Older Adult Protective Services Act (OAPSA). Documentation will be retained within the community. (Exhibit 3 – Inservice)
• Starting the week of 6/26/23, ED or designee will interview 2 residents and 2 employees weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 asking each if they are aware of instances of resident abuse that went immediately unreported to ensure compliance with regulation 2600.15a. Documentation will be retained within the community. (Exhibit 4 – Audit Tool).
• Starting on 6/29/23, ED or designee will discuss the results of the audit during the monthly Quality Improvement meetings x 3 months. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and what was reviewed.
• Date of Completion: 7/3/23

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented ([redacted] - 07/10/2023)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

There was an allegation of verbal abuse against staff person A involving resident #1. On [redacted]/2023, at approximately [redacted] pm, while providing care to the resident, staff person A was alleged to have chastised resident #1 for not cooperating with incontinence care said they would throw resident on floor if the resident did not cooperate. The staff person was not immediately placed on a plan of supervision or suspended pending investigation. Staff person A worked the 2:00 pm to 10:00 pm shift on [redacted]/2023 and [redacted]/2023 and was not suspended until was not suspended until [redacted]/2023.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

• On 5/31/23, after the RED was made aware of this situation, [redacted] immediately placed staff person A on administrative leave pending the outcome of the investigation.
• On 5/31/23, RED provided staff member who didn't report this incident right away with oral warning for failing to report this situation immediately and re-training on resident abuse reporting in accordance with OAPSA. Documentation will be retained within the community. (Exhibit 1 - Inservice)
• On 6/1/23, RED conducted an audit of shift change log as well as conducted resident and staff interviews and no other violations of regulation 2600.15b were found.
• On 6/1/23, Regional Director of Care Services (RDCS) re-educated RED on requirements set within regulation 2600.15b. Documentation will be retained within the community. (Exhibit 2 – Inservice)
• Starting the week of 6/26/23, RED or designee will interview 2 residents and 2 employees weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 asking each if they are aware of instances of resident abuse that went mmediately unreported to ensure compliance with regulation 2600.15b. Documentation will be retained within the community. (Exhibit 5 – Audit Tool).
• Starting on 6/29/23, ED or designee will discuss the results of the audit during the monthly Quality Improvement meetings x 3 months. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and what was reviewed.
• Date of Completion: 7/3/23

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented ([redacted] - 07/10/2023)

16c - Written Incident Report

3. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

There was an allegation of verbal abuse against staff person A involving resident #1. On [redacted]/2023, at approximately 8:00 pm, while providing care to the resident, staff person A was alleged to have chastised resident #1 for not cooperating with incontinence care said they would throw resident on floor if the resident did not cooperate. This

16c - Written Incident Report (continued)

incident was not reported to the Department until [redacted]/2023 at [redacted] pm.

Plan of Correction ***Accept ([redacted] 07/06/2023)***

On 5/31/23, when RED was made aware of this situation, [redacted] submitted a reportable incident to the Department's personal care home regional office regarding this incident.

• On 6/1/23, RED interviewed other residents and staff to ensure no other incidents which would require reporting under regulation 2600.16c occurred and had not been reported. No other incidents were identified.

• On 6/1/23, RED audited 24-hour report and concern log for past 90 days to ensure no other incidents which would require reporting under regulation 2600.16c occurred and had not been reported. No other incidents were identified.

• On 6/1/23, RDCS re-educated RED on requirements set within regulation 2600.16c. Documentation will be retained within the community. (Exhibit 2 – In-service)

• Starting the week of 6/26/23, RED or designee will interview 2 residents and 2 employees weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure no other incidents which would require reporting under regulation 2600.16c home occurred which were not reported Documentation will be retained within the community. Exhibit 6 – Audit Tool)

• Starting on 6/29/23, ED or designee will discuss the results of the audit during monthly Quality Improvement meetings x 3 months. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and what was reviewed.

• Completion Date: 7/3/23

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented ([redacted] - 07/10/2023)