pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: October 25, 2019

Mr. Pete Smith
Vice President
KJ Bethel Park LLC
30 West Monroe Street, Suite 1700
Chicago, Illinois 60603

RE: The Sheridan at Bethel Park
2000 Cool Springs Drive
Bethel Park, Pennsylvania 15234
Certificate #: 449480

Dear Mr. Smith:

As a result of the Department's Bureau of Human Services Licensing inspection on September 23, 2019, of the above facility, the citations 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.

Sincerely,

Larry Mazza
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* License Number: *44948*
Address: *2000 COOL SPRINGS DRIVE,, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Wendy Mildner* Phone: *4129234892* Email: *PETE@KAUFMANJACOBS.COM*

Legal Entity

Name: *KJ BETHEL PARK LLC*
Address: *30 W. MONROE STREET,SUITE 1700, CHICAGO, IL, 60603*

RECEIVED
10/22/2019
Western Region Field Office
Bureau of Human Services Licensing

Certificate(s) of Occupancy

Type: *I-1* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *114* Waking Staff: *86*

Inspection

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

Inspection Dates and Department Representative

09/23/2019 - On-Site: Amy Duncan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* Residents Served: *78*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *40* Residents Served: *17*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *77*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *36*
Have Physical Disability: *0*

25c2 - Fee Schedule

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Resident #1's resident-home contract , dated 7/25/19, indicates the resident receives "Level 3 Level of Care"; however, does not include the addendum for the fee schedule of actual amounts charged for available services, including the level of care charges.

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.)

Resident #1 no longer resides at the home. 10/22/19 FM

An audit of current residents home contracts to verify signatures by residents has been completed as of 10/15/19. The fee schedule or payment calculators has been placed in each file if applicable, memory care residents are all inclusive as identified in their resident agreement.

Effective immediately new resident home contracts will have the fee schedule or payment calculator included in the resident agreement, memory care is all inclusive. See the attached new resident file audit checklist.

Compliance date 10/31/19.

Legal Entity Representative

Wendy Mildner Wendy Mildner, QS 10/22/19

Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 10/22/19 (Date)

The above plan of correction was approved by FM (Initials)

Plan of correction implementation status as of 10/22/19 (Date)

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

25c8 - Smoking

Regulations

2600.
25.c. At a minimum, the contract must specify the following:
8. The home's rules related to home services, including whether the home permits smoking.

Description of Violation

Resident #1's resident-home contract, dated 7/25/19, does not include the home's rules related to home services.

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.)

An audit of current residents home contracts to verify that all addendum are present in the resident file with the check list initialed or the addendum signed was completed on 10/15/19.
Effective immediately new resident home contracts will have the addendum signed upon move in to the community. See the attached new resident file audit checklist.

Resident #1 no longer resides at the home. 10/22/19 FM

Compliance date: 10/31/19

Legal Entity Representative

Wendy Mildner Exec Dir 10/22/19

Signature | Printed Name and Title | Date

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- ☐ Not Implemented

25c13 - Complaint Procedure

Regulations

2600.
25.c. At a minimum, the contract must specify the following:
13. Written information on the resident's rights and complaint procedures as specified in § 2600.41 (relating to notification of rights and complaint procedures).

Description of Violation

Resident #1's resident-home contract, dated 7/25/19, does not include the resident rights or complaint procedures.

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.)

An audit of current residents home contracts to verify that all addendum are present in the resident file with the check list initialed or the addendum signed was completed 10/15/19.
Effective immediately new resident home contracts will have the addendum signed upon move in to the community. See the attached new resident file audit checklist.
Resident #1 no longer resides at the home. 10/22/19 FM
Compliance date: 10/31/19

Legal Entity Representative

Wendy J Mildner — Signature
Wendy Mildner, QD — Printed Name and Title
10/22/19 — Date

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- ☐ Not Implemented

42c - Treatment of Residents

Regulations

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 9/16/19 at approximately 8:30 pm, direct care staff person C overheard direct care staff person A say to resident #1, who resides in the secured dementia care unit (SDCU), "If you punch me, I'll punch you back".

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 community followed all procedures upon notification of the issue. The employee was immediately questioned (he was not on site working) and was suspended pending an employment decision. Current, active staff were notified of an online retraining to be completed on abuse observation and reporting, training was completed by 9/30/19. The employee was ultimately terminated from his employment on 9/17/19. Completed training records are attached.

All staff are trained on abuse and neglect upon hire and annually.

Compliance date:9/30/19

Legal Entity Representative

Wendy J Mildner — Wendy Mildner ED 10/22/19

Signature | Printed Name and Title | Date

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- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, hired on 1/4/19, and direct care staff person B, hired on 2/18/19, do not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

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.)Direct care staff person A did not have a high school diploma on file due to having the PA nurse aide registry on file. During employment however the employee left the nurse aide registry lapse and did not notify the employer. During the survey visit the employee requested the diploma/transcripts. They came within two weeks. The employee resigned time with an effective date of 10/4/19. Direct care staff person B had a diploma from out of the country and a waiver was not obtained. Staff person B no longer is employed effective 9/17/19.

Newly hired staff will provide a diploma or GED regardless of PA nurse aide registry status. Employee file audit will be completed by 10/25/19. Copies of their diploma/GED will be obtained or a waiver will be requested. See the attached new team member audit.

Compliance date: 10/31/19

Legal Entity Representative

Wendy Mildner ED 10/22/19

Signature | Printed Name and Title | Date

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65d - Initial Direct Care Training

Regulations

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B was hired 2/18/19 with active registry status on the Pennsylvania nurse aide registry; however, the certification expired on 3/17/19. Direct care staff person B continues to perform ADL services to residents; however, has not successfully completed and passed the Department-approved direct care training course and passed the competency test.

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.)

Staff person B is no longer employed at the home. FM 10/22/19

Direct care staff person A did not take the direct care test due to having the PA nurse aide registry on file. During their employment however the employee left the nurse aide registry lapse and did not notify the employer. This employee is no longer employed effective 10/4/19.

Newly hired staff will take the direct care test or will provide copy of prior completion regardless of their PA nurse aide registry on file.

Employee file audit will be completed by 10/25/19. Copies of their direct care test will be obtained or they will complete the course.

See the attached new resident file audit checklist.

Compliance date 10/31/19

Legal Entity Representative

Wendy Mildner — Signature

Wendy Mildner, ED — Printed Name and Title

10/22/19 — Date

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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 #1, was admitted to the SDCU on 7/26/19; however, does not have a preadmission screening form completed.

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.)

By the receipt of this report the resident moved out of the community.

New residents moving into the community will have a pre-admission screen completed within the required time frame. The executive director or designee will review the screen prior to move in to verify completeness. See the attached new resident file audit checklist.
Compliance date: 10/31/19

Within 7 days of receipt of the plan of correction: A designated staff person shall review each current resident's record to ensure a completed preadmission screening is present. 10/22/19 FM

Legal Entity Representative

Signature | Wendy Mildner 10/22/19 (Printed Name and Title / Date)

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

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

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 was admitted to the home on 7/26/19; however, the resident's initial assessment was not completed until 9/5/19.

Resident #1's initial medical evaluation, dated 7/9/19, indicates numerous diagnoses, including hypertension, renal disease, peripheral neuropathy and aortic stenosis; however, are these diagnoses are not indicated on the resident's initial assessment, dated 9/5/19.

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.)

As of the receipt of this report this resident no longer resides in the community
The health and wellness director completed a review of DME's to assessments and to verify all diagnosis present in the assessment and updated any assessments to match the DME.
New move in assessments will be reviewed by the executive director and health and wellness director during the weekly clinical meeting to verify compliance. See the attached new resident file audit checklist.
Within 7 days of receipt of the plan of correction: A designated staff person shall review each current resident's record to ensure a completed assessment is present. FM 10/22/19
Compliance date: 10/31/19

Legal Entity Representative

Wendy J Mildner
Signature

Wendy Mildner ED 10/22/19
Printed Name and Title Date

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

226a - Mobility Assessment

Regulations

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #1's initial assessment, dated 9/5/19, indicates the resident is independently mobile and the resident's most recent support plan, dated 9/5/19, indicates the resident has no mobility needs and can evacuate independently in an emergency. However, the resident resides in the SDCU, and the resident's support plan indicates the "resident requires regular supervision in the home and cannot leave the home unattended; unaware of unsafe areas" and that "extensive supervision is needed". Also, the safety/evacuation section of the resident's support plan indicates, "resident needs assistance to maintain personal safety and awareness. Assist resident during an evacuation."

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.)

As of the receipt of this report the resident no longer resides in the community.
Current resident assessments have been reviewed as of 10/15/19 to verify mobility needs are properly identified. Assessments/support plans have been updated to reflect current resident status
New residents moving in will be reviewed during the weekly clinical meeting to verify compliance. See the attached new resident file audit checklist.
Assessments/support plans will be updated as required weekly during the clinical meeting and as needed

Compliance date: 10/31/19

Legal Entity Representative

Signature

Wendy Mildner, ED 10/22/19
Printed Name and Title Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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 #1 was admitted to the SDCU on 7/26/19; however, the resident's initial medical evaluation, dated 7/9/19, did not indicate the need for the resident to be served in a 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.)

As of the receipt of this report the resident no longer resides in the community.
A 100% audit of current residents was completed by 9/30/19 per a previous plan of correction.
Current residents have DME's indicating need for SDCU.
New residents moving into the SDCU will be reviewed by the executive director or designee upon receipt of the DME to verify compliance. See the attached new resident file audit checklist.
Compliance date: 10/31/19.

Legal Entity Representative

Wendy Mildner, ED 10/22/19

Signature | Printed Name and Title | Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

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 #1 was admitted to the SDCU on 7/26/19; however, a written cognitive preadmission screening was not completed.

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.)

This resident no longer resides in the community as of 9/29/19.
Current resident pre-screens have been audited as of 9/30/19 to verify they are complete and contain a cognitive screen. New residents who move into the memory care unit of the community will have a completed pre-screen to include the cognitive section. The executive director will review new resident move in pre-screen forms to verify completion. See the attached new resident file audit checklist.
Compliance date 10/31/19

Legal Entity Representative

Signature | Wendy Mildner, ED | 9/30/19
Printed Name and Title | Date

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

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The above plan of correction was approved by FM (Initials)

Plan of correction implementation status as of 10/22/19 (Date)

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

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 #1 was admitted to the SDCU on 7/26/19; however, the resident's initial support plan was not completed until 9/5/19.

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.)

This resident no longer resides in the community as of 9/29/19
New residents who move into the community will have their assessment/service plans completed within the ~~15 day time~~ 72 hour requirement per the regulation. See the attached new resident file audit checklist. 10/22/19 FM
The executive director and the health and wellness director will review new move in paperwork for timely completion at the weekly clinical meeting.
Compliance date: 10/31/19

Legal Entity Representative

Signature

Wendy Mildner, ED 10/22/19
Printed Name and Title Date

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- ☐ Not Implemented

234b - Support Plan Needs Elements

Regulations

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #1's initial assessment, dated 9/5/19, indicates a moderate problem with aggression, and the resident's initial support plan, dated 9/5/19, indicates, "the resident becomes combative with staff at times"; however, the support plan does not include a plan to meet this need. Also, the resident's assessment indicates a severe problem with judgment, and the resident's support plan indicates, "Severe judgment lapses that impair everyday functions" and "Resident has poor judgment r/t to dx of dementia"; however, the support plan does not include a plan to meet this need.

Resident #1's initial assessment, dated 9/5/19, indicates the resident has difficulty sleeping, and the resident's initial support plan, dated 9/5/19, indicates, "During the night, check resident. (Note desired frequency of night time checks)"; however, the support plan does not include the frequency of the night time checks.

Resident #1's initial support plan, dated 9/5/19, does not include frequency of services for any care needs, including bladder management, judgment, aggression and irritability.

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.)

Resident 1 no longer resides in the community as of 9/29/19. His assessment and service plan were completed by someone helping to bring files up to date.
The health and wellness director will review current resident assessment/support plans to verify they represent the current status of the resident. Appropriate changes will be made or the assessment/support plan were revised as of 10/15/19.
The executive director and the health and wellness director will review changes to resident assessment/ support plans weekly during the clinical meeting.
Compliance date 10/31/19
Within 72 hours of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident support plans are immediately updated as care needs change. All staff persons responsible for the completion of resident support plans shall be educated on the new system. 10/22/19

234b - Support Plan Needs Elements *(continued)*

Legal Entity Representative

Signature

Wendy Mildrew ED 10/22/19
Printed Name and Title Date

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