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

December 13, 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 11/02/2023 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* **License #**: *44489* **License 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: *10960 FRANKSTOWN ROAD, PENN HILLS, PA, 15235*

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**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/02/2023*

Inspection Dates and Department Representative

11/02/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* **Residents Served**: *24*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

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

Have Mobility Need: *9* **Have Physical Disability**: *0*

Inspections / Reviews

11/02/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/24/2023*

11/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/12/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/01/2023*

Inspections / Reviews *(continued)*

12/04/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/12/2023*

12/13/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

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

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On the morning of 11/2/23, there was no soap present in the soap dispenser at the sink in the common dining area.

Plan of Correction ***Directed ([redacted] - 12/04/2023)***

1) Soap was immediately added to the dispenser while Inspector was still on-site.
2) Housekeeping follows a company specific "Task Sheet" indicating that every sanitizer and soap dispenser is checked on a weekly basis. This happens every Friday (Attachment #1 is the task sheet that is used and recorded as documentation)
3) ALL staff notified in "New Hire Orientation" as to where/how to complete a work order when a dispenser is empty and housekeeping/maintenance staff are NOT in the building. (Attachment #2 is the copy of that work order used) Staff doesn't have keys to refill those dispensers. Only housekeeping does. When they are in the building, staff to verbally call them over the walkie for refill.
4) There is only one housekeeper in this community, so Director of Facility Operations had an immediate discussion with housekeeper while surveyors still on-site. Until housekeeping is able to fill dispenser, staff instructed to use hand sink in Kitchen. (Attachment #3).
5) Following these exact procedures will keep community in compliance with 2600.85.a
6) Director of Facility Operations shall conduct random audits to ensure dispensers are being maintained properly. Director has signed off on weekly audit sheets with initials of CM ([redacted]) every Friday as proof of [redacted] checking all dispensers in house. (DIRECTED: The weekly audits shall begin on 12/7/23 and shall include a weekly check of at least 6 sinks to ensure a soap dispenser is present at each sink and is full of soap. [redacted] 12/4/23).
7) Weekly audit sheets are attachments 17-20.

DIRECTED: By 12/11/23: The home shall develop and implement procedures to ensure staff persons have access to hand soap at all times to ensure hand soap is immediately refilled at any sink which is found to be out of soap. Documentation of the procedures shall be kept. All staff persons shall be educated on the new procedures by 12/11/23. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 12/4/23

Proposed Overall Completion Date: 12/01/2023

Directed Completion Date: *12/11/2023*

Implemented [redacted] - 12/13/2023)

183e - Storing Medications

2. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #1's [redacted] was open and undated. According to the manufacturer's instructions, insulin pens must be discarded within 28 days of opening.

183e - Storing Medications *(continued)*

Plan of Correction ***Directed [redacted] - 12/04/2023)***

1) Dated sticker immediately placed on Insulin pen while Inspector still on site.
2) Director of Health & Wellness and [redacted] assistant did complete cart audits on 11/20/23 (2 carts) of all lotions, creams, inhalers, eye drops, patches, insulins, etc. for "Date open stickers". Those that needed to be, were immediately corrected. (Attachment #4, #5 are the audit sheets for each cart in the building (2 carts total) recorded & kept in a binder in Nurses office).
3) Meeting held on 11/20/23 with all med-techs and nurses as to proper procedure once items are opened and needing dated. (Attachments #6 is the meeting agenda, attachment #7 is the sign-in sheet for that meeting) (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 12/4/23).
4) Weekly card audits to be completed by Director or Assistant Director of Health and Wellness started on 11/20/23 to ensure open date stickers are being utilized properly. (Attachments 11-13 are weekly audits that have been completed since survey).
*5) Executive Director to randomly audit medications to ensure we remain in compliance with 2600.183.e. ** Executive Director signed as proof of her random audits on both carts on 11/27/23. (DIRECTED: Beginning on 12/11/23: The executive director shall audit all medication storage areas at least once per week to ensure all prescription medications, OTC medications and CAM are stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions. [redacted] 12/4/23)*

Proposed Overall Completion Date: 12/01/2023

Directed Completion Date: *12/11/2023*

Implemented ([redacted] - 12/13/2023)

187a - Medication Record

3. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 is prescribed, '[redacted] However, resident #2's November 2023 medication administration record (MAR) indicates, [redacted] and does not include the frequency or the amount of cream to be used per administration.

187a - Medication Record (continued)

Plan of Correction ***Directed [redacted] - 12/04/2023)***

1) Medication pulled immediately and held by Director of Health & Wellness until updated Rx was received by Physician.
2) Director of Health & Wellness and her assistant did complete cart audits (2 carts) of all medication labels to ensure they match Physician orders. Those that needed to be, were immediately corrected. (Attachment #4, #5 are the initial audits done on 11/20/23)
3) Meeting held with all med-techs and nurses as to proper procedure when a medication label doesn't match the MAR. (Attachments #6 is agenda for meeting, #7 is the sign-in sheet for employees that attended the meeting)
4) Weekly card audits to be started on 11/06/23 by Director or Assistant Director of Health and Wellness to ensure medication labels and MARS match. If they do not, meds will be pulled until order clarification is received. The weekly cart audits done so far are attachments 11-13. All resident MARS are checked during these audits. (DIRECTED: The weekly cart audits shall include a review of at least 4 resident MAR's per week to ensure accuracy and completeness in accordance with prescribers' orders.[redacted] 12/4/23).
5) Executive Director to randomly audit medications to ensure we remain in compliance with 2600.187.a. Again, ED participated in the total census of MARS on 11/27/23. (DIRECTED: Beginning on 12/11/23: The executive director shall audit at least 3 resident MAR's per week to ensure accuracy and completeness in accordance with prescribers' orders. [redacted] 12/4/23).
6) Attachment 14 is the order clarification for the muscle rub received 11/3/23. DHW, S. Harris took the order and transcribed it on the MAR herself. Attachment #15 is the resident's MAR.

Proposed Overall Completion Date: 12/01/2023

Directed Completion Date: *12/11/2023*

Implemented [redacted] - 12/13/2023)

187b - Date/Time of Medication Admin.

4. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed [redacted] -Apply a quarter size amount topically 2 times a day with changes for skin irritation. However, resident #2's November 2023 MAR does not include the initials of the staff person who administered the ointment to resident #2 on [redacted] pm.

REPEAT VIOLATION: 1/19/2023, et. al.

Plan of Correction ***Directed [redacted] - 12/04/2023)***

1) Director of Health & Wellness and her assistant did complete MAR audits (2) on 11/20/23 to ensure medications were being given as ordered and documented properly as proof of administration. If needed, individual

187b Date/Time of Medication Admin. (continued)

conversations had with med techs and/or nursing personnel as to the "Five Rights" of medication administration and proper documentation. (Attachment #4, #5 are the two cart audits done)
2) Meeting held with all med techs and nurses as to the Five Rights + proper documentation of med administration. (Attachments #6 is agenda , #7 is the sign in sheet) (DIRECTED: By 12/11/23: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 12/4/23).
3) Weekly MAR audits to be completed by Director or Assistant Director of Health and Wellness to start immediately after survey and continue weekly to ensure medication administration is being done properly. Attachments 11 13 are those audits. (DIRECTED: The weekly cart audits shall include a review of at least 4 resident MAR's per week to ensure medication administration is documented on resident MAR's at the time of medication administration. Documentation of the weekly audits shall be kept for 2 months. [redacted] 12/4/23).
4) Executive Director to randomly audit MARS to ensure we remain in compliance with 2600.187.b. ED started on 11/27 cart audit and did her random checks This included all Residents. Our audit sheets have a complete list of everything checked for every resident. Attachment 16 is the residents MAR. (DIRECTED: Beginning on 12/11/23: The executive director shall audit at least 3 resident MAR's per week to ensure medication administration is documented on resident MAR's at the time of medication administration. . [redacted] 12/4/23).

Proposed Overall Completion Date: 12/01/2023

Directed Completion Date: *12/11/2023*

Implemented [redacted] - 12/13/2023)

227i - Support Plan Accessible

5. Requirements

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

Resident support plans are stored in the Director of Nursing's office, which is locked during the hours that the Director of Nursing is not present in the home, and are not accessible to all direct care staff persons at all times.

REPEAT VIOLATION: 5/10/2022, et. al.

Plan of Correction ***Directed [redacted] - 12/04/2023)***

~~1) Copies of all Support Plans / RASP's placed in a binder upon admission or changes and put into the Med Room, which is closed and locked, however available to all staff at all times. MedTechs and nurses all have keys to RASP Binder in medroom. (Attachment #8 is a picture of the binder in medroom)~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 12/4/23)
(DIRECTED: By 12/11/23: The administrator shall relocate all resident support plans to an area that is accessible to all direct care staff persons at all times, which includes access to all aides. All direct care staff persons shall be educated on the new location of resident support plans by 12/11/23. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 12/4/23).

227i - Support Plan Accessible (continued)

2) Meeting held with all med-techs and nurses as to the new location of PA RASP's for all residents. (Attachments #6 is the meeting agenda, #7 is the sign-in sheet for the meeting)
3) Staff to continue being notified when new residents arrive, residents have changes or a resident is discharged so that staff is cued to look at an updated or new RASP. Attachment #9 is a memo placed in medroom concerning the RASP's.
5) Executive Director to randomly audit RASP Binder in Med Room to ensure we remain in compliance with 2600.227.i. ED has looked for the binder 3x and it has been exactly where staff was told to look for it. On one of my audits on 11/27/23, there was a staff member actually reading it.

DIRECTED: Beginning on 12/12/23: The administrator shall inspect the new resident support plan storage area weekly for 1 month then monthly thereafter to ensure resident support plans are accessible to all direct care staff persons at all times. [redacted] *12/4/23*

Proposed Overall Completion Date: 12/01/2023

Directed Completion Date: *12/12/2023*

Implemented [redacted] ***- 12/13/2023)***