November 4, 2019

Mr. Alvin W. Allison, Jr.
President/CEO
Baptist Homes Society
489 Castle Shannon Boulevard
Pittsburgh, Pennsylvania 15234

RE: Providence Point
200 Adams Avenue
Pittsburgh, Pennsylvania 15243
Certificate #: 441430

Dear Mr. Allison:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 18, 2019 and June 19, 2019, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

RECEIVED
SEPT 27 2019
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report

Facility Information

Name: *PROVIDENCE POINT*
License Number: *44143*
Address: *200 ADAMS AVENUE,, PITTSBURGH, PA 15243*
County: *ALLEGHENY*
Region: *WESTERN*

Administrator

Name: *Kim Salvio*
Phone: *4124893560*
Email: *AALLISON@BAPTISTHOMES.ORG*

Legal Entity

Name: *BAPTIST HOMES SOCIETY*
Address: *489 CASTLESHANNON BOULEVARD, PITTSBURGH, PA, 15234*

Certificate(s) of Occupancy

Type: *I-1*
Date: *06/09/2009*
Issued By: *Scott Township*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *115*
Waking Staff: *86*

Inspection

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

Inspection Dates and Department Representative

06/18/2019 - On-Site: Courtney Barry, Lauren Spagna, Josh Hoover

06/19/2019 - On-Site: Courtney Barry, Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84*
Residents Served: *77*

Secured Dementia Care Unit

In Home: *Yes*
Area: *Portion of 1st floor, a to PCH*
Capacity: *20*
Residents Served: *20*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *77*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *38*
Have Physical Disability: *0*

81b - Resident Personal Equipment

Regulations

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 6/18/19, there was an opening measuring approximately 18 inches across on the enabler on resident #1's bed, posing an entrapment hazard. Also, the enabler bar attachment is missing one of two bolts and is not tightly secured to the bed, posing a fall and entrapment hazard.

2600.81(b)

Immediate Correction:

:eps to

- Enabler bar removed from residents' bed IMMEDIATELY.
- New enabler purchased and applied/SECURED to bed.
- Enabler bar tested with Bionix tool to ensure secureness and resident safety.
- See attached photos and safety sheet for bed rail.

Ongoing plan:

- Administrator or designee will inspect rails on all residents quarterly for continued safety compliance and document on safety sheets (see example from Resident #1 attached). Initially, all residents using bed enabler were evaluated and safety documentation completed on 8-26-19 by Administrator and EVS Supervisor. Next evaluation due in 4th quarter (Nov/Dec 2019 and quarterly going forward).
- All side rails or enablers used are ordered by Providence Point and are deemed safe by standardization with use of BIONIX tool. Opening in rail measures 4 inches.
- Administer and designees will maintain continuous compliance Baptist Homes Society bed rail policy (see attached).

Kim Salvio | Kim Salvio PCHA | 9/27/19
Signature | Printed Name and Title | Date

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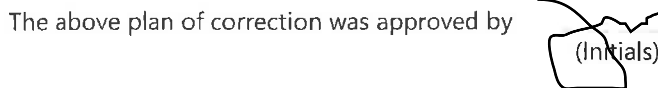
The above plan of correction is approved as of 9/30/19 (Date)

Plan of correction implementation status as of 9/30/19 (Date)

The above plan of correction was approved by

(Initials)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

101j7 - Lighting/Operable Lamp

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The bed belonging to resident #1 does not have a source of lighting that can be turned on/off from bedside.

Plan of Correction (POC)

; to

2600.101(j)

Immediate Correction:

- Operable lamp was immediately provided to resident #1 while inspectors still on site.
- See photo attached in bed rail plan of correction.

Ongoing Plan:

- All resident rooms will be checked by Administrator or designee by October 30,2019 to ensure compliance with bedroom regulatory requirement101(j).
- Administrator or designee will inspect resident rooms within 24 hours after new resident moves in to ensure resident rooms meet regulatory requirement beginning immediately.
- Check list of furniture items needed will be provided to residents and families by Admissions Coordinators inquiring about a move to personal care. See attached checklist.
- Monthly audits of random rooms (20%) to ensure compliance by Administrator or designee include on QI audits beginning 4th quarter Nov./Dec.

Legal Entity Representative

Signature

Kim Salvio PCHA
Printed Name and Title

9/27/19
Date

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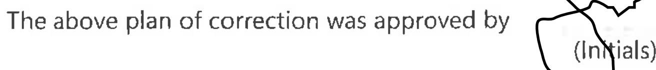

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132c - Fire Drill Records

Regulations

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted in the secured dementia care unit (SDCU) on 5/7/19 at 10:11a.m. does not indicate the number of staff participating in the drill.

Plan of Correction (POC)

2600.132 (c)

; to

Immediate Correction:

- Number of staff participating in the fire drill on 5-7-19 was researched from Fire Drill Report and correct number of staff was inserted into Fire Drill Record by Administrator in the presence of the inspectors on site when they identified the missing information.
- See attached record.

Ongoing Plan:

- Beginning immediately, Administrator will review previous drill and current drill on Fire Drill Record monthly to ensure all information is correctly completed.
- Beginning immediately, Administrator will initial log each month to signify that review was completed.

Legal Entity Representative

Kim Salvio | Kim Salvio PCHA | 9/27/19

Signature | Printed Name and Title | Date

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132d - Evacuation

Regulations

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Ten minutes is the home's maximum evacuation time designated in writing by a fire safety expert on 5/5/19 . The evacuation time for the fire drill conducted on 11/24/18 at 11:31p.m. in the personal care section, was 15 minutes.

2600.132(d)

Immediate Correction:

ps to

- Administrator immediately investigated why the evacuation time exceeded 10 min.
- Result of Investigation: Time was not stopped because staff did not communicate when their floor was "all clear" on radio.
- Radios mounted to each med cart with charger to facilitate quick access and use during an emergency. Completed by Administrator June 2019 following inspection. (see photo).

Ongoing Plan:

- All staff to have fire education/training according to 2600.132 and 123 review by October 30, 2019 to include discussion on use of annunciator panel, evacuation time, and use of radio's and pickle phones for communication by Administrator or designee. Education will also include review of regulations 130, 131, 132 and 133. Education will be conducted by Fire Safety Expert Richard Bookser.
- Above training to include scenario's depicting situations that may cause delays in evacuation in order for staff to critically think through adverse situations.

Legal Entity Representative By 10/31/19 and monthly thereafter - The administrator will review fire drill logs to ensure fire drills meet evacuation time requirements. - JRW 9/30/19

Kim Salvio — Kim Salvio PCHA — 9/27/19

Signature — Printed Name and Title — Date

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183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Diltiazem HCL ER 120mg was packaged inside the "meds on time" packaging, dated 6/18/19, prescribed to resident #1, with multiple current medications for both am and pm dosages. However, this 120mg dosage was discontinued on 5/16/19.

Also, there was an Eliquis tablet packaged inside the "meds on time" packaging, dated 6/18/19, prescribed to resident #1, with multiple current medications for both am and pm dosages. However, this medication was discontinued on 2/21/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attached POC. SEE PAGE 6A of 11

Legal Entity Representative

Signature: Kim Salvio

Printed Name and Title: Kim Salvio PCHA

Date: 9/27/19

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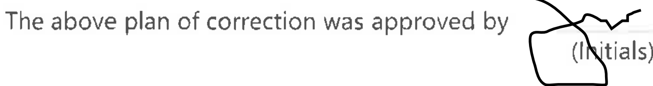
The above plan of correction was approved by  (Initials)

- [ ] Fully Implemented
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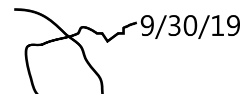
2600.183(d)

Immediate Correction:

- Discontinued medications were highlighted with a highlighter and noted to be *"discontinued"* on "meds on time" packaging by Medication Aide in presence of inspectors.

Ongoing Plan:

- Health Direct pharmacy contacted on 9-26-19 and is sending labels to label "meds on time" packaging that say, "refer to MAR" when a med in the pillow pack is discontinued.
- When labels arrive, a roll of the above labels will be placed in each med cart by Administrator or designee after Med Tech and LPN training is conducted on proper way to denote a medication is discontinued.
- Policy 683 *Discontinuation of a Medication or Treatment u*pdated by Administrator to include #6. See attached policy.
- Education will be Policy review of policy 683 DISCONTINUATION OF A MEDICATION OR TREATMENT with all Medication Aides and LPN's to review proper way of discontinuing medication.
- Training will be conducted by Administrator and/or RN Supervisor.
- Training will be completed by October 30, 2019.
- Documentation of training will be maintained for inspectors to view.



Kim Salvio, PCHA 9/27/19
Kim Salvio

184b - Resident's Meds Labeled

Regulations

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

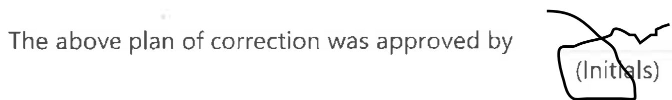
Description of Violation

Resident #1 is ordered Prednisolone acetate, beginning on 6/12/19, one drop in right eye once a day; however, the label indicates 4 times daily.

Resident #1 is ordered Sodium Chloride 1 drop to right eye twice daily; however, the label indicates 1 drop to right eye.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)



SEE PAGE 7A of 11

Legal Entity Representative

Signature: Kim Salvio

Printed Name and Title: Kim Salvio PCHA

Date: 9/27/19

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- [ ] Partially Implemented - Inadequate Progress
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2600.184(b)

Immediate Correction:

- Resident #1 Prednisolone Acetate eye drop and Sodium Chloride eye drop labeled with a change in direction label, refer to MAR immediately by Medication Aide.
- Resident Sodium Chloride eye drop bottle labeled with "change in direction see MAR" sticker.

Ongoing Plan:

- Medication Cart Audit of all residents in personal care and memory support to ensure correct labeling of medications according to physician orders to be completed by Administrator or designee by October 30, 2019.
- Daily review of new orders over the previous 24 hours to be completed by Administrator or designee daily to maintain compliance with new medication orders or medication changes.
- Administrator or designee will continue with monthly QI audits to ensure compliance using a random sample of 20% of residents on each floor.
- Medication Aide and LPN education on 24-hour order review 184(b) compliance to be completed by RN Supervisor by October 30, 2019.
- Record of training to be maintained for inspector review by RN Supervisor.

9/30/19

Kim Salvio PCHA
Kim Salvio 9/27/19

187a - Medication Record

Regulations

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).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1's medication administration record (MAR) has multiple errors as follows:

-Resident #1 is ordered Potassium Cl ER 10meq; however, the medication administration record (MAR) indicates an incorrect dosage of 10mg.

- Resident #1 is ordered Sodium Chloride, 1 drop to right eye twice daily; however, the MAR indicates 1 drop to right eye.

- Resient #1 is ordered Morphine every hour as needed for shortness of breath; however, the medication administration record indicates for severe pain.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attached POC. SEE PAGE 8A OF 11

Legal Entity Representative

Kim Salvio | Kim Salvio PCHA | 9/27/19

Signature | Printed Name and Title | Date

9/30/19

2600.187(a)

Immediate Correction:

- Resident #1 Potassium CL ER 10 MEQ. MAR corrected to read 10meq immediately LPN. See attached.
- Resident #1 Sodium Chloride eye drop corrected immediately by LPN. See attached.
- Resident #1 Morphine ordered corrected immediately by LPN. See attached.

Ongoing Plan:

- Medication Cart Audit of all residents in personal care and memory support to ensure correct labeling of medications according to physician orders to be completed by Administrator or designee by October 30, 2019.
- Daily review of new orders to be completed by Administrator or designee to maintain compliance with new medication orders or medication changes.
- Administrator or designee will continue with monthly QI audits to ensure compliance using a random sample of 20% of residents on each floor.

9/27/19
Kim Salvio, PCHA
Kim Salvio

9/30/19

187a - Medication Record *(continued)*

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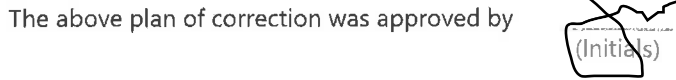


- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Kim Salvio PCHA 9/27/19

231b - Medical Evaluation

Regulations

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the secure dementia care unit on 4/29/19; however the medical evaluation was not completed until 5/1/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.231(b)

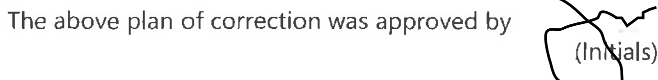
Immediate Correction:

- Unable to correct this DME.

Ongoing Plan:

- Administrator or designee will not admit residents to secured dementia unit without a compliant DME that is within 60 days of admission.
- Administrator or designee will continue to audit charts monthly for DME compliance (this practice has been in place and will continue).
- Record of audits to be maintained by Administrator/RN Supervisor for inspector review and QI.

Legal Entity Representative



Signature | Kim Salvio PCHA — Printed Name and Title | 9/27/19 — Date

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233c - Key-Locking Devices

Regulations

2600.
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 6/18/19, there were no instructions posted for unlocking the keypad locking mechanism near the courtyard gate in the SDCU.

Plan of Correction (POC)

2600.233(c)

ign and date any attached pages. Include steps to correct the violation described above and steps to cannot be completed immediately, include dates by which the steps will be completed.)

Immediate Correction:

- Temporary codes applied to keypad to enable unlocking of gate immediately by Security Supervisor R. Bookser.
- See attached photos.
- Permanent code obtained and applied by Security Supervisor, R. Bookser.
- See attached photos.

Ongoing Plan:

- Beginning immediately with the October 2019 audits, Administrator or designee will conduct monthly audits on gates to ensure tags are present and gate locking/unlocking in operational.
- Documentation of audits will be maintained for inspector review by Administrator.

Legal Entity Representative

Kim Salvio — Kim Salvio PCOA — 9/27/19

Signature — Printed Name and Title — Date

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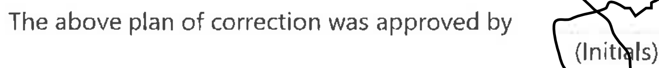

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