Department of Human Services
Bureau of Human Service Licensing

February 16, 2021

[redacted] PRESIDENT & CEO
VALLEY MEDICAL FACILITIES INC
720 BLACKBURN ROAD
SEWICKLEY, PA 15143

RE: THE RESIDENCE AT WILLOW LANE
30 HECKEL ROAD
MCKEES ROCKS, PA, 15136
LICENSE/COC#: 45191

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/25/2021, 01/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jon Kimberland

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

Facility Information

Name: *THE RESIDENCE AT WILLOW LANE* **Licen e #**: *45191* **Licen e Expiration Date**: *07/01/2021*
Addre : *30 HECKEL ROAD, MCKEES ROCKS, PA 15136*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *412-331-1820* **Email**: [redacted]

Legal Entity

Name: *VALLEY MEDICAL FACILITIES INC*
Address: *720 BLACKBURN ROAD, SEWICKLEY, PA, 15143*
Phone: *412-331-1820* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/26/1997* **Issued By**: *L&I*
Type: *Other* **Date**: *04/30/2021* **Issued By**: *Allegheny County Health Department*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *85* **Waking Staff**: *64*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *01/26/2021*

Inspection Dates and Department Representative

01/25/2021 - On-Site: [redacted]
01/26/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *107* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Pathways* **Capacity**: *17* **Residents Served**: *13*

Hospice

Current Re ident : *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *54*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *29* **Have Physical Disability**: *1*

Inspections / Reviews

01/25/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *02/11/2021*

2/10/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/15/2021*

2/16/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

On 1/25/2021 at approximately 11:10 a.m., there was no carbon monoxide detector located near the home's first floor laundry room containing UniMac and Cissell natural gas operated industrial clothes dryers. The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, requires that "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from any fossil fuel burning device or appliance."

On 1/25/2021 at approximately 11:15 a.m. in the home's basement there is a carbon monoxide detector affixed to the ceiling that is within 15 feet of 3 natural gas operated hot water heaters. The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, requires that "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel burning device or appliance."

Repeat violation 7/10/2020

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• A carbon monoxide detector was installed in the first floor laundry room immediately during the survey. The carbon monoxide detector in the basement was moved to be within 15 ft. of the three water heaters.

• All other carbon monoxide detectors were audited to ensure that each of them was in close proximity, but not less than 15 ft., from any fossil fuel burning appliance.

• The Director of Environmental Services was educated on the Carbon Monoxide Alarms Standard Act and the importance of installing carbon monoxide detectors within 15 ft. of fossil fuel burning appliances.

• Audits will be performed by the Director of Environmental Services or designee weekly for 4 weeks then monthly for 2 months.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date: *03/02/2021*

18 - Compliance With Laws *(continued)*

Document Submission	Implemented
Photos of detector placement	
Audit of other detectors near fossil fuel burning appliances	
Education of Director of Environmental Services	
Audits weekly for 4 weeks monthly for 2 months	
Review at QA	

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A whose first day of work was [redacted] *did not receive training required for orientation until 10/8/2020 to include:*

(1) Evacuation procedures

(2) Duties during fire drills, emergency evacuation, transportation and emergency location

(3) Designated meeting place outside the building or within fire safe areas in the event of a fire

(5) Location and use of fire extinguishers

(6) Smoke detectors and fire alarms

65a - FS Orientation 1st Day *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• All managers were educated on 65a – which requires training on the first work day for fire safety and emergency preparedness that includes:

? Evacuation procedures

? Staff duties and responsibilities during fire drills

? Designated meeting place outside the building or within a fire-safe area in the event of a fire

? Smoking safety procedures

? Location and use of fire extinguishers

? Smoke detectors and alarms

? Telephone use and emergency services

• The Executive Director or designee will audit the general orientation check off forms for timeliness of the completion on all new hires as each orientation day is scheduled.

• Audit results will be reviewed at the facility's Quality Management committees for further review and any recommendations.

Completion Date: *03/02/2021*

Document Submission **Implemented**

Managers educated on required training for 1st day of work.
Audit of orientation of new employees to make sure required training done on first day.
Review results in Quality Management meeting.

81b - Resident Personal Equipment

1. Requirements

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

On 1/25/2021 at approximately 1:10 p.m. in resident room #[redacted] the enabler bar for resident #1 is mounted to the left side of the resident's bed and has an uncovered opening measuring approximately 6 inches wide by 8 inches high. The enabler bar is attached to the mattress frame and located between the resident's bedside table/light and the resident's pillows creating a risk of limb entanglement for resident #1.

81b - Resident Personal Equipment *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• Resident #1's enabler bar was immediately covered during the survey.

• The Director of Residential Care Services completed a whole house audit during the survey and one other enabler was identified and covered.

• The department managers and direct care staff were educated on 81b – wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good condition, and free of hazards.

• The therapy department will notify the Director of Residential Care Services when a device is issued to a resident to ensure that it is clean, in good repair, and free of hazards.

• Such devices will be audited by the Director of Residential Care Services or designee weekly for 4 weeks and then monthly for 2 months.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date: *03/02/2021*

Document Submission **Implemented**

Enabler bar was immediately covered during the survey.
A whole house audit was completed during the survey.
Managers and direct care staff educated on regulation.
Therapy department form put into place to notify Resident Care Director of added resident personal equipment so it can be monitored.
Weekly audits for 4 weeks then monthly for 2 months.
Results reviewed in Quality Management.

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.

Description of Violation

On 1/25/2021 at approximately 10:15 a.m. emergency telephone numbers to include the nearest hospital and fire department were not posted on or by the telephone located to the right of the emergency exit door in the home's dining room.

91 - Telephone Numbers *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• Numbers for the nearest hospital and fire department were immediately posted by the phone near the exit door in the dining room.

• All other phones in the fac lity that have lines to calls outside of the facility were audited to ensure that emergency numbers were posted appropriately.

• All managers were educated on 91 – emergency telephone numbers – telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management, and personal care complaint hotline on or by each telephone with an outside line.

• The Director of Environmental Services or designee will audit weekly for 4 weeks and then monthly for 2 months to ensure that emergency numbers are posted.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date: *03/02/2021*

Document Submission **Implemented**

Photo of phone identified during the survey that has the emergency phone list attached.
Audit of phones throughout the facility that have outside lines.
Managers were educated on the regulation.
Weekly audit for 4 weeks and then monthly for 2 weeks.
Results reviewed at the Quality Management meeting.

101j7 - Lighting/Operable Lamp

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 1/25/2021 at approximately 11:45 a.m., the bedside light in resident room [redacted] belonging to resident #2 in the Pathways secured dementia care unit is inoperable.

101j7 - Lighting/Operable Lamp *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• A light bulb was replaced in Resident #2's lamp immediately during survey.

• The Director of Environmental Services and designees completed a whole house audit to ensure all other residents did not have a lamp that was inoperable.

• Department managers and direct care staff were educated on 101j7 that each resident shall have an operable lamp or other source of lighting that can be turned on at bedside.

• Random audits will be conducted by the Director of Environmental Services or designee weekly for 4 weeks then monthly for 2 months.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date: *03/02/2021*

Document Submission **Implemented**

The light bulb was replaced during the survey.
Whole house audit was completed to identify other lightbulb issues.
Managers and direct care employees were educated on the regulation.
Audits conducted weekly for 4 weekly and monthly for 2 months.
Results reviewed in the Quality Management meeting.

183d - Prescription Current

1. **Requirements**

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 1/26/2021 at approximately 12:05 p.m., "Risperidone 0.5MG - Take 1 tablet at bedtime routinely" prescribed for resident #3, was in the home's medication cart; however, the medication was discontinued on 1/11/2021.

183d - Prescription Current *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane s written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• The medication Risperidone 0.5 mg for Resident #3 was immediately removed from the medication cart.

• The Director of Resident Care Services (RN) and the Memory Care Coordinator (LPN) completed an audit of all remaining medication carts to ensure there were no other discontinued medications in the carts. None were found.

• The Director of Resident Care Services, Memory Care Coordinator, and Medication Technicians were educated on 183d which states that only current prescription, OTC, sample and CAM for individuals living in the home, may be kept in the home.

• Audits of all medication carts will be performed weekly for 4 weeks and then monthly for 2 months by the Director of Residential Care Services and/or the Memory Care Coordinator.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date *03/02/2021*

Document Submission **Implemented**

Medication immediately removed from the med cart.
Audit of all med carts completed.
Education of regulation done for RN, LPN and Med Techs.
Weekly audits of all med carts done for 4 weeks then monthly for 2 months.
Results reviewed in the Quality Management meeting.

184a - Labeling OTC/CAM

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for resident #4's Losartan Potassium 25MG indicates "Take 2 tablets by mouth in the morning, 1 tablet at 4 p.m., and 1 tablet at bedtime." However, the resident's physicians orders indicate "Take one tablet 3 times daily."

The pharmacy label for resident #4's Combigan Sol 0.2/0.5% indicates "Instill one drop every day into the right eye." However, the resident's physicians orders indicate "Instill 1 drop into right eye twice daily."

184a - Labeling OTC/CAM *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane s written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• A "directions changed" label was placed on Resident #4 s Losartan Potassium 25mg and Combigan Sol 0.2/0.5%.

• A whole house audit of all medication carts was completed by the Director of Residential Care Services and Memory Care Coordinator to ensure that all labels on medications match the physician order.

• The Medication Technicians will be educated on 184a, which indicates that the original container for prescription medications shall be labeled with a pharmacy label that includes: (1) The resident s name, (2) The name of the medication, (3) The date the prescription was issued, (4) The prescribed dosage and instructions for administration, and (5) The name and title of the prescriber.

• Audits of all medication carts will be performed weekly for 4 weeks and then monthly for 2 months by the Director of Residential Care Services and/or the Memory Care Coordinator.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date *03/02/2021*

Document Submission **Implemented**

"Directions changed" label placed on the meds.
Whole house audit of med carts.
Education of Med Techs on regulation.
Weekly audits of med carts for 4 weeks then monthly for 2 months.
Review of results in Quality Management meeting.

187d - Follow Prescriber's Orders

1. **Requirements**

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

*Resident #5 is prescribed Acetaminophen Tab 325mg Take 2 tablets (650mg) orally every six hours as needed for fever / pain *Not to exceed 3GM APAP/24HRS. However, the home only has Tylenol Extra strength over the counter 500MG caplets, and the resident was administered the incorrect dosage (1000MG) on 1/18/2021, 1/20/2021, 1/21/2021, and 1/22/2021.*

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• The correct dose of Acetaminaphen Tab 325 mg. was obtained for Resident #5.

• A whole house audit of all medication carts will be completed by the Director of Residential Care Services and Memory Care Coordinator to ensure that all medications are the proper dosage per physician orders.

• The Medication Technicians were educated on 187d, which states that the home shall follow the directions of the prescriber.

• Audits of all medication carts will be performed weekly for 4 weeks by the Director of Residential Care Services and/or the Memory Care Coordinator, then monthly for 2 months.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date: *03/02/2021*

Document Submission **Implemented**

Correct dose of medication was obtained.
Whole house audit of med carts completed.
Med Techs educated on regulation.
Weekly audits of med carts for 4 weeks and monthly for 2 months.
Review of results in Quality Management meeting.

234a - Admission Support Plan

1. Requirements

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 #6 was admitted to the homes secured dementia care unit on [redacted] *However, the home did not develop and implement a support plan within 72 hours prior to admission or within 72 hours following admission for resident #6.*

234a - Admission Support Plan *(continued)*

Plan of Correction **Accept**

This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Residence at Willow Lane agrees with the allegations and citations on the statement of deficiencies. The Residence at Willow Lane maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Residence at Willow Lane's written credible allegation of compliance. By submitting this plan of correction, The Residence at Willow Lane does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Residence at Willow Lane reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.

• Resident #6 had [redacted] support plan revised to reflect the transfer to a secured dementia unit.

• An audit will be conducted on all residents residing on the unit to ensure their support plan reflects that they were residing on a secured dementia unit.

• The Memory Care Coordinator was educated on 234a, that within 72 hours of admission to a secured dementia unit, a support plan shall be developed, implemented, and documented in the resident record.

• Audits of all new admissions to the secured unit will be completed to ensure that the support plan reflects admission on the secured dementia unit.

• Audit results will be reviewed at the facility Quality Management committee for further review and any recommendations.

Completion Date: *03/02/2021*

Document Submission **Implemented**

Resident support plan was updated.
Audit of all resident support plans on secured unit.
Education of Memory Care Coordinator of regulation.
Audit of new admissions for timely completion of support plans.
Results reviewed in the Quality Management meeting.