



December 12, 2019

Mr. Luis Serrano
President
The Haven at North Hills, LLC
114 Pacifica, Suite 310
Irvine, California 92618

RE: The Haven at North Hills
One Windsor Way
Pittsburgh, Pennsylvania 15237
License #: 449380

Dear Mr. Serrano:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 31, 2019 and August 2, 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,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written over a white background.

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

Violation Report

Facility Information	
Name: <i>THE HAVEN AT NORTH HILLS</i>	License Number: <i>44938</i>
Address: <i>1 WINDSOR WAY,, PITTSBURGH, PA 15237</i>	
County: <i>ALLEGHENY</i>	Region: <i>WESTERN</i>

Administrator		
Name: <i>JENNIFER GROSS</i>	Phone: <i>4123646411</i>	Email: <i>MHUBER@ELMHOLDING.COM</i>

Legal Entity	RECEIVED
Name: <i>THE HAVEN AT NORTH HILLS LLC</i>	NOV 15 2019
Address: <i>807 SW INDUSTRIAL WAY, C-O SUNSHINE RETIREMENT, BEND, OR, 97701</i>	

Certificate(s) of Occupancy	Western Region
Type: <i>I-2</i>	Date: <i>06/21/1998</i>
Issued By: <i>Ross Township</i>	

Staffing Hours		
Resident Support Staff: <i>0</i>	Total Daily Staff: <i>86</i>	Waking Staff: <i>65</i>

Inspection		
Type: <i>Full</i>	BHA Docket #:	Notice: <i>Unannounced</i>
Reason: <i>Renewal</i>		

Inspection Dates and Department Representative	
<i>07/31/2019 - On-Site: Lisa Flinner-Alman, Lauren Spagna</i>	
<i>08/02/2019 - On-Site: Lisa Flinner-Alman, Lauren Spagna</i>	

Resident Demographic Data as of Inspection Dates			
General Information			
License Capacity: <i>90</i>		Residents Served: <i>67</i>	
Secured Dementia Care Unit			
In Home: <i>Yes</i>	Area: <i>1st Floor</i>	Capacity: <i>24</i>	Residents Served: <i>18</i>
Hospice			
Current Residents: <i>2</i>			
Number of Residents Who:			
Receive Supplemental Security Income: <i>0</i>		Are 60 Years of Age or Older: <i>67</i>	
Diagnosed with Mental Illness: <i>0</i>		Diagnosed with Intellectual Disability: <i>0</i>	
Have Mobility Need: <i>19</i>		Have Physical Disability: <i>0</i>	

THE HAVEN AT NORTH HILLS

44938

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. No carbon monoxide detectors were present in the home in accordance with The Care Facility Carbon Monoxide Alarms Standards Act. The home has gas stove in the kitchen.

Plan of Correction (POC)

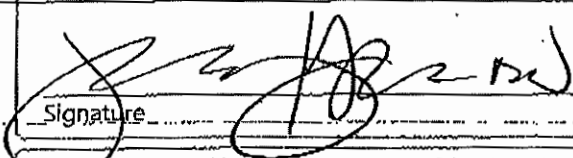
At time of inspection the building currently had a total of 9 carbon monoxide detectors that were already installed and in operation. Please see pictures attached. In following the carbon monoxide detectors manufacturer's instructions, the detectors were properly placed. One of the detectors was placed 15 feet from the gas stove outside the doorway of the kitchen. Please see picture attached. Upon inspection the surveyor instructed the maintenance director to move the detector that was located 15 from the gas stove to place it in the kitchen 15 feet from the gas stove. Immediately the maintenance director moves the carbon monoxide detector. Please see pictures attached. I have also attached the manufactures instructions of carbon monoxide detector placement that states "do not place in kitchen".

December 1, 2019 Training for the staff on Carbon Monoxide Detectors will be completed. Please see attached.

Now and ongoing

Maintenance Director will conduct monthly inspections of placement and operation of all carbon monoxide detectors. This was added to our Maintenance program in order to keep track of the timing for the checks.

Legal Entity Representative



Jennifer Grossman PCHA

11/15/2019

Signature

Printed Name and Title

Date

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The above plan of correction is approved as of

11/21/19
(Date)

Plan of correction implementation status as of

11/21/19
(Date)

The above plan of correction was approved by


(Initials)

- Fully Implemented
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THE HAVEN AT NORTH HILLS

44938

25e - Contract Rescission

Regulations

2600.

25.a. The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract and pay only for the services received. Rescission of the contract must be in writing addressed to the home.

Description of Violation

The contract, dated 4/10/19, for resident #4 does not include the resident's right to rescind the contract for up to 72 hours after the initial dated signature.

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.)

The contract that was in place was sent to DHS for approval on 8.29.2018. On September 6, 2018 a conversation was held between me and DHS to go over minor adjustments and approval. It was approved at that time. Please see attached conformation of those emails.

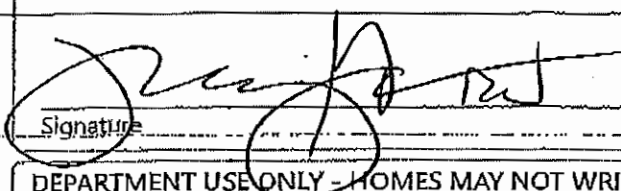
Once violation, 2600.25, was noted at the exit interview on August 2, 2019, an internal audit was completed on the resident's files to establish which Resident Agreement Contracts required the additional paperwork. Once completed, a mailing was made that day with the required paperwork to be signed by the Resident or the POA and returned to The Haven at North Hills. A follow up call was made so that all signed copies would be returned in a timely manner.

This addendum was added to our contract. Please see attached.

Our sales team were retrained on importance of all regulatory requirements for the residency agreement.

Administrator/Designee will review all contracts at time of move in for accuracy.

Legal Entity Representative



Jennifer Gross RN PLHA 11.15.2019

Signature

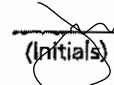
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91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 7/31/19, there were no emergency telephone numbers posted on or by the telephone in the 1st floor dining room.

On 8/2/19, there were no emergency telephone numbers posted on or by resident # 1's telephone in bedroom 217.

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.)

Immediately emergency numbers were attached to the dining room phone. Please see picture attached.

Immediately the emergency number sticker was placed on the resident's phone. Please see attached photo.

12.1.2019 Staff training on placement of emergency number placement will be completed.

Quarterly checks will be completed to ensure compliance of 2600.91

Legal Entity Representative

Signature

Printed Name and Title

Date

Jennifer Gross RN PCAA 11.15.2019

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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

Resident #2 in bedroom 306 does not have a source of lighting that can be turned on/off from bedside.

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.)

Immediately a Light White Battery Operated Round mini tap light was placed on the wall next to the bed for the resident to reach with ease. Please see attached photo.

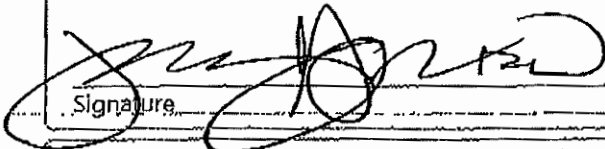
Maintenance and housekeeping staff will be retrained on 2600.101J regarding items that are required to be in the apartments.

Immediately a whole house apartment audit was completed to ensure that we are in compliance with DHS regulations. Please see attached.

Quarterly the maintenance director/Designee will complete an apartment audit to ensure compliance for 2600.101J

Please see attached audit forms

Legal Entity Representative


Signature

Jennifer Gross RN RCHA
Printed Name and Title

11.15.2019
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184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following;

Description of Violation

Resident #3 is prescribed Clonazepam 0.5mg 1 tablet twice a day as needed; however, the medication label indicates Clonazepam 0.5mg once daily.

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.)

Immediately a change in order sticker was placed on the label of the straight order medication as we did have an order for it to be given as a straight order as well. The PCP of the resident was contacted, and we received an order to discontinue the PRN dose of the medication. Please see attached copies of order for the discontinuation and documentation of it being changed on EMAR.

8.3.2019 - Cart audit was completed to ensure that all PRN medication labels were correct and in the cart.

Monthly for 3 months a cart audit will be completed to ensure compliance.

Quarterly the Resident Care Coordinator/Designee will complete a cart audit to ensure compliance of all PRN medication labels and check against EMAR to be sure of accuracy.

Dec 1, 2019 - all staff that pass medication will be trained on importance of checking MAR to medication label 2600.184.a. Please see attached.

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231c - Preadmission Screening

Regulations

2600.

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

Description of Violation

Resident #5 was admitted to the secured dementia care unit (SDCU) on 7/25/19; however, a written cognitive readmission screening was completed on 7/27/19.

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.)

Immediately and ongoing the Health Services Director will ensure that the Physician obtains and assess 72 hours prior to moving into the SDCU.

Immediately a file audit was completed by the HSD to ensure all forms completed according to regulation 2600.231c. please see attached.

Quarterly the HSD will conduct a file audit to ensure all forms have been completed according to regulation 2600.231c.

Dec 1, 2019 - training will be completed by the HSD and the Sales Director regarding timeline for Pre-admission screening. Please see attached.

Legal Entity Representative

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231e - No Objection Statement

Regulations

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #5 was admitted to the SDCU on 7/25/19. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

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.)

Immediately Resident #5 and the POA was given the No Objection Statement. The statement is now signed and in their file. Please see attached.

Immediately a file audit was completed by the sales director to ensure compliance with the No Objection Statement being present in their file.

Immediately the contract for memory care was checked for compliance regarding the content of the No Objection Statement being in the contract.

Quarterly an audit will be completed by the sales director/designee to ensure compliance.

Sales director was trained on the importance of having the memory care addendum signed during the move in process.

Legal Entity Representative

Signature

Printed Name and Title

Date

Jennifer Gross RN RCHA 11.15.2019

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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 7/31/19, there was no code posted for the locking mechanism for the door leading from the SDCU to the patio.

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.)

Immediately the code was reposted inside the SDCU at the patio door. Please see picture attached!

12.1.2019 Staff training on placement of code placement will be completed.

Quarterly checks will be completed to ensure compliance of 2600.91

Legal Entity Representative

Signature

Printed Name and Title

Date

[Handwritten Signature]

Jennifer Gross RN RCHA 11.15.2019

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251b - Record Entries Legible

Regulations

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

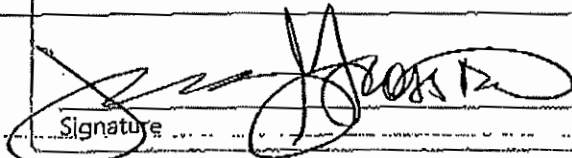
Correction fluid was used on the 2nd page of the resident #2's credit/debit memo, dated 7/9/18, and "return" was written on top over it.

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.)

1. The specific change that will be made, is that going forward when there is a written spelling error instead of using white out correction a line will be drawn through the word so that the error is legible.
2. The Business Office Manager will make the change as this is the person completing the Company's internal document.
3. The change was made effective immediately on all future internal calculation paperwork prior to submitting and filing.
4. The change was made by an internal notation added to the blank paperwork file as a guideline.
5. The system implemented is a paperwork completion guideline and a review of the paperwork before being submitted and filed.
6. The training provided is that a guideline for completion of the paperwork has been issued and attached to the paperwork folder.

Legal Entity Representative

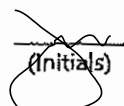

Signature

Jennifer Gross PA
Printed Name and Title
11.15.20
Date

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