Department of Human Services
Bureau of Human Service Licensing

August 10, 2021

[redacted] FACILITY ADMINISTRATOR
PENNWOOD NURSING AND REHABILITATION CENTER LLC
909 WEST STREET
PITTSBURGH, PA 15221

RE: PENNWOOD NURSING AND REHABILITATION CENTER
909 WEST STREET
PITTSBURGH, PA, 15221
LICENSE/COC#: 45019

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/22/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Larry Mazza

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: *PENNWOOD NURSING AND REHABILITATION CENTER* **Licen e #**: *45019* **Licen e Expiration Date**: *06/03/2021*
Addre : *909 WEST STREET, PITTSBURGH, PA 15221*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *412-243-7800* **Email**: [redacted]

Legal Entity

Name: *PENNWOOD NURSING AND REHABILITATION CENTER LLC*
Address: *909 WEST STREET, PITTSBURGH, PA, 15221*
Phone: *4122437800* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-1* **Date**: *10/14/1992* **Issued By**: *Dept of Health*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal,Complaint* **Exit Conference Date**: *06/22/2021*

Inspection Dates and Department Representative

06/22/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* **Residents Served**: *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *17* **Are 60 Years of Age or Older**: *10*
Diagnosed with Mental Illness: *17* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

06/22/2021 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2021*

Inspections / Reviews *(continued)*

7/22/2021 - POC Submission

Lead Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *07/28/2021*

7/29/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/02/2021*

8/10/2021 - Document Submission

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

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, hired on [redacted], did not receive orientation on any of the topics specified in 2600.65a, to include evacuation procedures, staff duties and responsibilities during fire drills and the designated meeting place outside the building or within the fire safe area in the event of an actual fire.

Plan of Correction **Directed**

To ensure that all new hires and staff members receive the proper first day of work orientation that covers evacuation procedures, staff duties and responsibilities during fire drills, designated meeting place, smoking safety procedures, smoking policy, location and usage of fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services, the new employee orientation packet will include the Documentation of Direct Care Staff Training and Orientation paperwork to be filled out with all onboarding information including staff responsibilities. The administrator or the assistant to the administrator will conduct all new orientation intake sessions that will cover evacuation procedures moving forward.
This will allow for orientation to regulation 2600.65.a and make sure that documentation is included in the staff member's orientation file. A new hire checklist monitor will be put in place and checked monthly to ensure that all employee documentation is complete.

DIRECTED: Within 5 days of receipt of the plan of correction: Staff person A shall receive training on all topics specified in 2600.65a. Documentation of the training shall be kept in staff person A's record. LM 7/29/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall review all current staff person records to ensure each staff person has received training on all topics specified in 2600.65a. Documentation of the training shall be kept in each staff person's record. LM 7/29/21

Completion Date: *06/25/2021*

Document Submission **Implemented**

See attached

65b - Rights/Abuse 40 Hours

1. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.

65b - Rights/Abuse 40 Hours *(continued)*

2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, hired on [redacted], did not receive training on any topics specified in 2600.65b, to include resident rights, emergency medical plan and mandatory reporting of abuse and neglect under the Older Adult Protective Services Act.

Plan of Correction **Directed**

n an effort to maintain compliance with regulation 65b, Rights/Abuse 40 Hours, staff will be required to complete the Documentation of Direct Care Staff Training and Orientation packet as a part of the onboarding process. The staff training packet will be completed by all new staff with either the PC Administrator or the assistant to the administrator to ensure that all employees are properly educated on resident rights, the emergency medical plan, mandatory reporting under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions. This will be done and documented during the first day and within the first 40 hours of employment.
A monitor will be put in place to ensure that the staff training packet is completed and monthly employee files are reviewed to ensure that the employee training is documented.

DIRECTED: Within 5 days of receipt of the plan of correction: Staff person A shall receive training on all topics specified in 2600.656. Documentation of the training shall be kept in staff person A's record. LM 7/29/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall review all current staff person records to ensure each staff person has received training on all topics specified in 2600.65b. Documentation of the training shall be kept in each staff person's record. LM 7/29/21

Completion Date: *06/25/2021*

Document Submission **Implemented**

see attached

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

No cover was present on either of resident #5's two bed enablers, creating a possible entrapment hazard. Also, the enabler on the left side of resident #5's bed was not secured to the mattress and moved approximately 1" in each direction.

81b - Resident Personal Equipment *(continued)*

Plan of Correction **Accept**

During the survey, the enabler was tightened and repaired immediately to ensure that the apparatus was in good repair and free of hazards. Covers were ordered and placed on over the enabler to keep the resident safe. The resident had a consult with Physical therapy to ensure that safe practices were in place when enablers are being utilized.

A monitor will be in place that requires staff to check daily for the proper placement of the enabler covers and that the enablers are properly secured to the bed.

Completion Date: *06/22/2021*

Document Submission **Implemented**

See attached

225a - Assessment 15 Days

1. **Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #2's initial assessment does not indicate the date that the assessment was finalized. Resident #2 was admitted to the home on [redacted]

Resident #3's initial assessment does not indicate the date that the assessment was finalized. Resident #3 was admitted to the home on [redacted].

Plan of Correction **Directed**

To remain in compliance with regulation 2600.225.a and to make certain that all resident documentation and initial assessments are completed, a monitor will be put in place that requires a monthly post document check will be done by the administrator or other PC staff to make sure that all sections have been properly completed. This will ensure that all support plans and other documents are complete and up to date.

DIRECTED: Within 5 days of receipt of the plan of correction: Residents #2 and #3's assessments shall be updated to nclude the date the assessment was completed, the initials of the staff person who updated the assessment and the date the assessments were updated. LM 7/29/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a completed assessment, which includes the date the assessment was finalized. LM 7/29/21

Completion Date: *06/25/2021*

Document Submission **Implemented**

See attached

225c - Additional Assessment

1. Requirements

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

Description of Violation

Resident #1's most recent assessment does not indicate the date the assessment was finalized.

Resident #4's most recent assessment does not indicate the date the assessment was finalized.

Plan of Correction **Directed**

The Village of Pennwood works to stay in compliance with all state regulations, including 2600.225.c which states that all assessments and additional assessments will be completed annually. To allow for compliance to be met and kept, a monthly monitor was created to do a post-check of all completed documentation to ensure that it is signed and properly dated.

DIRECTED: Within 5 days of receipt of the plan of correction: Residents #1 and #4's assessments shall be updated to nclude the date the assessment was completed, the initials of the staff person who updated the assessment and the date the assessments were updated. LM 7/29/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a completed assessment, which includes the date the assessment was finalized. LM 7/29/21

Completion Date: *06/25/2021*

Document Submission **Implemented**

See attached

227a - Support Plan 30 Days

1. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2's initial support plan does not indicate the date that the support plan was finalized. Resident #2 was admitted to the home on [redacted].

Resident #3's initial support plan does not indicate the date that the support plan was finalized. Resident #3 was admitted to the home on [redacted]

227a - Support Plan 30 Days *(continued)*

Plan of Correction **Directed**

Resident support plans must be developed and implemented within 30 days of admission to the home and will be completed in accordance with regulation 2600.227.a within the mandated time frame. To ensure that this is done, a monitor will be put in place to make certain that the PC Administrator and or a designated staff person reviews the initial assessment upon completion and then hand it over to another staff person to double-check for completion. All support plans will be checked monthly to ensure completion.

DIRECTED: Within 5 days of receipt of the plan of correction: Residents #2 and #3's support plans shall be updated to include the date the support plan was completed, the initials of the staff person who updated the support plan and the date the support plan were updated. LM 7/29/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a completed support plan, which includes the date the support plan was finalized. LM 7/29/21

Completion Date: *06/25/2021*

Document Submission **Implemented**

See attached

227h - Support Plan Refuse Sign

1. **Requirements**

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident # 1's most recent support plan is not signed by the resident and does not indicate if the resident was unable to sign, refused to sign, declined to participate or was unable to participate.

227h - Support Plan Refuse Sign *(continued)*

Plan of Correction **Directed**

All support plans must fall within compliance with regulatory standard 2600.227.h and have a signature or notation that the resident or their designated person is unable or refuses to sign the document upon its completion. If or when a resident or their designee refuses to sign the support plan, the person completing the support plan and an additional PC employee will both sign and document that the resident/designee has made the decision to not completed the necessary form.
A monitor will be put in to check all resident support plans monthly for proper completion of all sections.

DIRECTED: Within 5 days of receipt of the plan of correction: Resident #1's support plan shall be reviewed with the resident and updated with the resident's signature. A notation shall be made on the resident's support plan if the resident was unable to participate, declined to participate or is unable to sign. LM 7/29/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has signed their support plan, or there is a notation made on the resident's support plan indicating the resident was unable to participate, declined to participate or is unable to sign LM 7/29/21

Completion Date: *06/25/2021*

Document Submission **Implemented**

See attached