Department of Human Services
Bureau of Human Service Licensing

November 17, 2021

[redacted], EXECUTIVE DIRECTOR
REBECCA RESIDENCE
3746 CEDAR RIDGE ROAD
ALLISON PARK, PA 15101

RE: CONCORDIA AT REBECCA RESIDENCE
3746 CEDAR RIDGE ROAD
ALLISON PARK, PA, 15101
LICENSE/COC#: 43007

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/15/2021, 09/16/2021, 09/17/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

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: *CONCORDIA AT REBECCA RESIDENCE* **License #:** *43007* **License Expiration Date:** *03/08/2022*
Address: *3746 CEDAR RIDGE ROAD, ALLISON PARK, PA 15101*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *7244440600* **Email:** [redacted]

Legal Entity

Name: *REBECCA RESIDENCE*
Address: *3746 CEDAR RIDGE ROAD, ALLISON PARK, PA, 15101*
Phone: *7244440600* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/13/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *N/A* **Total Daily Staff:** *NaN* **Waking Staff:** *NaN*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal,Complaint* **Exit Conference Date:** *09/17/2021*

Inspection Dates and Department Representative

09/15/2021 - On-Site: [redacted]
09/16/2021 - On-Site: [redacted]
09/17/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served:** *59*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *60*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*
Have Mobility Need: *14* **Have Physical Disability:** *0*

Inspections / Reviews

09/15/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/03/2021*

10/8/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/12/2021*

10/13/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/05/2021*

11/17/2021 - Document Submission

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

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #3's resident-home contract, dated [redacted], was not signed by the resident until [redacted].

Plan of Correction **Directed**

Resident's responsible party had signed contract on [redacted] in residents presence and with their knowledge, but we subsequently had them sign the contract on [redacted] once the issue was identified. The admissions team was reeducated on 10/5/21 on the requirements of the signatures on the resident home contracts as seen on the attached education. An audit will be performed ongoing by the administrator (DIRECTED: The audit of current resident records shall be completed within 10 days of receipt of the plan of correction. [redacted] 10/13/21) or designee as an admissions checklist to determine all documents are present and signed within 24 hours of admission. (DIRECTED: A copy of the new admission checklist shall be kept in each newly-admitted resident's record. [redacted] 10/13/21)

Completion Date: *10/22/2021*

Document Submission **Implemented**

Attachments A, B, and C

54a - Direct Care Staff

1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person C, hired on [redacted], does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction **Directed**

Staff person C does have a diploma as evidenced by the attached. All employee files will be audited for the appropriate educational requirements by 10/30/21 and any deficit addressed immediately. An HR file audit will then be maintained by the HR department or designee on an ongoing basis to ensure compliance is maintained on any new hires. A more complete audit checklist has been attached that will be maintained by the HR team on an ongoing basis and communicated to supervisors about any missing information that needs to be obtained. (DIRECTED: The completed new hire checklist shall be kept in each new hire's record. [redacted] 10/13/21)

Completion Date: *10/30/2021*

Document Submission **Implemented**

Attachment D, E, and F

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

60a - Staff/Support Plan *(continued)*

Description of Violation

On 8/30/21 and 9/3/21, there were 60 residents in the home, including 14 residents with mobility needs. Of the 14 residents with mobility needs, 9 residents require the assistance of 2 staff persons to transfer in/out of bed/chair.

On 9/6/21, there were 59 residents in the home, including 14 residents with mobility needs. Of the 14 residents with mobility needs, 9 residents require the assistance of 2 staff persons to transfer in/out of bed/chair.

On 9/8/21, 9/9/21 and 9/11/21, there were 61 residents in the home, including 14 residents with mobility needs. Of the 14 residents with mobility needs, 9 residents require the assistance of 2 staff persons to transfer in/out of bed/chair.

The home's most recent fire safety inspection conducted by a fire safety expert, dated 7/6/21, indicates the maximum safe evacuation time to the numerous fire-safe areas in 10 minutes. On the below dates and times, only 1 staff person was present in the home, which is not adequate to safely evacuate all residents in the event of an emergency:

- *8/30/21, 9/3/21 and 9/6/21 from 10:30 pm-7:00 am*
- *9/8/21 and 9/9/21 from 10:30 pm-3:00 am*
- *9/11/21 from 10:30 pm-12:00 am, 1:00 am-3:00 am and 4:00 am-7:00 am*

Plan of Correction **Accept**

Hiring efforts continue to recruit staff in general and specifically for the night shift. A daylight staff member has requested transfer to the night shift which has improved staffing on that shift moving forward. Re-education was also provided to staff on where the fire safe areas are on the facility to promote an understanding of safe evacuation procedures and also their ability to rely on skilled staffing for assistance in an emergency due to their availability in the same building at all times. This connection to the skilled building facilitates evacuations in an emergency situation and is what is practiced in all fire drills. Our current immobile status has also reduced to 11 due to changes in census as of 10/5/21. Staffing will be monitored by the RCC and Administrator on a daily basis to ensure adequate and safe staffing on all shifts to ensure the needs of the residents are being met

Completion Date: *10/23/2021*

Document Submission **Implemented**

Attachment G

65d - Initial Direct Care Training

1. **Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d - Initial Direct Care Training *(continued)*

Description of Violation

Direct Care Staff Person A was hired on [redacted]; however, the staff person did not successfully complete and pass the Department-approved direct care training course and pass the competency test.

Direct Care Staff Person B was hired on [redacted]; however, the staff person did not successfully complete and pass the Department-approved direct care training course and pass the competency test until [redacted]

Direct Care Staff Person C was hired on [redacted]; however, the staff person did not successfully complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction **Directed**

The staff members listed all took competency test by October 23rd if not before and all staff files audited for appropriate training by Human resources designee by October 30th and any deficient practice addressed immediately with the appropriate competency test. (DIRECTED: Copies of the certificates for staff persons A, B and C shall be kept in their staff records. [redacted] 10/13/21). Moving forward all direct care staff will have the department approved training course within the required time period and pass the required competency test or will not be placed on the schedule. An ongoing audit will be kept by human resources on an ongoing basis to ensure these training requirements are kept in compliance. The updated audit for HR to complete has been attached. (DIRECTED: The completed new hire checklist shall be kept in each new hire's record. [redacted] 10/13/21)

Completion Date: *10/30/2021*

Document Submission **Implemented**

Attachment H Audit, Attachment F new hire checklist

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/15/21, multiple areas of dried egg yolk covered the bottom of the refrigerator in the PC North Pantry.

Plan of Correction **Accept**

The eggs broke during breakfast service on the day of survey and were immediately cleaned up once discovered. An education will be completed with dietary personnel as to their responsibility to monitor sanitary conditions and for quickly addressing any issues. See attached education. The dietary manager or designee will perform weekly rounds for 3 months of the pantry kitchens to ensure compliance with these sanitary conditions and report on findings to the Personal Care Administrator on the attached audit sheet.

Completion Date: *10/30/2021*

Document Submission **Implemented**

Attachment J and K

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 9/17/21, no emergency telephone numbers were posted on or near the telephone in resident #3's bedroom.

Plan of Correction **Accept**

The Emergency telephone numbers were found the same day laying on the floor next to the residents chair and were replaced in a more visible location. Phone numbers are audited by our managers on weekly rounds sheets and rarely missed in a room except if removed by a resident or accidently have fallen down and then quickly replaced by our staff. I feel that's why this was only found in one room. I would ask that is be removed as a violation, but I'm including an audit and education that we have prepared in advance for the purpose of the plan of correction.

Completion Date: *10/07/2021*

Document Submission **Implemented**

Attachment L

100a - Exterior - Free of Hazards

1. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 9/15/21, 2 of the cement slabs of the sidewalk in the PC North courtyard were each raised approximately 1.5", posing a tripping hazard.

Plan of Correction **Accept**

The area in question has been blocked off for now until repairs can be completed. This is not an exit but a patio area and the sidewalk being removed will not hinder evacuation. An outside contractor has been contacted and the enclosed bid shows the agreed upon removal of the concrete in question. This work is scheduled to be completed by 10/30/21. Work was completed and picture attached to show area was blocked off safely and where cement was removed. Rounds are to be completed by maintenance director with the administrator or designee on a monthly basis moving forward of the outside grounds to ensure all areas are in good repair and address any areas of concern promptly.

Completion Date: *10/15/2021*

Document Submission **Implemented**

Attachment M, N1, N2, and O

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted], is not signed by the physician.

Resident #2's most recent medical evaluation, dated [redacted], is not signed by the physician.

Resident #6's most recent medical evaluation was completed on [redacted].

Resident #8's most recent medical evaluation, dated [redacted], is not signed by the physician.

Resident #10's most recent medical evaluation was completed [redacted]; however, does not include the date the resident was evaluated. Also, the medical evaluation is not signed by the physician.

Plan of Correction **Accept**

The Resident Medical Evaluations for Resident #1, #2, #8 and #10 will be updated to include physician signature and an updated DME will be completed by 10/23/21 for resident #6. Resident Medical Evaluations will be evaluated for timeliness and necessary signatures by Resident Care Coordinator or Designee by 10/30/21 and then monthly for 3 months. Staff will be re-educated by 10/30/21 on the proper procedures and timing for completion of the medical evaluation and locking it in the electronic medical record to ensure the doctor's signature is then prompted. A tracking calendar to assist staff in keeping better track of these will be part of this education and has been added to this plan of correction and attached.

Completion Date: *10/30/2021*

Document Submission **Implemented**

Attachments P and Q

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 9/9/21 at 8:37 am, resident #1's blood glucose was 128; however, the blood glucose was documented on the resident's September 2021 medication administration record (MAR) as 116.

On 9/11/21 at 8:34 am, resident #1's blood glucose was 137; however, the blood glucose was documented on the resident's September 2021 MAR as 136.

On 9/11/21 at 7:16 pm, resident #1's blood glucose was 186; however, the blood glucose was documented on the resident's September 2021 MAR as 189.

On 9/12/21 at 8:47 am, resident #1's blood glucose was 156; however, the blood glucose was documented on the resident's September 2021 MAR as 154.

On 9/12/21 at 12:10 pm, resident #4's blood glucose was 289; however, the blood glucose was documented on the resident's September 2021 MAR as 284.

Plan of Correction **Directed**

The two residents who had incorrect glucometer readings documented were re-evaluated to will be evaluated to ensure no ill effects from improper documentation of glucometer readings. Nurse completed assessments by 10/14/21 and will notify physician of any concerns. Education on glucometer use and proper documentation is being completed with responsible staff members and will be completed by 10/22/21. That education is attached. An audit then will be performed by our nurse consultant or designee to determine that we have improved compliance in the accuracy of these documented blood glucose numbers. These audits will be performed weekly for 3 months and results turned in to the Personal Care Administrator. See attached audit form. (DIRECTED: The audits shall continue on a monthly basis after the weekly audits have been completed. LM 10/13/21)

Completion Date: *10/15/2021*

Document Submission **Implemented**

Attachments S and T

187d - Follow Prescriber's Orders

1. **Requirements**

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

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

Description of Violation

Resident #1 is prescribed [redacted] 3 times daily at 8:00 am, 12:00 pm, and 6:00 pm per the following sliding scale: 70 give NO insulin initiate hypoglycemic protocol; 71-89=12 units; 90-119=13 units; 120-150=14 units; 151-200=15 units; 201-250=16 units; 251-300=17 units; 301-350=18 units; 351-400=19 units; 401-450=20 units; >450 give 21 units.
On 9/9/21 at 8:37 am, resident #1's blood glucose was 128, requiring 14 units of insulin to be administered; however, only 13 units of insulin was administered to the resident. .

Resident #4 is prescribed [redacted] 3 times daily at 8:00 am, 12:00 pm, and 6:00 pm per sliding scale; however, the resident's blood glucose was not taken on 9/6/21 at 12:00 pm, so it is unable to be determined if the resident would have required insulin to be administered.

Plan of Correction **Directed**

Residents #1 and #4 assessed to ensure no ill effects from insulin being miscalculated. Completed by nurse prior to 10/14/21 and any concerns communicated to physician. Nursing staff being re-educated on how to read insulin sliding scale, amount to administer, documentation and notifying doctor as needed. Education to be completed by Resident Care Coordinator or designee by 10/30/21. Administrator or designee will audit EMAR on all residents on sliding scale daily for one week beginning 10/18/21 and then weekly for 3 months to ensure compliance.
(DIRECTED: The audits shall continue on a monthly basis after the weekly audits have been completed. [redacted] 10/13/21)

Completion Date: *10/30/2021*

Document Submission **Implemented**

Attachments U and V

224a - Preadmission Screen Form

1. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening form, dated [redacted], does not include a determination that the home can meet the needs of the resident. This section of the form is blank.

224a - Preadmission Screen Form *(continued)*

Plan of Correction **Accept**

Resident #2 was assessed upon learning of this to confirm they were appropriate for Personal care and determined to be so. We will audit all prescreen forms by 10/23/21 by administrator or designee to ensure no other forms have been left incomplete and address immediately if any concerns found. The Administrator or designee will complete an audit of preadmission screenings monthly for 6 months to ensure all sections are complete on form and in compliance. A copy of that audit is attached. The requirements of the form being complete were reviewed as an education with individuals who carry responsibility for completing the pre-screen form for the facility and that education is attached.

Completion Date: *10/23/2021*

Document Submission **Implemented**

Attachment W and X

225c - Additional Assessment

1. **Requirements**

2600.

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

1. Annually.

Description of Violation

Resident #6's most recent assessment was completed on [redacted].

Plan of Correction **Accept**

Resident #6 did have an assessment completed on [redacted] *which was due to a significant change. It is attached. Please withdraw this violation. This updated RASP was misfiled and not found in time for exit. All resident records are being validated for correct information and filing by the RCC or designee and education provided to the staff on the same by 10/30/21. A tracking system was provided to assist them in keeping better track of the completion and filing of these and is attached.*

Completion Date: *10/30/2021*

Document Submission **Implemented**

Tracking system attachment Z

227d - Support Plan Medical/Dental

1. **Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

227d - Support Plan Medical/Dental *(continued)*

Description of Violation

Resident #7's most recent support plan, dated [redacted], does not indicate the resident's need for 2-person assistance with transfers.

Resident #8's most recent support plan, dated [redacted], does not indicate the resident's need for 2-person assistance with transfers, or the use of a Broda chair.

Resident #9's most recent support plan, dated [redacted], does not indicate the resident's need for 2-person assistance with transfers, or the use of a Broda chair.

Resident #10's most recent support plan, dated [redacted] does not indicate the resident's need for 2-person assistance with transfers.

Plan of Correction **Directed**

The support plans were updated for residents 7,8,9 and 10 on 10/7/21 to reflect the correct mobility needs and to match the current DME. An audit is being performed on all other charts to confirm that the mobility status of other residents are also correctly reflected and will be completed by 11/5/21 and then continued as an ongoing audit by the Resident care coordinator or designee for 90 days. An updated tracking form for RASP's has been included to better assist staff in tracking support plan due dates and also the requirements for them.

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident support plans are updated as resident care needs change. Documentation of the system shall be kept. All staff persons involved in the completion of resident support plans shall be educated on the new system within 10 days of receipt of the plan of correction. Documentation of the education shall be kept. LM 10/13/21

Completion Date: *11/05/2021*

Document Submission **Implemented**

Attachment AA and BB

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

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

Resident #7's most recent support plan, dated [redacted] is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #8's most recent support plan, dated [redacted], is not signed by the assessor or resident, and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #10's most recent support plan, dated [redacted], is not signed by the assessor.

Plan of Correction **Accept**

Support plans for resident #1, 7, 8 and 10 are being updated to capture the resident and assessor's signature to bring them into compliance by 11/5/21. An education will be completed with staff by 11/5/21 to reiterate the signature requirements on support plans and what to do if the resident is unable to sign or refused. An audit will be completed by the Administrator or designee ongoing for 6 months to ensure improved compliance with this requirement and address any deficient practice immediately. See attached education and audit. An updated tracking calendar to assist staff to better track when support plans are required on each resident has been attached.

Completion Date: *11/05/2021*

Document Submission **Implemented**

Attachment CC and DD