COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **NORTHLAND HEIGHTS LLC**
LEGAL ENTITY

To operate **NORTHLAND HEIGHTS**
NAME OF FACILITY OR AGENCY

Located at **4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

To provide **Assisted Living-Special Care**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **123**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 19

Restrictions:

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

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 4, 2020** until **February 4, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450840**

Robert E. Robinson
ISSUING OFFICER

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

HS 628 – 7/19

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: February 7, 2020

Mr. Jack Turesky
President / COO
Northland Heights, LLC
10 Lafayette Square, Suite 1900
Buffalo, New York 14203

RE: Northland Heights
4859 McKnight Road
Pittsburgh, Pennsylvania 15237
License/COC #: 450840

Dear Mr. Turesky:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on December 12, 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. 2800 (relating to Assisted Living Residence), 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 § 2800.11(b) (relating to procedural requirements for licensure or approval of assisted living residences) 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 Licensing Inspection Summary were found. All citations specified on the Licensing Inspection Summary must be corrected by the dates specified on the Licensing Inspection Summary and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

Your NEW license is enclosed.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

RECEIVED
1/29/2020
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *NORTHLAND HEIGHTS* **License Number**: *450840*
Address: *4859 MC KNIGHT ROAD, PITTSBURGH, PA 15327*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: *CHERYL FESTER* **Phone**: *724.638.6088* **Email**:

Legal Entity

Name: *NORTHLAND HEIGHTS, LLC*
Address: *10 LAFAYETTE SQUARE , SUITE 1900, BUFFALO, NY, 14203*

Certificate(s) of Occupancy

Type: *C-1* **Date**: *01/21/2020* **Issued By**: *Ross Township*

Staffing Hours

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

Inspection

Type: *Partial* **BHA Docket #**: **Notice**: *Announced*
Reason: *New*

Inspection Dates and Department Representative

12/12/2019 - On-Site: Laurie Garrigan, Cindy Mulick

12/16/2019 - Off-Site: Laurie Garrigan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *123* **Residents Served**: *0*

Special Care Unit

In Home: *Yes* **Area**: *2nd floor* **Capacity**: *19* **Residents Served**: *0*

Hospice

Current Residents: *0*

Number of Residents Who:

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

3d Post license/VR/Regs

Requirements

2800.

3.d. The assisted living residence 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 assisted living residence.

Description of Violation

At 10:37 a.m., a copy of 55 PA. Code Chapter 2800 was not posted in a conspicuous and public place in the home.

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 2800 DHS Regulations were placed on the receptionist desk counter on 1/22/2020. The Administrator or designee will check placement at least monthly, for six months, and document on Building Checklist beginning January 22, 2020. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A'.

Legal Entity Representative

Cheryl Fester — Signature

Cheryl Fester, Administrator — Printed Name and Title

01/29/2020 — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

14a Fire Safety Approval

Requirements

2800.

14.a. Prior to issuance of a license, a written fire safety approval from the Department of Labor and Industry, the Department of Health or the appropriate local building authority under the Pennsylvania Construction Code Act (35 P. S. § § 7210.101—7210.1103) is required.

Description of Violation

On 12/12/2019 the residence had a temporary certificate of occupancy that was issued on 10/1/2019. The certificate stated "This occupancy is strictly to allow state agencies access to perform their inspections. No employees or training are permitted on sight until the issuance of a permanent certificate of occupancy."

On 12/16/2019, the residence submitted another certificate of occupancy that expires on 1/15/2020 and states "Final inspection report accessibility items to be inspected per approved plans prior to permanent certificate of occupancy issuance."

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 Certificate of Occupancy was issued 1/21/2020 and was posted at the Reception Desk by the Administrator. Placement will be monitored by the Administrator or designee monthly, for six months, on the Building Checklist beginning 1/22/2020. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'B'.

Legal Entity Representative

Signature	Printed Name and Title	Date
Cheryl Fester	Cheryl Fester, Administrator	01/29/2020

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

18 Other laws, regs, ordins.

Requirements

2800.

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

Description of Violation

According to the Influenza Awareness Act standards of July 2016, homes are required to post a copy of the Influenza Awareness Poster in a public and conspicuous place. However, a copy of the Influenza Awareness Poster was not posted in the residence.

According to the Clean Indoor Air Act of 2008, if smoking is prohibited in assisted living residences, the residence must post a sign at each entrance that states "No Smoking" or has the international "No Smoking" symbol. The residence's policy prohibits smoking; however, there were no signs were posted indicating "No Smoking."

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.)

Influenza posters were posted on 12/12/19. The posters were placed in the lobby, at the reception desk and by the resident mailboxes. On 1/22/2020 the Administrator checked for placement. The Administrator or designee will monitor at least monthly, for six months, and log on the Building Checklist that posters are in place. Monitoring began 1/22/2020. Director of Personal Care will replace missing posters as needed.
Attachment "C"

On 12/18/19, "No Smoking" signs were posted on the exterior of the building to the right and left of entrance doors. The Maintenance Director or designee will monitor at least monthly for six months, for placement and document on the Building Checklist. Monitoring began 1/22/12020. The Maintenance Director will replace signs if missing or not legible on an as needed basis. Attachment "D"

All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A'.

Legal Entity Representative

Cheryl Fester — Signature

Cheryl Fester, Administrator — Printed Name and Title

01/29/2020 — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

42s Privacy - self/possessions

Requirements

2800.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home is video recording at the main entrance, elevator, stairwells and outside in the front and back patio areas. However, there were no signs posted indicating that images were being recorded.

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 similarviolation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 12/18/19, a "Video Surveillance" sign was posted in the lobby by the Maintenance Director. On 1/22/2020, the Admiinistrator placed video surveillance notifications on each perimeter exit door. Administrator or designee will moitor for placement of nitifications at least monthly for six months and document on the Building Checklist and replaced as needed. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A' and 'C'.

On 1/28/2020, a privacy block was digitally placed over the elevator view and south hall on the camera. The privacy block will be monitored by the Administrator or designee at least monthly for six months and documented on the Building Checklist. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

Cheryl Fester — Signature

Cheryl Fester, Administrator — Printed Name and Title

01/29/2020 — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

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

85d Trash cans – kitchen/bath

Requirements

2800.

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 9:49 a.m., there was a 3/4 full uncovered cardboard box of trash in the first floor women's common bathroom across from the activity 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.)

On 12/16/19 the cardboard box was removed from the bathroom and replaced with steel trash cans. Trash cans were emptied by staff as the receptacles were half full. The Administrator educated staff on 1/22/2020, to check the trash receptacles. The Maintenance Director or designee will check all trash receptacles in the first-floor bathrooms at least monthly, for six months and log on the Building Checklist. The checks began 1/22/2020. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A'

Legal Entity Representative

Cheryl Fester
Signature

Cheryl Fester, Administrator — 01/29/2020
Printed Name and Title — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

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

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

87 Lighting

Requirements

2800.

87. Lighting - The residence's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The following exit doors not located in the special care unit (SCU) of the residence were set to a "night mode" configuration that locked the doors with a 15 second pressure panic bar:

- The 2 exit doors from the main dining room to the dining room patio
- The exit door from the hallway to the patio near the activity room
- The 1st floor north end hallway exit by the activity room

However, there were no signs indicating "Push until alarm sounds. Door can be opened in 15 seconds" or similar directions for operation of the doors.

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 1/30/2020, the wanderguard locking feature was removed from all doors on the 1st floor. Doors now all provide free egress while on day mode and delayed egress while on night mode 8pm-8am. Instructions for operating each door when on night mode have been posted on each door's push bar. "When door is on night mode, 8pm-8am, push the bar until the alarm sounds. Continue to push bar for 15 seconds at which time the door will open. Verification of the system will be performed at least monthly, for six months, by Maintenance Director or designee and documented on the Building Checklist. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting, April 2020.

See attachment 'A' and 'B'

Legal Entity Representative

Cheryl Fester — Signature

Cheryl Fester, Administrator — Printed Name and Title

01/31/2020 — Date

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

The above plan of correction is approved as of 1/31/2020 (Date)

Plan of correction implementation status as of 1/31/2020 (Date)

☑ Implemented
☐ Not Implemented

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

96c First aid kit - Accessible

Requirements

2800.

96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

The residence's automatic external defibrillation device was located in the Staff person A's office, which is locked when she is not present. The case for the external defibrillation device was empty and on the floor behind the main reception area.

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 12/12/19, the Maintenance Director hung the defibrillator cabinet and defibrillator in the reception area. The Administrator educated staff where the defibrillator is located. On 1/22/2020, the Administrator checked and logged on the Building Checklist that the defibrillator is located at the Receptionist area. Administrator or designee will monitor the placement and log onto the Building Checklist at least monthly for six months. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A', 'F' and 'G'.

Legal Entity Representative

Cheryl Fester
Signature

Cheryl Fester, Administrator — 01/29/2020
Printed Name and Title — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

103f Fridge/Freezer Temps

Requirements

2800.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:44 a.m., there was no thermometer in the freezer compartment of the first floor activity room freezer.

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 12/12/19 the Culinary Director placed a thermometer in the Activity Room freezer. The Culinary Director or designee have been recording the temperature daily. On 1/22/2020 the Culinary Director educated members of the Culinary and Recreation departments in proper freezer temperatures. Monitoring by the Culinary Director or designee of the thermometer will continue at least monthly for six months. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'H'.

Legal Entity Representative

Cheryl Fester
Signature

Cheryl Fester, Administrator
Printed Name and Title

01/29/2020
Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

121a Unobstructed egress

Requirements

2800.

121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

The following exit doors not located in the SCU of the residence, were equipped with a locking wander system requiring a keypad to override and no codes were posted for operation of the locking device:

- The 2 exit doors from the main dining room to the dining room patio
- The exit door from the hallway to the patio near the activity room
- The 1st floor north end hallway exit by the activity room

At 10:54 a.m., there was no sign indicating "not an exit" on the door leading to the gated front patio near the first floor activity room and at 11:11 a.m., there was no sign indicating "not and exit" on the door leading to the enclosed 2nd floor patio in the special care unit.

At 11:20 a.m., there were two large card board boxes and two long metal painting roller handles blocking the egress route in stairwell B-2 and at 11:45 a.m., there was a ladder in stairwell #1 between the 6th floor and 7th floor blocking the egress route.

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 1/30/2020, the wanderguard locking feature has been permanently removed from all doors on the 1st floor. Doors now all provide free egress while on day mode and delayed egress while on night mode, 8pm-8am. Verification of the system will be performed at least monthly, for six months, by Maintenance Director or designee and documented on the Building Checklist. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

(Video demonstration attached to email)

(Please see next page for continuation).

See attachment 10a of 15 1/30/2020

Legal Entity Representative

Signature

Cheryl Fester, Administrator — Printed Name and Title

01/29/2020 — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

121(a) continued:

On 12/18/19 the Administrator posted signs "Not an Exit" on the door leading to the gated front patio and the door leading to the enclosed 2nd floor patio in the SCU. On 1/22/2020, the Administrator checked signs for placement. The Administrator or designee will monitor at least monthly, for six months, for placement and document on the Building Checklist. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A'.

Items in stairwell #1 and B-2 were removed on 12/12/19. On 1/22/2020, the Maintenance Director checked stairwells for items preventing egress. Monitoring by Maintenance Director or designee will be conducted at least monthly documenting, on the Building Checklist. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A'.

Cheryl Fester Cheryl Fester, Administrator 01/29/2020

121b Locking device approval

Requirements

2800.

121.b. Except as provided in § 2800.101 (relating to resident living units), doors used for egress routes from living units and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the residence has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

The following exit doors not located in the SCU of the residence were locked with a 15 second pressure panic bar as well as a wander guard system with a keypad override that locks when a resident wearing a wander guard is between 10-15 feet from the door:

- The 2 exit doors from the main dining room to the dining room patio
- The exit door from the hallway to the patio near the activity room
- The 1st floor north end hallway exit by the activity room

The residence does not have written approval or a variance from the Department of Labor and Industry, The Department of Health or the local building authority for use of the locking system in the assisted living section of the building.

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 1/30/2020, the wanderguard locking feature has been permanently removed from all doors on the 1st floor. Doors now all provide free egress while on day mode and delayed egress while on night mode8pm-8am. Verification of the system will be performed at least monthly, for six months, by Maintenance Director or designee. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting, April 2020. [video demonstration attached to email]

Legal Entity Representative

Cheryl Fester

Signature

Cheryl Fester, Administrator — Printed Name and Title

01/29/2020 — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

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

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

124 Notice to fire department

Requirements

2800.

124. The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The residence does not have documentation of written notification to the local fire Department of the address of the residence, location of the living units and bedrooms, and the assistance needed to evacuate in an emergency.

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 1/4/2020 an email was sent to the Ross Township Fire Marshall providing the address of Northland Heights, location of living units and bedrooms, and the assistance needed to evacuate in case of an emergency (see attached email). There are currently no residents served in the residence; this was included in the email. Beginning 1/29/2020, the Administrator or designee will send monthly emails to the Fire Marshall detailing the locations of the residents and their physical or cognitive needs for assistance to evacuate the building. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'J'.

Each resident will be assessed by the Director of Personal Care or designee, upon admission or a significant change, to determine the resident's evacuation needs. The results of these assessments will be kept in a binder located at the reception desk and given to emergency personnel if an emergency situation occurs. This binder will be updated weekly by the Director of Personal Care or designee and reviewed at the quarterly Quality Assurance meeting in April 2020.

Legal Entity Representative

Signature	Printed Name and Title	Date
Cheryl Fester	Cheryl Fester, Administrator	01/29/2020

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

131f Fire extinguisher inspection

Requirements

2800.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the basement near the elevators had not been inspected by a fire safety expert since June of 2018.

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 1/15/2020, the fire extinguisher in the basement was replaced by the Maintenance Director.

The Maintenance Director performed an audit of all fire extinguishers in the facility on 1/21/2020 and verified that all fire extinguishers are inspected and the dates are clearly visible on the extinguisher. These audits will be conducted monthly by the Maintenance Director. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

Attachment 'I'

Legal Entity Representative

Cheryl Fester
Signature

Cheryl Fester, Administrator — 01/29/2020
Printed Name and Title — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

132b Safety inspection/fire drill

Requirements

2800.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The residence did not have a fire safety inspection conducted by a fire safety expert.

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.)

Ross Township Fire Marshall conducted a fire safety inspection on 12/13/2019. A copy of that inspection report has been provided to the Department of Human Services. Another fire safety inspection and drill will be conducted in conjunction with the Ross Township Fire Marshall on or before 12/12/2020.

On 1/28/2020 the facility clarified with the Ross Township Fire Marshall that the fire safety areas on floors #2 through #6 are located in the middle/center of each floor's hallway on either side, north or south, of the fire safety doors on those floors, and additionally that on floor #1 the fire safety area is to exit to the outside via an appropriate exit door. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

Attachments 'L + M'

Legal Entity Representative

Cheryl Fester
Signature

Cheryl Fester, Administrator 01/29/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented

233c Key-locking devices

Requirements

2800.

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 directions for operating the residence's locking mechanism are not conspicuously posted near the following exits in the special care unit:

- The elevator
- The 2nd floor back exit leading to the upper parking lot

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 1/22/2020 signs were posted near the locking mechanism keypad on the elevators and 2nd floor back exit leading to the upper parking lot. These signs stated the code for exiting those areas. The Administrator or designee will conduct a walk-through at least monthly for six months, monitoring for sign placement and documenting on the Building Checklist. All violations will be reviewed for compliance at the quarterly Quality Assurance meeting in April 2020.

See attachment 'A', N, O'

Legal Entity Representative

Cheryl Fester — Signature

Cheryl Fester, Administrator — Printed Name and Title

01/29/2020 — Date

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

The above plan of correction is approved as of 1/30/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 1/30/2020 (Date)

☑ Implemented
☐ Not Implemented