Department of Human Services
Bureau of Human Service Licensing

September 1, 2021

DIANA PONTERIO, SR. VICE PRESIDENT OF OPERATIONS/REGULATORY COMPLIANCE
COUNTRY MEADOWS ASSOCIATES
830 CHERRY DRIVE
HERSHEY, PA 17033

RE: COUNTRY MEADOWS OF SOUTH HILLS I
3560 WASHINGTON PIKE
BRIDGEVILLE, PA, 15017
LICENSE/COC#: 43066

Dear Ms. Ponterio,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/21/2021, 07/22/2021 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: *COUNTRY MEADOWS OF SOUTH HILLS I* **License #**: *43066* **License Expiration Date**: *09/11/2021*
Address: *3560 WASHINGTON PIKE, BRIDGEVILLE, PA 15017*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: *Corrie Froats* **Phone**: *4122572855* **Email**: *cfroats@countrymeadows.com*

Legal Entity

Name: *COUNTRY MEADOWS ASSOCIATES*
Address: *830 CHERRY DRIVE, HERSHEY, PA, 17033*
Phone: *4122572855* **Email**: *DPONTERIO@COUNTRYMEADOWS.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/26/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *07/22/2021*

Inspection Dates and Department Representative

07/21/2021 - On-Site: Lauren Spagna

07/22/2021 - On-Site: Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *67*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *50* **Residents Served**: *38*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *67*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *42* **Have Physical Disability**: *0*

Inspections / Reviews

07/21/2021 - Full

Lead Inspector: *Lauren Spagna* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/08/2021*

8/6/2021 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/12/2021*

8/13/2021 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/31/2021*

9/1/2021 - Document Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Not Required*

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 7/21/21, resident #1's bed enabler was not secured to the bed and could be pulled approximately 4" from the bed, and could be moved approximately 1/2" in each direction from left to right.

On 7/21/21, resident #2's bed cane was not secured to the bed and could be pulled approximately 8" from the bed.

On 7/21/21, resident #3's bed enabler was not secured to the bed and could be pulled approximately 2" from the bed.

On 7/22/21, resident #4's bed enabler was positioned approximately 2" from the mattress.

Plan of Correction **Directed**

All bed enablers including residents #1, 2, 3, and 4 were reinforced by maintenance and verified by Campus Director on 7/23/2021. Non-slip mattress pads were placed on all hospital beds that have a bed enabler on 8/5/2021 to prevent the mattress from sliding away from the bed cane. A monthly documented audit will be completed by maintenance on each bed cane to ensure it is tight and secure and will be documented on a flow record to begin 8/23/2021. Maintenance staff and direct care givers are being in-serviced on how to check the security of the cane itself. The care givers were directed to report to their supervisor if any bed enabler is loose-- they are to contact maintenance as well and have it tightened at that time. In-services will be completed by 8/31/2021 which includes checking the bed enabler, who to report if there are any issues found and any enabler that is not open ended will be covered. See Training Sheets and Photo (DIRECTED: The care giver training shall include daily checks of resident bed enablers to ensure they are secured to the bed, and that a cover is placed over bed enablers which have openings greater than 4.75". Documentation of the education, as well as daily audits, shall be kept. LM 8/13/21)

Within 5 business days of receipt of the plan of correction: The administrator shall be responsible for a review of the assessments for all residents who currently use a bed enabler to ensure there is a need for the enabler, and that all safety precautions are indicated on the resident's support plan. Within 15 business days the administrator will be responsible for developing a policy to address the use of enablers in this facility to include an assessment of need, proper installation and on-going confirmation of safe use. LM 8/23/21

Completion Date: *08/12/2021*

Document Submission **Implemented**

92 - Windows

1. **Requirements**

2600.

92 - Windows *(continued)*

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 7/21/21, there were no screens present in the windows of bedroom #2 and bedroom #8.

Plan of Correction **Accept**

Screens were replaced at time of inspection. The grounds will be walked weekly and after any storm by maintenance and screens will be checked to ensure they are in place and secure. The Director will audit routinely to ensure compliance.

Completion Date: *08/05/2021*

Document Submission **Implemented**

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 7/21/21, resident #2's bedside lamp was approximately 2' from the resident's bed and could not be turned on/off at bedside.

On 7/22/21, resident #4's bedside lamp was approximately 2.5' from the resident's bed and could not be turned on/off at bedside.

On 7/22/21, resident #5 bedside lamp was approximately 2.5' from the resident's bed and could not be turned on/off at bedside.

Plan of Correction **Directed**

The nightstands that hold the lamps were all moved back next to the bed by the Campus Director and all completed on 7/23/2021. To permanently address the ongoing issue, wall mounted lights are being purchased and installed next to the bed so that the co-workers can properly have access to the resident without reaching over the nightstands. (DIRECTED; Wall mounted lights shall be accessible to residents from bedside. LM 8/13/21). There will be a monthly documented audit of all rooms to continually assess any new needs for proper lighting. Various staff members including the director and caregivers have been in-serviced on the regulation, which is documented. They have been instructed to notify their direct supervisor if they find any need for a change in the lighting that is required next to the bed. Assessments of each resident room and the need for wall mounted lighting will be completed and installed by 8/31/2021. See training sheets and photo

A full audit was completed by the Campus Director on 7/23/2021 and corrected on-site. LM 8/18/21

Completion Date: *08/12/2021*

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

Document Submission **Implemented**

123b - Emergency Procedures Posted

1. **Requirements**

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 7/21/21, the municipal emergency preparedness plan was not posted in a conspicuous and public place in the home.

Plan of Correction **Accept**

The Municipal Emergency plan was place in the emergency preparedness manual in the public area during time of inspection. A copy was also posted on the posting board to avoid omitting the local plan when updating our internal plan binders. The Director will routinely audit the postings board to ensure compliance.

Completion Date: *08/05/2021*

Document Submission **Implemented**

231c - Preadmission Screening

1. **Requirements**

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #6's written cognitive preadmission screening, dated 9/11/20, is not signed by the person who completed the screening.

Plan of Correction **Accept**

All secured files were audited for the physician signature on the cognitive prescreen and all were in compliance. Resident #6's screening was sent back to the PCP for signature and was completed and returned on 8/9/2021. Marketing members were in-serviced on the requirement for the MD signature for all screens. They were instructed to ensure they are sending a clean copy to all physicians to ensure the signature line is visible. Please see copy that was sent to MD. Upon admission, the three part check will be completed and signed off for every new admission within 30 days of admission and on-going. Audits are the responsibility of the receptionist, office manager, and final review by the campus director once the marketer has completed the file. See prescreen correction. See Training Sheets.

Completion Date: *08/12/2021*

Document Submission **Implemented**

251b - Record Entries Legible

1. **Requirements**

2600.

251b - Record Entries Legible *(continued)*

251.b. The entries in a resident’s record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #6's written cognitive preadmission screening, dated 9/11/20.

Correction fluid was used on resident #7's preadmission screening form, dated 3/1/21.

Plan of Correction **Accept**

An audit of all existing files was completed by the campus director on 7/30/2021. All staff members responsible for the prescreens have been retrained on this regulation. Specifically, that correction fluid is NOT permitted to be used on any document. The three part check system will be completed and signed off for every new admission within 30 days of admission ongoing. Audits are the responsibility of the receptionist, office manager and final review by the campus director once the marketer has completed the file. See Training Sheets.

Completion Date: *08/12/2021*

Document Submission **Implemented**