pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: wmildner@seniorlifestyle.com
pete@kaufmanjacobs.com

MAILING DATE: April 20, 2020

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 Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 6, 2020; January 7, 2020 and January 13, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Janine Wenzig
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
March 16 2020
WEST REGION FIELD OFFICE
Human Services Licensing

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*

Certificate(s) of Occupancy

Type: *I-1* **Date:** *12/13/2018* **Issued By:** *Municipality of Bethel Park*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *146* **Waking Staff:** *110*

Inspection

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

Inspection Dates and Department Representative

01/06/2020 - On-Site: Lisa Flinner-Alman, Lauren Spagna

01/07/2020 - On-Site: Lisa Flinner-Alman, Lauren Spagna

01/13/2020 - On-Site: Lisa Flinner-Alman, Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* **Residents Served:** *91*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st & 2nd Floor* **Capacity:** *40* **Residents Served:** *26*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *91*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *55*
Have Physical Disability: *0*

3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 1/6/2020, the copies of the current license inspection summaries, dated 5/30/19 and 9/23/19, were in a binder behind the front desk, which is not a conspicuous and public place.

Repeat Violation: 3/26/19

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 binder was moved to the mail room and attached to the wall on 1/20/2020. See attached.

The executive director, or designee, will monitor monthly for compliance.

Completed.

Legal Entity Representative Signature — Wendy Mildner, E.D. — Printed Name and Title — 3/16/2020 — Date

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

The above plan of correction is approved as of 3/17/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/17/20 (Date)

☒ Implemented

☐ Not Implemented

16c - Written Incident Report

Regulations

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 12/31/19 at approximately 7:00 p.m., the local fire department responded when smoke from burned food in resident #1's room set off the fire alarm. The home did not report this incident to the Department.

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 fire department incident was reported on 1/13/2020, final day of survey. Attached.

The executive director inserviced the management team on 2600.16c on 1/14/2020.

The executive director, or designee, will verify during standup meeting that all reportables are completed and reported within the time frame required. Incidents will be reviewed as part of the community QA program.

Immediate and ongoing.

Legal Entity Representative Signature | Wendy Milsner, Exec Dir Printed Name and Title | 3/16/2020 Date

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☒ Implemented
☐ Not Implemented

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

The enabler bar on resident #2's bed was uncovered and had an opening on the top, measuring approximately 12 inches across. The enabler was also loose and not secured to the bed, allowing the enabler to slide from under the mattress, posing an entrapment hazard.

The enabler bar on resident #3's bed was uncovered and had an opening on the top portion, measuring approximately 12 inches across. The enabler was also loose and shifted from under the mattress approximately 1 inch, posing an entrapment hazard.

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 revised POC per DHS request 4/10/2020

SEE PAGE 4A OF 19

Legal Entity Representative

Signature

Wendy Mildner, QS 4/10/2020
Printed Name and Title Date

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The above plan of correction is approved as of 4/14/20 (Date)

Plan of correction implementation status as of 4/14/20 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

2600.81.b

Revised 4/10/2020 per DHS request

Current enabler bars were reviewed and addressed on 1/8/2020. The attached letter was given to all residents with an enabler bar in place at the time of survey. The enabler bar information was also added into the resident handbook. All staff were advised of the process regarding enabler bars and the letter given to the residents was posted by the time clock.

Resident #2 – bar was secured to the bed.

Resident #3 – the bar was covered.

Direct care staff will report any new bars that are applied to the health and wellness director. Direct care staff will observe enabler bars daily to verify they are firmly connected and are covered in accordance with the regulation.

The health and wellness director, or designee, will review enabler bar use monthly to verify compliance.

Direct care staff will be fully re-inserviced on the enabler bar regulation and process by 4/24/2020.

Enabler bars will be noted on the resident support plan.

4/10/2020

4/14/20

82c - Locking Poisonous Materials

Regulations

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 1/6/2020 at approximately 10:30 a.m., multiple cleaning supplies were unlocked, unattended and accessible in the cabinet under the sink located in the 1st floor Secured Dementia Care Unit (SDCU) kitchenette including a bottle of Soft Scrub with Bleach, and a jug of cleaner/sanitizer with manufacturers' labels indicating "If swallowed, call a poison control center or doctor immediately." Not all residents of the home, including resident #10 have been assessed as capable of safely using or avoiding poisons.

Repeat Violation: 3/26/19

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.)

All staff have been reminded about the locking of chemicals in the kitchen area. The dining staff have the locking of the cabinet as a task on their daily checklists.

The med techs are to verify the chemicals are locked after each meal and anytime someone uses them to clean. The dining services director, or designee, rounds in the memory care daily at the start an end of the day. The memory care director, or designee, checks the locks at the start and end of their shift. The executive director rounds weekly to verify chemicals are locked and the processes are being followed.
The medication techs/nurses will document twice per shift that the locks and supplies have been checked-compliance date- 3/20/2020.
Immediate and ongoing

Wendy Gardner — Signature
Wendy Mildner, E.D. — Printed Name and Title
3/16/2020 — Date

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☒ Implemented
☐ Not Implemented

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/6/2020, numerous dried brown spots of an unknown brown substance, approximately 1" each, covered the floor of the spa room on the 2nd floor 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.)

The spa room was cleaned 1/6/2020 during the survey. The spa room is included on the housekeeping checklist and is cleaned weekly and as needed. The maintenance director, or designee, checks the spa daily to verify cleanliness.

Immediate and ongoing.

Legal Entity Representative

Wendy Mildner, ED 3/16/2020

Signature | Printed Name and Title | Date

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88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The fire doors next to bedrooms 140 and 141 do not close securely, leaving an approximate 1" opening when they are closed. Also, the fire doors next to bedrooms 238 and 239 do not close securely, leaving an approximate ¼" opening when they are closed.

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 doors were adjusted during the survey 1/6/2020. The doors are currently closing securely, photos attached.

The maintenance director, or designee, will check the closing of fire doors during the fire drill monthly.

Immediate and ongoing.

Legal Entity Representative

Signature | Wendy Mildren, ED Printed Name and Title | 3/16/2020 Date

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☐ Not Implemented

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 1/6/2020, there were no emergency telephone numbers posted on or nearby the telephones in the following locations:

- 2nd floor SDCU Serenity Room

- Bedroom 307

Repeat violation: 3/26/19

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 emergency information was placed on the phone in the SDCU 2nd floor serenity room during the survey. 1/7/2020

At the recommendation of the surveyor, since many residents have a cell phone or portable phone they carry with them the emergency numbers have been placed in the resident apartment on the back of the door, 3/10/2020.

The maintenance director, or designee, will monitor that the emergency information is maintained in accordance with the regulation.

Completed.

Legal Entity Representative Signature

Wendy Mildner, QD Printed Name and Title

3/16/2020 Date

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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

On 1/13/2020, the first aid in the 2nd floor medication room did not include a thermometer and eye coverings.

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 items were replaced in the first aide kit, 1/15/2020.

The maintenance director, or designee, will check the first aid kits monthly to verify all contents present. Staff will notify the maintenance director if they remove something from the kit.

Staff trained in first aid kit process -compliance 3/20/2020.

Immediate an ongoing

Legal Entity Representative

Signature

Wendy Mildner Exec Div. 3/16/2020

Printed Name and Title Date

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102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

Regulations

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There were no grab bars in the 1st two bathroom stalls of the shared women's bathroom across from the 1st floor entertainment room.

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 grab bars were placed in the women's bathroom on 1/24/2020. Photos attached.

Legal Entity Representative

Signature | Wendy Mildner, ED | 3/16/2020
Printed Name and Title | Date

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☒ Implemented
☐ Not Implemented

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107a - Emergency Preparedness

Regulations

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home does not have a copy of the emergency preparedness plan for the local municipality.

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 emergency plan for the municipality of Bethel Park was obtained and placed in the community emergency binder on 2/26/2020.

The executive director, or designee, will monitor the emergency binder monthly to verify compliance.

Legal Entity Representative

Signature | Wendy Mildner, ED Printed Name and Title | 3/16/2020 Date

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☐ Not Implemented

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

The home's maximum safe evacuation time as determined by a fire safety expert on 10/28/19 is 5 minutes 30 seconds. The home exceeded this time on the following fire drills:
- On 10/28/19 at 7:45 p.m., the evacuation time was 6 minutes 32 seconds
- On 11/15/19 at 11:17 (a.m./p.m. not indicated), the evacuation time was 6 minutes 20 seconds
- On 11/26/19 at 1:30 a.m., the evacuation time was 7 minutes 0 seconds
- On 12/24/19 at 6:40 p.m., the evacuation time was 7 minutes 10 seconds

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 fire letter prepared by the fire chief was not accurate, he had based it off his "memory" not looking at the previous fire letter. A revised fire letter was obtained on 2/18/2020 and is attached. The evacuation time indicated in this letter is 7 minutes. - JRW 4/6/20

The maintenance director will verify each drill is within the time identified and will re-drill to maintain compliance with the letter.

The drill in January and February were within the time noted on the fire letter.
Fire drills conducted on 1/31/20 at 9:40pm and on 2/20/20 at 4:15pm. All residents were evacuated in under 7 minutes. - JRW 4/6/20

The executive director will review and initial each drill to verify compliance.
Immediate and ongoing.

Legal Entity Representative

Signature | Wendy Mildner, ED | Printed Name and Title | 3/16/2020 | Date

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☒ Implemented
☐ Not Implemented

132h - Designated Meeting Place

Regulations

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

For the fire drill conducted on 5/16/19 at 11:30 p.m., there were 59 residents in the home, however, only six residents were evacuated.

For the fire drill conducted on 7/24/19 at 5:00 p.m., there were 70 residents in the home, however, no residents were evacuated.

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.)

In discussing the documentation process with the maintenance director there may have been an error in his documentation as all residents participated in the drills in some fashion which would have constituted evacuation to the appropriate areas.

The documentation is correct for January and February. Fire drills conducted on 1/31/20 at 9:40pm and on 2/20/20 at 4:15pm. All residents were evacuated. - JRW 4/6/20

The executive director, or designee, will review and initial each drill to verify compliance. and ensure all residents are evacuated to the designated meeting areas and that the fire drill record reflects this accurately. - JRW 4/6/20

Immediate and ongoing

Legal Entity Representative

Wendy Mildner ED 3/16/2020

Signature | Printed Name and Title | Date

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☐ Not Implemented

183b - Meds and Syringes Locked

Regulations

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 1/6/2020, there were two tubes of Topicort 0.25% cream unlocked, unattended and accessible in the 2nd floor SDCU medication room.

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.

Medications are now stored in a locked cabinet in the first floor care team room .

All med techs and nurses are responsible to ensure that no medications are left out or unattended. Locking procedures were reviewed with the med techs and any agency nurses present on day of survey.

The health and wellness director, or designee, monitors the storage on a daily basis.

Immediate and ongoing.

Legal Entity Representative

Signature | Wendy Mildner, QD Printed Name and Title | 3/16/2020 Date

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☒ Implemented
☐ Not Implemented

190b - Insulin Injections

Regulations

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person A has not successfully completed the Department-approved diabetes patient education program within the past 12 months. Staff person A most recently completed diabetes training on 11/20/18. Staff person A administered insulin to resident #7 on 12/22/19 at 9:00 a.m., and to resident #8 on 12/23/19 at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.

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 med techs were immediately instructed not to administer any insulin or complete blood glucose checks.

The med techs were inserviced by a diabetic trainer on 1/22/2020, sign off records attached.

The med techs will receive annual training in accordance with the regulations.

The health and wellness director, or designee, will monitor next training dates to ensure training is completed timely. The executive director will review training expiration dates monthly with the health and wellness director.

Immediate and ongoing.

Legal Entity Representative

Wendy Meedma — Wendy Mildner, QS — 3/16/2020

Signature — Printed Name and Title — Date

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☒ Implemented
☐ Not Implemented

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191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Multiple residents have not been educated to the resident's right to question or refuse medication if the resident believes that there may be a medication error, including residents #4, #5, and #9.

Repeat Violation: 3/26/19

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.)

When an unreadable copy of the resident rights addendum of the resident agreement was removed it was missed that the right to refuse medications was not on the replaced copy. The right to refuse medication information has been added to the resident handbook in the medication section. effective 1/17/2020. All new residents were given the the new handbook and existing residents were given the information in a notice of handbook change, attached dated 1/17/2020.

Legal Entity Representative

Wendy J Muldrow — Wendy Muldrow, QS — 3/16/2020

Signature — Printed Name and Title — Date

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☒ Implemented

☐ Not Implemented

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

The most recent assessment for resident #11 was completed on 12/10/18.

Repeat violation: 11/25/19, 7/31/19

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.)

The assessment was updated immediately after survey 1/8/2020.

An audit of the existing assessments was completed to verify compliance. All residents have a current assessment or rasp on file.

The executive director will review assessment due dates weekly with the health and wellness director to verify ongoing compliance.

immediate and ongoing.

Legal Entity Representative

Signature | Wendy Mildner, ED | 9/16/2020
Printed Name and Title | Date

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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 #10 was admitted to the secured dementia care unit on 2/11/19; however, the written cognitive preadmission screening was completed on 2/6/19.

Repeat violation: 7/31/19, 9/23/19.

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 moved in before this executive director started working. All pre-screens since ED started 9/1/2019 are completed with dates in compliance with the regulation.

The executive director, or designee, reviews the pre-screen on move in and for any in-house transfers to the SDCU.

Immediate and ongoing

Legal Entity Representative

Signature | Wendy Mildner, QIDP | 3/16/2020
Printed Name and Title | Date

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☐ 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 #10 was admitted to the secured dementia care unit on 2/11/19; however, the support plan was completed on 2/15/19.

Repeat violation: 9/23/19.

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 moved in before the current executive director started working, 9/1/2019. All residents moving into the SDCU since ED started have support plan dates compliant with the regulations.

The executive director, or designee, review SDCU move in within 72 hours to verify compliance.

Immediate and ongoing.

Legal Entity Representative

Wendy Meadows Wendy Meadows 3/16/2020
Signature Printed Name and Title Date

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