

Department of Human Services
Bureau of Human Service Licensing

February 22, 2021

JOHNATHAN BAILEY, BOARD PRESIDENT
PARTNERS IN SENIOR CARE INC
ONE ELSTON WAY
HERMITAGE, PA 16148

RE: RIDGEWOOD AT SHENANGO
VALLEY
ONE ELSTON WAY
HERMITAGE, PA, 16148
LICENSE/COC#: 40302

Dear Mr. Bailey,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/05/2020, 10/21/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC**

Facility Information

Name: *RIDGEWOOD AT SHENANGO VALLEY* License #: *40302* License Expiration Date: *07/02/2021*
 Address: *ONE ELSTON WAY, HERMITAGE, PA 16148*
 County: *MERCER* Region: *WESTERN*

Administrator

Name: *Robin Knight* Phone: *7243470998* Email: *rknight@sp1867.org*

Legal Entity

Name: *PARTNERS IN SENIOR CARE INC*
 Address: *ONE ELSTON WAY, HERMITAGE, PA, 16148*
 Phone: *724-589-6245* Email: *baileyjr@upmc.edu; suzquinn@pa.gov*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *08/28/1998* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *27* Waking Staff: *20*

Inspection

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal,Incident* Exit Conference Date: *10/21/2020*

Inspection Dates and Department Representative

03/05/2020 - On-Site: Joe Eveges, Trish Bartlett
10/21/2020 - On-Site: Joe Eveges, Trish Bartlett

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *52* Residents Served: *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *23*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *4* Have Physical Disability: *0*

Inspections / Reviews

03/05/2020 - Full

Lead Inspector: *Joe Eveses*Follow-Up Type: *POC Submission*Follow-Up Date: *12/19/2020*

12/23/2020 - POC Submission

Lead Reviewer: *Suzy Quinn*Follow-Up Type: *POC Submission*Follow-Up Date: *12/28/2020*

1/14/2021 - POC Submission

Lead Reviewer: *Suzy Quinn*Follow-Up Type: *Document Submission*Follow-Up Date: *02/01/2021*

2/22/2021 - Document Submission

Lead Reviewer: *Suzy Quinn*Follow-Up Type: *Not Required*

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Repeat Violation

On 10/6/20 at 4:00 PM, direct care staff A used resident #1's glucometer to measure the blood glucose level for resident #2.

Repeat Violation: 02/14/2019

Plan of Correction

Directed

1. Resident #1 glucometer was removed from service on 10-7-2020 and replaced with a new glucometer purchased by the home.
2. Resident, responsible party and physician notified 10-7-2020
2. The machine and storage bag for both Resident #1 and Resident #2 and all other residents who receive glucometer checks have been labeled clearly with resident name.
3. Any new resident with glucometer checks will have machine and storage bag labeled upon admission or upon any new order for glucometer checks.
4. Staff member was re-educated on 10/14/2020 regarding obtaining blood sugar using the proper machine for each resident(see #1 attachment)
5. The daylight lead PCA/LPN will continue daily audits of each individual machine. The previous days blood sugar readings on MAR are compared with readings on machine.
6. Any discrepancy will be reported to administrator immediately.

(Directed)-

Immediately upon receipt, weekly thereafter for 3 months and monthly thereafter for 3 months, the administrator or designated staff person qualified to administer medication shall observe each staff person responsible for diabetic care perform blood glucose checks to ensure each resident glucometer is used only for the resident to whom it belongs. Documentation shall be kept for Department review. **S.Q. 1/8/21**

(Directed)-

By 2/8/21, all staff responsible for blood glucose testing shall receive re-training from a certified diabetic educator. Documentation shall be kept for Department review. **S.Q 1/8/21**

(Directed)-

By 2/8/21, the home shall review and amend the home's policies regarding §2600.185a, specifically addressing the safe storage, access, distribution, and use of glucometers and testing equipment. A copy of the updated policy will be provided to and reviewed with all medication administration staff. Documentation shall be kept for Department review. **S.Q. 1/8/21**

Completion Date: 10/07/2020

Document Submission

Implemented

See 2-17-21 attachments

2. Requirements

2600.

85a - Sanitary Conditions *(continued)*

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/5/20, a garbage bag containing a soiled brief was on the ground outside the common lounge exit door between the 400 and 500 wings.

Plan of Correction

Accept

1. *Garbage was removed immediately.*
2. *A garbage can with lid was added outside the door.*
3. *Trash will be placed in that can outside until removed to dumpster.*
4. *Trash is taken to dumpster each shift and dumpster is emptied weekly.*
5. *During weekly building walk thru Administrator will ensure compliance.*

Completion Date: 03/06/2020

Document Submission

Implemented

See 85.a attachment

85d - Trash Receptacles

1. Requirements

2600.

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

Description of Violation

On 3/5/20, there was an uncovered trash can, approximately ¼ full, next to the dish wash station in the kitchen.

Plan of Correction

Accept

1. *Lid was beside garbage can near the dish wash station.*
2. *Lid was applied at time of inspection 3-5-2020.*
3. *All dining staff re-educated verbally 3-5-2020 regarding the regulation.*
4. *Dining manager will conduct weekly audit to ensure compliance.*
5. *Dining manager will conduct dining staff mtg. by 2/28/21 to review regulation.*

Completion Date: 02/28/2021

Document Submission

Implemented

see 2-17-21 attachments

91 - Telephone Numbers

1. Requirements

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.

91 - Telephone Numbers *(continued)*

Description of Violation

On 3/5/20, there were no emergency telephone numbers to include the nearest hospital and fire department on or by the white cordless telephone next to the beverage area in the kitchen.

Plan of Correction

Accept

1. *Emergency sticker was added 3/6/2020(see attachment #4)*
2. *Dining manager will audit phones in kitchen area including beverage room weekly.*
3. *Housekeeper will check all resident phones during weekly housekeeping.*
4. *By 2/1/2021 all staff will be educated by LPN nurse educator and/or administrator on the regulation.*

Completion Date: *02/21/2021*

Document Submission

Implemented

See 2-17-21 attachments

95 - Furniture and Equipment

1. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/5/20, there was a 3/8" gap between the 2 fire doors next to bedrooms #301 and #302.

On 3/5/20, there was a 1/2" gap between the 2 fire doors next to bedrooms #501 and #502.

Plan of Correction

Accept

1. *The doors were repaired by adding a vertical fire door extension on 6-10-2020(see #2 and #3 attachments)*
2. *All staff shall be educated by 1/30/2021 regarding the requirement that furniture and equipment must be in good repair, clean and free of hazards.*
3. *During monthly maintenance rounds fire doors will be inspected,*

Completion Date: *01/31/2021*

Document Submission

Implemented

See 2/17/21 attachments

103f - Refrigerator/Freezer Temps

1. Requirements

2600.

- 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

On 3/5/20, there was no thermometer in the freezer section of the white stand up refrigerator/freezer in the kitchen.

On 3/5/20, there was no thermometer in the silver Hoshizaki double door refrigerator in the kitchen.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction

Accept

1. A thermometer was added to both the stand up refrigerator/freezer and the double door refrigerator in the kitchen on 3/6/2020(see attachment #5 and #6)
2. All dining staff was educated verbally 3/6/2020 on this regulation.
3. Staff will verify presence of thermometer daily while doing temperature checks, a log is maintained.
4. Weekly the dining manager will verify that all refrigerators in the kitchen have the required thermometer.
5. By 2/28/2021 dining manager will hold staff mtg. and discuss this regulation.

Completion Date: 02/28/2021

Document Submission

Implemented

See 2-17-21 attachments

103g - Storing Food

1. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 3/5/20, there was an unsealed bag of white bread in the bread refrigerator.

Plan of Correction

Accept

1. Twist tie was added to unsealed bag of bread 3/5/2020.
2. Dining staff was re-educated by dining manager on 3/5/2020 regarding this regulation.
3. Weekly audits will be conducted by dining manager to ensure compliance.
4. Dining manager will hold staff mtg. by 2/28/21 to discuss this regulation.

Completion Date: 02/28/2021

Document Submission

Implemented

See 2-17-21 attachments

121a - Unobstructed Egress

1. Requirements

2600.

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

Description of Violation

On 3/5/20, the gate leading from the courtyard to the back walkway was locked and could not be opened from the inside of the courtyard to evacuate.

121a - Unobstructed Egress (continued)

Plan of Correction

Directed

- 1. Gate was unlocked immediately 3/5/2020.
- 2. Mag lock system will not be engaged (due to withdrawal of request for SDCU)(9-2-2020) Is no longer necessary that the gate locks.(see attachments #7,8,9)
- 3. By 2/1/2021 Mag lock and card reader will be removed.
- 4. During the week Maintenance will be responsible to ensure all areas of egress are free and clear of obstacles . On weekends the lead PCA/LPN on daylight will ensure areas of egress are clear.
- 5. By 2/1/2021 all staff will be educated on this regulation.

(Directed)-

Immediately upon receipt and daily thereafter, step 4 indicated above shall be completed at least daily. **S.Q. 1/8/21**

Completion Date: 02/01/2021

Document Submission

Implemented

See 2-17-21 attachments

123c - Evacuation Diagrams

1. Requirements

2600.

- 123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

On 3/5/20, the fire evacuation diagram next to bedroom #301 was not correctly oriented. The diagram indicated the line of travel to the exit door was straight ahead; however, the line of travel to the exit door was to the right.

Plan of Correction

Accept

- 1. The fire evacuation diagram was corrected 3/6/2020 to indicate correct line of travel to exit(see attachment #11)
- 2. All other diagrams in building were checked to ensure correct line of travel to exits
- 3. Maintenance will monthly while conducting extinguisher audit ensure that diagrams are place throughout building.

Completion Date: 03/06/2020

Document Submission

Implemented

See attachments

133.1 - Exit Signs

1. Requirements

2600.

- 133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

133.1 - Exit Signs *(continued)*

Description of Violation

On 3/5/20, there was no exit sign posted at the courtyard gate or any signage indicating direction of evacuation visible from the home's courtyard. On 3/5/20, the home served 21 residents.

Plan of Correction

Accept

- 1. Exit sign was added to the courtyard gate(see attachment #12)*
- 2. Directional exit signs were also added when you evacuate the interior wings of building(see attachments #13,14)*
- 3. Maintenance during monthly fire extinguisher audits will ensure signs are present.*

Completion Date: *12/15/2020*

Document Submission

Implemented

See attachments

141b1 - Annual Medical Evaluation

1. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Repeat Violation

On 10/21/20, resident #3's most recent medical evaluation was dated 11/13/19. However, the previous medical evaluation was dated 10/25/18.

Repeat Violation: 02/14/2019

Plan of Correction

Accept

- 1. Audit was conducted 10/26/2020 and those needing updates/appts. were scheduled.*
- 2. On*
- 2. Resident Care Coordinator will be responsible to ensure DME's are conducted annually. This will be done by using an excel spread sheet.*
- 3. Beginning 1/1/2021 LPN staff educator will audit DME's monthly, documentation shall be kept.*
- 4. Administrator will meet with Resident Care Coordinator by 1/8/2021 and review this regulation to ensure expectations are understood.*

Completion Date: *01/08/2021*

Document Submission

Implemented

See 2-17-21 attachments

144b - Policy on Smoking

1. Requirements

2600.

144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

144b - Policy on Smoking (continued)

Description of Violation

On 3/5/20, there was a sign outside the exit door next to bedroom #509 indicating, "This is a no smoking facility." However, the home does permit smoking in the designated smoking area on the back dock and the home rules state that smoking is permitted in designated areas.

Plan of Correction

Accept

1. This sign was removed 3/6/2020 (see attachment #15)
2. The exterior of the building including all exit doors were inspected(3/6/2020) to ensure there were no signs present indicating No Smoking.

Completion Date: 03/06/2020

Document Submission

Implemented

Removed sign - see attachments

185a - Implement Storage Procedures

1. Requirements

2600.

- 185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 10/21/20, resident #4's glucometer was not calibrated to the correct time.

Plan of Correction

Accept

1. Resident #4's glucometer was calibrated to correct time on 10/21/2020
2. All glucometers will have correct date and time verified when a new meter is put in place, when time changes occur and when batteries are replaced.
3. By 2/1/2021 all med trained staff will be educated by LPN staff educator or administrator on process and regulation.
3. During daily accucheck audits conducted by daylight lead PCA the correct date and time shall be verified.

Completion Date: 02/01/2021

Document Submission

Implemented

See 2-17-21 attachments

225c - Additional Assessment

1. Requirements

2600.

- 225.c. The resident shall have additional assessments as follows:
 1. Annually.

Description of Repeat Violation

On 10/21/20, resident #3's most recent assessment was dated 11/28/19. However, the resident's previous assessment is dated 10/28/18.

Repeat Violation: 02/14/2019

225c - Additional Assessment *(continued)***Plan of Correction****Accept**

1. *Audit of assessments will be conducted by Resident Care Coordinator and LPN Staff educator by 2/15/2021*
2. *Assessments will be completed by Resident Care Coordinator timely in conjunction with DME's that are tracked via spreadsheet.*
3. *Audits will be conducted monthly by LPN staff educator.*
4. *Administrator will met with Resident Care Coordinator by 1-8-2021 to educate on this regulation and to ensure expectations are understood.*

Completion Date: 01/08/2021**Document Submission****Implemented***See 2-17-21 attachments*