



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to GRANDVIEW ESTATES MEMORY CARE LLC  
LEGAL ENTITY

To operate GRANDVIEW ESTATES MEMORY CARE  
NAME OF FACILITY OR AGENCY

Located at 1151 SCENERY DRIVE, ELIZABETH, PA 15037  
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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To provide Personal Care Homes  
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 18  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.  
(MAXIMUM CAPACITY)

**Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 18**

Restrictions: \_\_\_\_\_

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes  
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from August 29, 2019 until August 29, 2020,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **449920**

Robert E. Robinson  
ISSUING OFFICER

[Signature]  
DEPUTY SECRETARY

**NOTE:** This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



August 29, 2019

Ms. Lori Lasosky  
Chief Executive Officer  
1151 Scenery Drive  
Elizabeth, Pennsylvania 15037

RE: Grandview Estates of Elizabeth  
License #: 449920

Dear Ms. Lasosky:

As a result of the Department's Bureau of Human Services Licensing inspection on July 26, 2019, of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because the home is new and not yet serving four or more residents.

In accordance with 55 Pa.Code § 2600.11(b) relating to procedural requirements for licensure or approval of personal care homes 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.

During the inspection, citations on the enclosed violation report were found. All citations specified on the 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.

Your NEW license is enclosed, based on substantial but not complete compliance with 55 Pa.Code Ch. 2600.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services provider application submission experience. To participate in the online applicant survey, launch your web browser and go to [https://www.surveymonkey.com/r/BHSL\\_Application](https://www.surveymonkey.com/r/BHSL_Application).

Ms. Lori Lasosky

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 applicant responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kevin Hancock', written in a cursive style.

Kevin Hancock  
Deputy Secretary  
Office of Long Term Living

Enclosures  
License  
Violation Report

## Violation Report

## Facility Information

Name: *Grandview Estates Memory Care*License Number: *44992*Address: *1151 Scenery Drive, Elizabeth, PA 15037*County: *ALLEGHENY*Region: *WESTERN*

## Administrator

Name: *Lori Lasosky*Phone: *412-872-4856*Email: *lori.lasosky@grandvieweoe.com*

## Legal Entity

Name: *Grandview Estates Memory Care, LLC*Address: *1151 Scenery Drive, Elizabeth, PA, 15037*

## Certificate(s) of Occupancy

Type: *C-2 LP*

Date:

Issued By:

Type: *I-2*Date: *05/30/2019*Issued By: *Elizabeth Township*

## Staffing Hours

Resident Support Staff: *0*Total Daily Staff: *6*Waking Staff: *5*

## Inspection

Type: *Partial*

BHA Docket #:

Notice: *Announced*Reason: *New*

## Inspection Dates and Department Representative

*07/26/2019 - On-Site: Desmond Grace*

## Resident Demographic Data as of Inspection Dates

## General Information

License Capacity: *18*Residents Served: *3*

## Secured Dementia Care Unit

In Home: *Yes*Area: *all*Capacity: *18*Residents Served: *3*

## Hospice

Current Residents: *0*

## Number of Residents Who:

Receive Supplemental Security Income: *0*Are 60 Years of Age or Older: *3*Diagnosed with Mental Illness: *0*Diagnosed with Intellectual Disability: *0*Have Mobility Need: *3*Have Physical Disability: *0*

85d - Trash Receptacles

Regulations

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11:45 a.m., there was a 13"x 6" hole in the side of the lid on the tall trash receptacle in the main kitchen on the second floor preventing full coverage of the trash. The trash receptacle was 3/4 full.

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.)

At 12 noon on July 26th the receptacle was ~~was~~ replaced with a receptacle with full covered lid. All staff educated regarding proper trash receptacle regulations. Staff to ensure proper receptacle coverage on daily flow sheet. (each shift)

Staff education will include, at a minimum, staff responsibilities in ensuring that all trash receptacles in kitchens and bathrooms are kept covered to prevent penetration of insects and rodents in accordance with §2600.85(d). 8/28/19

Legal Entity Representative

*Lori Lasosky*  
Signature

Lori Lasosky Admin 8/27/19  
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/28/19 (Date)

Plan of correction implementation status as of 8/28/19 (Date)

The above plan of correction was approved by (Initials)

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

96a - First Aid Kit

Regulations

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

At 10:16 a.m., the home's first aid kit located in the nurse's station did not include a breathing shield.

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.)

On July 26, 2019 at 10:30 the breathing shield was added to the first aid kit. All staff educated regarding the first aid contents. LPN will check proper contents monthly and document on the flow sheet. (see attached)

Legal Entity Representative

Lori Lasosky  
Signature

Lori Lasosky Administrator 8/27/19  
Printed Name and Title Date

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102i - Soap Dispenser

Regulations

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At 11:14 a.m., there was an unlabeled bar of soap in the middle stall of the shared resident shower room on the south wing of the home.

At 11:30 a.m., the private bathroom in resident bedroom #103 did not contain soap or a soap dispenser.

At 11:35 a.m., the shared bathroom in resident bedroom # 101 did not contain soap or a soap dispenser.

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.)

On July26, 2019 at 11:35 am the unlabeled bar of soap as removed from the shared shower. Soap dispensers were added to resident rooms 103 and 101. All staff educated on 8/27/2019 regarding reg 102.i. Supervisor to monitor shower and resident bathrooms for soap weekly and as needed. Results of monitoring will be reviewed a quarterly quality management meeting.

Legal Entity Representative

*Lori Lasosky*  
Signature

LORI Lasosky Administrator 8/27/19  
Printed Name and Title Date

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8/28/19  
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*LL*  
(Initials)

- Fully Implemented
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224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening, completed 5/5/19, did not include a determination that home could meet the resident's needs.


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.)

A DHS representative authorized via email on 04/30/2019 that we were permitted to have 3 residents prior to licensing. At physical site inspection on 7/26/2019 residents records were reviewed. We were notified by DHS representative that only physical site and administrator file would be inspected.

Resident #2's preadmission screening was updated to include the determination that the home could meet her needs on 8/27/2019. All other residents records were reviewed for accuracy regarding 224a. Supervisors educated were educated on 8/27/2019 regarding prescreening requirements. All records will be audited monthly by supervisor and submitted to quality management meetings. quarterly.

Legal Entity Representative


  
Signature

Lori Lasosky Administrator 8/27/19  
Printed Name and Title Date

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225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #1's initial assessment, dated 6/1/19, does not include an assessment of the resident's supervision needs. The assessment also does not include the diagnoses of Dementia and Hypertension as indicated on the resident's medical evaluation dated 5/29/19.

Resident #2's initial assessment, dated 5/17/19, does not include an assessment of the resident's supervision needs. The assessment also does not include the diagnoses of Frontal Lobe Dementia and Hypothyroidism as indicated on the resident's medical evaluation dated 5/27/19.

Resident #3's initial assessment, dated 6/13/19, does not include an assessment of the resident's supervision needs. The assessment also does not include the diagnoses of Dementia, Hypothyroidism and Hypertension as indicated on the resident's medical evaluation dated 6/8/19.

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.)

A DHS representative authorized via email on 04/30/2019 that we were permitted to have 3 residents prior to licensing. At physical site inspection on 7/26/2019 residents records were reviewed. We were notified by DHS representative that only physical site and administrator file would be inspected.

Resident #1, 2 and 3 record was updated to include assessment of supervision on 08/27/2019. Resident #1 added Diagnosis of HTN and Dementia to assessment on 8/27/2019. Resident #2 added DX of Frontal lobe dementia and hypothyroidism on 8/27/2019. Resident #3 added DX of dementia, hypothyroidism and HTN on 8/27/2019. Supervisors educated on 8/27/2019 regarding reg 225.a. Resident records will be reviewed for accuracy monthly by supervisor and sent to the quarterly quality management meetings.

During the next quarterly quality management plan review and evaluation and ongoing-The home will place an increased emphasis on these plans of correction and take action to improve the quality of its training of staff involved in the development of support plans in accordance with §2600.225(a). *JL* 8/28/19

Legal Entity Representative

Signature

Lori Lasosky Administrator

Printed Name and Title

8/27/19

Date

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(Date)

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(Date)

The above plan of correction was approved by *JL*  
(Initials)

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- Not Implemented

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's support plan was completed on 6/1/19; however, the support plan was not signed by the resident or any of the individuals who participated in the development of the support plan.

Resident #2's support plan was completed on 5/17/19; however, the support plan was not signed by the resident or any of the individuals who participated in the development of the support plan.


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.)

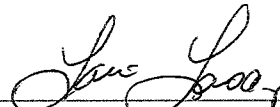
A DHS representative authorized via email on 04/30/2019 that we were permitted to have 3 residents prior to licensing. At physical site inspection on 7/26/2019 residents records were reviewed. We were notified by DHS representative that only physical site and administrator file would be inspected.

Resident #1's support plan was Signed by resident and person who participated on 8/27/2019. Resident #2's support plan was updated that resident was unable to participate and signature of individual who participated signed on 8/27/2019.

Supervisors educated regarding reg 227.g on 8/27/2019 as well as all records reviewed for accuracy of 227.g. All records will be monitored by supervisors monthly for accuracy and submitted to quarterly quality management meetings.

Monthly monitoring by supervisors will include, at a minimum, a review of all support plans for newly admitted residents to ensure completion including signatures of those involved in the development of the plan.  8/28/19

Legal Entity Representative

  
Signature


Lori Lasosky Administrator  
Printed Name and Title

8/27/19  
Date

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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 (SDCU) on 5/13/19. However, the resident did not have a medical evaluation completed until 5/27/19.

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.)

Supervisors educated on 8/27/2019 regarding reg 231.b. All records will be audited by supervisors monthly for accuracy and submitted to quarterly quality management meeting.

Monthly audits completed by supervisors will include, at a minimum, a review of admission documentation for all newly admitted residents to ensure medical evaluations are completed within timeframes specific to secured dementia care units (SDCUs) in accordance with §2600.231(b). *[Signature]* 8/28/19

Legal Entity Representative

*[Signature]*  
Signature

Lori Lasostky Admw 8/27/19  
Printed Name and Title 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

The SDCU has number code magnetic locking devices on all of the exit doors. However, at 11:05 a.m., there were no directions for operating the home's magnetic locking devices conspicuously posted near any of the doors in the SDCU.

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.)

Directions for magnetic locking devices added on 6/26/2019 at 12 noon. Staff educated regarding reg 233.c. Staff to monitor that directions are posted by each device by each shift daily and documented on daily flow sheet.

Directions for the number code magnetic locking devices were added to all doors in the home on 7/26/19 at 12:00 p.m. *[Signature]* 8/28/19

Legal Entity Representative

*[Signature]*  
Signature

*Lore Lasosky Admin*  
Printed Name and Title

8/27/19  
Date

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234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the SDCU on 5/13/19; however, the resident did not have a support plan completed until 5/17/19.

Resident #3 was admitted to the SDCU on 6/8/19; however, the resident did not have support plan completed until 6/13/19.

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.)

A DHS representative authorized via email on 04/30/2019 that we were permitted to have 3 residents prior to licensing. At physical site inspection on 7/26/2019 residents records were reviewed. We were notified by DHS representative that only physical site and administrator file would be inspected.

Supervisors educated regarding reg 234.a on 8/27/2019. All records will be reviewed for accuracy by supervisors monthly and submitted to quarterly quality management meeting.

Monthly review of records completed by supervisors, will include, checking that support plans are completed within the specified timeframes for residents admitted to a SDCU in accordance with §2600.234(a). *JL* 8/28/19

During the next quality management plan review and evaluation and ongoing-The home will place an increased emphasis on these plans of correction and take action to improve the quality of its training specific to timeframes for development, implementation and documentation of support plans for residents admitted to a SDCU in accordance with §2600.234(a). *JL* 8/28/19

Legal Entity Representative

*Loei Lasosky*  
Signature

*Loei Lasosky Administrator* 8/27/19  
Printed Name and Title Date

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