pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: rivercliffannex@gmail.com

MAILING DATE: February 21, 2020

Ms. Jennifer Luffey
Administrator
Rivercliff Terrace, Inc.
120 Allegheny Avenue
Kittanning, Pennsylvania 16201

RE: Rivercliff Terrace Annex
322 North McKean Street
Kittanning, Pennsylvania 16201
License #: 426930

Dear Ms. Luffey:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 11, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Received BHSL
2/18/2020

Violation Report

Facility Information

Name: *RIVERCLIFF TERRACE ANNEX* **License Number:** *42693*
Address: *322 NORTH MCKEAN STREET,, KITTANNING, PA 16201*
County: *ARMSTRONG* **Region:** *WESTERN*

Administrator

Name: *JENNIFER LUFFEY* **Phone:** *7245435923* **Email:** *RIVERCLIFFANNEX@GMAIL.COM*

Legal Entity

Name: *RIVERCLIFF TERRACE INC*
Address: *120 ALLEGHENY AVENUE, KITTANNING, PA, 16201*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/10/1983* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *20* **Waking Staff:** *15*

Inspection

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

Inspection Dates and Department Representative

12/11/2019 - On-Site: Karen Georgoulis, Joe Eveges

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served:** *19*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *1*
Are 60 Years of Age or Older: *19*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

132f - Alternate Exit Routes

Regulations

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

On 12/11/19, review of the home's 2019 fire drill record indicated the home failed to use alternate routes when conducting fire drills, using only the front and back stairwells consecutively on the following dates: 11/14/19, 10/7/19, 9/19/19, 8/26/19, 7/30/19, 6/25/19, 5/17/19, 4/30/19, 3/8/19, 2/22/19 and 1/31/19.

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.)

On 01/31/2019 all exits to the front stairwell were blocked and on 06/25/2019 all exits to the rear stairwell were blocked. It is correct to say that all of the fire drills during February, March, April, May, June, August, September, October, and November used all exits.

Beginning with the first fire drill conducted after the inspection, which was on December 31, 2019, an exit has been blocked. I have reviewed the fire drill regulations. To correct 132.f I have preplanned all drills for 2020 noting which exits will be blocked. I also alternated shifts and days of the week to assure that all employees will experience fire drills. I will vary the time of the drills throughout the year during those shifts. I have attached the Fire Drill Records for 2019 and 2020 documenting the December and January fire drills that were conducted with a blocked exit and the preplanned Fire Drill Record. This Plan of correction will assure the drills in the future will follow regulation 132.f.

Legal Entity Representative

Signature | Jennifer Luffey - Administrator | 2/14/20
Printed Name and Title | Date

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

The above plan of correction is approved as of 2/18/2020 (Date)

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

Plan of correction implementation status as of 2/18/2020 (Date)

☒ Implemented
☐ 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's initial assessment dated, 5/23/19, did not include a diagnose of Cutaneous Squamous Cell Carcinoma and Diverticular Disease of Colon as indicated in the resident's medical evaluation, dated 5/6/19.

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.)

The violation present on Resident #1's Assessment was corrected during the inspection on December 11, 2019. Resident #1's move in date was 05-11-2019. I completed the assessment on 05-23-2019, but did not have the DME from the doctor at this point. I used the information provided on the Preadmission Screening to complete the Assessment to the best of my knowledge at that point. When receiving the signed DME from the doctor on 06-03-2019 I did not update the information that I had previously completed. To assure that this step is not missed in the future, I have added an item to the New Resident Checklist. Along with, complete the Assessment within 15 days and Support Plan within 30 days, I have added Verify that the information from the completed DME is present and accurate on the Assessment and Support Plan. I have attached the updated page from Resident #1 and the new checklist that will be used for all residents from this point forward.

Legal Entity Representative

Signature | Jennifer Luffey - Administrator (Printed Name and Title) | 2/14/20 (Date)

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