





Emailing Date: September 27, 2021

[REDACTED]  
Kevin & Romona Donahue  
1143 Lapish Road  
Pittsburgh, Pennsylvania 15212

RE: Donahue's Personal Care I  
1610 Hybla Street  
Pittsburgh, Pennsylvania 15212  
License #: 430340

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on July 20, 2021 and September 10, 2021, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Jamie F. Buchenauer". The signature is written in a cursive style.

Jamie Buchenauer  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

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

**Facility Information**

Name: *DONAHUE'S PERSONAL CARE I* License #: *43034* License Expiration Date: *10/22/2021*  
Address: *1610 HYBLA STREET, PITTSBURGH, PA 15212*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

Name: [REDACTED] Phone: *4127616421* Email: [REDACTED]

**Legal Entity**

Name: *KEVIN & ROMONA DONAHUE*  
Address: *1143 LAPISH ROAD, PITTSBURGH, PA, 15212*  
Phone: *4127616421* Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *10/26/1985* Issued By: *City of Pittsburgh*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *17* Waking Staff: *13*

**Inspection**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal,Provisional* Exit Conference Date: *07/20/2021*

**Inspection Dates and Department Representative**

07/20/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *17* 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: *5* Are 60 Years of Age or Older: *11*  
Diagnosed with Mental Illness: *9* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *0* Have Physical Disability: *0*

**Inspections / Reviews**

**07/20/2021 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/23/2021*

Inspections / Reviews (*continued*)

## 8/27/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/30/2021*

## 9/17/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *09/17/2021*

## 85a - Sanitary Conditions

### 1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

#### Description of Violation

*At approximately 11:03 a.m., the second floor bathroom does not have paper towels, hand dryer or other sanitary method of drying hands.*

*At approximately 11:13 a.m., a portable urinal filled with approximately 23 ounces of urine, was on resident #1's bedside table.*

*There was trash under the rear deck, including potato chip bags, paper plates and approximately 35 cigarette butts.*

## 85a - Sanitary Conditions (continued)

## Plan of Correction

Accept

2600.85a

*The 2nd floor bathroom did not have paper towels. Immediate Action: On July 20, 2021, the home's staff person retrieved paper towels and delivered them to the 2nd floor bathroom. Compliance was met same day. On August 7, 2021, the homes Administrator purchased and installed four new paper towel dispensers for each bathroom in the home. On August 7, 2021, the home Administrator held a staff meeting and each staff person was shown how to open and install paper towels. The Administrator instructed the night time staff to ensure that all paper towel dispensers are filled each morning which will last the entire day. On August 10th, 14th, and 22nd, the Administrator performed 3 unannounced spot checks and found all dispensers to be full of paper towels. The Administrator will continue to perform periodic checks to ensure compliance is being maintained.*

*Completion date: August 7, 2021. See attachment B1 & B2 and figure 1*

*In resident #1's room there was a bedside urinal found and was filled with urine. Immediate Action: On July 20, 2021 resident #1 immediately emptied the portable urinal in the bathroom to resolve the unsanitary condition. Resident #1 is very independent and usually responsible, able to self-assist and manage many ADL's including room tidiness and ensuring if a bedside urinal is use that it is emptied and clean as soon as the resident wakes up in the morning. On July 20, 2021, resident #1 apologized to site surveyor and added [REDACTED] was just extremely tired from receiving dialysis. On August 7, 2021, the Administrator spoke to all staff persons to ensure compliance is maintained. The Administrator informed the staff that even though some residents are independent and responsible that they should be identifying such conditions and immediately resolving and then continue to remind residents that they are more than happy to help especially when one's tired following certain treatments. The daylight staff is responsible daily to ensure compliance each day when performing room cleaning duties. The Administrator performed unannounced spot checks on August 10th, 14th, and 22nd, which resulted in continued compliance.*

*Completion date: July 20, 2021. Training date: August 7, 2021. See Attachment B1 & B2*

*There was debris and cigarette butts under and around the deck in the back yard. Immediate Action: On July 27, 2021, the Administrator cleaned up the debris and raked up the cigarette butts and discarded. On August 7, 2021, the Administrator held discussions with the residents and the staff to ensure the problem does not persist and compliance is maintained. The Administrator reminded everyone that this is a group effort and everyone needs to ensure they are not littering and properly discarded garbage and using the extinguishing urns every time. The Administrator trained the staff to perform building ground checks to ensure debris and cigarette butts are cleaned up and discarded. The Administrator has added building grounds to the bi-monthly building checks and assigned the Administrator Designee to inspect bi-monthly to ensure ongoing compliance is achieved. Bi-monthly building check lists will be filed and stored in the home. The Administrator will check the check lists monthly to ascertain if further action is needed.*

*Completion date: July 27, 2021. See figure 2 Training date: See attachment B1& B2 and C1 & C2*

**Completion Date: 08/07/2021**

## 88a - Surfaces

## 1. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

## 88a - Surfaces (continued)

**Description of Violation**

*At 10:35 a.m., there was approximately 2 inches of stagnant water near the drain area of the first floor shower, next to the living room, posing a slipping hazard.*

**Plan of Correction****Accept**

*2600.88a*

*The 1st floor shower was clogged and had stagnant water sitting in the base of the shower. On July 17, 2021, the staff made the Administrator aware of the problem. Immediate Action: The same day the Administrator attempted to unclog and snake out the drain, but was unsuccessful. The 1st floor shower was then blocked off and the Administrator advised the residents to use the other 1st floor shower until repairs are made. Also on the same day, the Administrator contacted a plumber to resolve. The plumber advised that the first earliest opening was on July 23, 2021. On July 23, 2021, the plumber arrived and was successful clearing the clog and resolving the issue... turned out to be hair and gunk that was clogging the drain. The staff is responsible to report any and all such problems daily as they arise. The Administrator is responsible to first try to correct the problem and if unsuccessful the Administrator is responsible to call and schedule for professional repairs. Clogged drains are rare, however, going forward it is the Administrator's responsibility to resolve same day and called professional contractors as needed. On August 10th, 14th, and 22nd, the Administrator tested the drain and observed the water draining with no issues. Completion date: July 23, 2021. See attachment A*

**Completion Date:** 07/23/2021

## 89a - Water Pressure

**1. Requirements**

*2600.*

- 89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.*

**Description of Violation**

*At 10:41 a.m., there was not sufficient cold water pressure in the second floor bathroom shower.*

**Plan of Correction****Accept**

*2600.89a*

*There was not sufficient cold water pressure in the bathroom. The handle to the cold side was loose and in need of repair. On July 17, 2021, the Administrator spoke to a plumber to schedule repairs. The plumber advised [REDACTED] will be there on July 23, 2021 to repair. The Administrator delivered a tub and shower handle kit to be on site for the plumber's arrival. Immediate Action: On July 23, 2021, the plumber had replaced the inside stem to the cold side handle which corrected the problem. The staff is responsible to identify and report any or all such problems to the Administrator as problems arise. It is the Administrator's responsibility to troubleshoot and resolve within 24hrs or sooner depending on the urgency. On August 10th, 14th, and 22nd, the Administrator tested the shower handles during the walkthroughs and observed the shower handles to be operating as intended.*

*Completion date: July 23, 2021. See attachment A and figure 3*

**Completion Date:** 07/23/2021

## 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**

*There was a panel of raised wood on the outside deck, measuring approximately 6 inches, posing a tripping hazard.*

*Repeat Violation: 1/28/2020.*

**Plan of Correction****Accept**

2600.100a

*There was a raised decking board on the back deck posing a tripping hazard. The raised decking board was first seen by the staff on July 18, 2021, at which point the staff placed two milk crates stacked over it to prevent the residents from walking over it or tripping over it. Immediate Action: On July 21, 2021 the Administrator brought a drill and extra-long screws to refasten the deck board and pull it flush to eliminate the possible tripping hazard. On July 21, 2021 the repair was made and compliance was met. It is the staff's responsibility to identify and report any or all issues that may pose a tripping hazard and to immediately block off or secure the area for the safety of the residents. It is the Administrators responsibility to immediately correct if possible or call a contractor for repairs. On August 10th, 14th, and 22nd the Administrator did a visual walkthrough of the back deck and did not observe any deck boards raised. The Administrator has assigned the Administrator Designee to add the back deck to the bi-monthly building check lists to ensure compliance is being maintained. Building checklists are filed on site and accessible to be reviewed at any time.*

*Completion date: July 21, 2021. See attachment B & B 1. See figure 5*

**Completion Date:** 07/21/2021

## 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**

*At 11:50 a.m., the emergency exit door in the basement was stuck and required an excessive amount of force to open.*

*Repeat Violation: 1/28/2020.*

## 121a - Unobstructed Egress (continued)

**Plan of Correction****Accept**

2600.121a

The exit door in the basement was stuck and not easily able to be opened. The staff reported the problem to the Administrator following the site survey. On July 21, 2021 the Administrator immediately investigated and found two issues causing the problem. The latch was bent outward making it hard to move the latch back and forth to be able to open and the top door hinge was loose causing the door to rub and stick in the top left corner. Immediate Action: On July 21, 2021 the Administrator was able to bend the latch back into proper position and inserted new screws into the door hinge to allow it to open and close with out rubbing against the door jam. The Administrator check the basement door on August 10th, 14th, and 22nd, and found no issues obstructing easy open and closing of door. The Administrator has assigned the Administrator Designee to add to the bi-monthly checklists and will be responsible to ensure ongoing compliance is met. The building check list will be saved and filed on site for future viewing purposes. The Administrator Designee is responsible to report any issues to the Administrator at which point the Administrator will contact the contractor for repairs.

Completion date: July 21, 2021. (Short video)

Completion Date: 08/21/2021

## 141a - Medical Evaluation

**1. Requirements**

2600.

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

**Description of Violation**

Resident #2 was admitted to the home on [REDACTED]/2020, however, the medical evaluation was not completed until [REDACTED]/2020.

**Plan of Correction****Accept**

260.141a

Resident #2's medical evaluation was nearly 3 weeks past the 30-day period to be completed by the physician. The problem occurred for two reasons. First, the resident came was accepted without a regular PCP, which made it very difficult for the Administrator to have the medical evaluation filled out in a timely manner. Second, the home's visiting physician was not performing site visits at this time due to Covid safety guidelines. Transporting the resident to and from the physician's office was not the safest option for the resident at this particular time. In [REDACTED] of 2020, the home's visiting physician was able to evaluate the resident and complete the DME as needed for the resident's file. The Administrator believes the delay to be an unusual occurrence due to the worries surrounding Covid exposure and is confident the same issues will not occur again in the future. It is the Administrators responsibility to ensure all medical evaluations are completed 60 days prior to admission or 30 days post admission. Immediate Action: The Administrator will not accept placements in the future unless it's guaranteed that the medical evaluation will be completed in a timely manner in order to ensure compliance is maintained.

Completion/ Training date: August 7, 2021. See attachment B1 & B 2

Completion Date: 08/07/2021

## 183c - Refrigerated Meds Locked

**1. Requirements**

2600.

183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

**Description of Violation**

*At approximately 1:10 p.m., there was a bottle of Latanaprost 1% eye drops prescribed for resident #3, unlocked and accessible in the refrigerator.*

**Plan of Correction****Accept**

2600.183c

*The problem is that resident #3's eye drops were not in the lock box inside the fridge and were just sitting on fridge's side shelf. Immediate Action: On July 20, 2021, the staff person on duty retrieved the eye drops and placed them inside the fridge lock box to remedy the problem. Compliance was met same day. On August 7, 2021, the Administrator held a training/discussion session with all staff members to ensure all staff fully understand that any medications (including eye drops) shall be properly stored and locked inside the lock box inside the fridge. The Administrator made it very clear to the staff during this training session that all medications no matter how harmless they may seem must be properly stored or locked inaccessible to other residents for many reasons. The staff is now fully aware of the proper procedure for storing medicated eye drops in the fridge. On August 10th, 14th, and 22nd the Administrator performed unannounced spot checks and did not observe refrigerated meds to be outside of the fridge lock box. The Administrator has assigned the Administrator Designee to add the fridge lock box/meds to the bi-monthly building check lists. The Administrator Designee is responsible to ensure ongoing compliance is maintained. The bi-monthly building check lists will be saved and file for future viewing purposes. On August 24, 2021 the Administrator held a more detailed training session regarding safe storage of medications. In this training there was special emphasis directly for refrigerated medications as well as other proper medication storage practices. Completion date: July 20, 2021. See figure 4 Training date August 7, 2021: See attachment D1 & D 2*

*ached*

**Completion Date:** 08/07/2021