Department of Human Services
Bureau of Human Service Licensing

November 10, 2021

[redacted]
JUNIPER VILLAGE AT SOUTH HILLS LLC
1320 GREENTREE ROAD
PITTSBURGH, PA 15220

RE: JUNIPER VILLAGE AT SOUTH HILLS
1320 GREENTREE ROAD
PITTSBURGH, PA, 15220
LICENSE/COC#: 45265

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/28/2021, 09/29/2021 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: *JUNIPER VILLAGE AT SOUTH HILLS* **License #**: *45265* **License Expiration Date**: *07/12/2022*
Address: *1320 GREENTREE ROAD, PITTSBURGH, PA 15220*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *412-571-1300 ext 141* **Email**: [redacted]

Legal Entity

Name: *JUNIPER VILLAGE AT SOUTH HILLS LLC*
Address: *1320 GREENTREE ROAD, PITTSBURGH, PA, 15220*
Phone: *4124043342* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/11/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Interim* **Exit Conference Date**: *09/29/2021*

Inspection Dates and Department Representative

09/28/2021 - On-Site: [redacted]
09/29/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *96* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd Floor* **Capacity**: *26* **Residents Served**: *15*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *27* **Have Physical Disability**: *2*

Inspections / Reviews

09/28/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date**: *10/17/2021*

10/18/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date**: *10/22/2021*

10/26/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date**: *11/04/2021*

11/10/2021 - Document Submission

Lead Reviewer: [redacted] **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 9/29/21, both bed enablers on resident #1's bed were not secured to the bed and each moved approximately 2" in each direction.

Plan of Correction **Accept**

Consulted with physician, resident and resident's [redacted] POA and devices were not being used so they were removed. All residents requiring a bed enabler will have a physician's order and be secured to the proper bed that they will fit according to manufacturer's instructions. All resident's with assisted devices will be checked (a weekly audit) weekly by Environmental Services Director and recorded on this audit form. Please see attached. Care staff, housekeeping and Maintenance team were educated on October 15-16

Completion Date: *10/22/2021*

Document Submission **Implemented**

all care staff , housekeeping and EVS teams were educated on assisted devices and how they must be attached. Please see the weekly audit form

89b - Hot Water Temperature

1. **Requirements**

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Repeat Violation

On 9/29/21 at 11:26am, the hot water temperature at the sink in bedroom #202 measured 128.8 degrees Fahrenheit.

On 9/29/21, at 1:00pm, the hot water temperature at the sink in the 1st floor common restroom across from bedroom #103 was 129.9 degrees Fahrenheit.

REPEAT VIOLATION: 5/5/2021

Plan of Correction **Accept**

We have an older building and where the placement is of the boiler either makes the water hot in some of the rooms in order for it to be warm enough in some rooms. It will require adjustment throughout the day. We will have environmental services check each side of the building each morning 9am and each afternoon 2pm in order to adjust the mixing valve accordingly to make sure it reads below 120 degrees as the temperature does change throughout the day. A revised spreadsheet to record the temperatures is attached.

Completion Date: *10/11/2021*

89b - Hot Water Temperature *(continued)*

Document Submission **Implemented**

water sources in each part of the building are tested to maintain a water temperature between 80-120 degrees fahrenheit twice a day. If the temperatures do not meet this criteria then the mixing valve is adjusted. Please see audit sheets

92 - Windows

1. **Requirements**

2600.

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 Repeat Violation

On 9/28/21, there were no screens present in the following windows:

- *1st floor window in stairwell C*
- *2nd floor window in stairwell C*
- *2nd floor window in stairwell A*

REPEAT VIOLATION: 5/5/2021

Plan of Correction **Accept**

In accordance with2600.92 all Windows that can open must have screens in good condition and in good repair. ██ did not have screens in the stairwell windows. █e only thought it was a requirement in the resident's rooms. ██ were informed of the regulation, and all maintenance and housekeeping staff were educated immediately on 9/28 and 9/29 and ██ had screens installed immediately. All windows in the building were examined and verified for screens. Please see attached photos. ██ will maintain all screens in all windows throughout the building by checking them monthly for holes, or other wear and tear. Environmental Services Director is the responsible party and will turn in audit sheets to Executive Director to be reviewed monthly. Please see attached audit tool. Beginning November 1st

Completion Date: *11/01/2021*

Document Submission **Implemented**

each month all windows are inspected for proper screens. They are checked for holes or other wear and tear. any window that can be opened must have a screen in good condition. Please see attached audit.

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 9/29/21, resident #2's bedside lamp was approximately 4' from the bed and unable to be turned on/off from bedside.

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

Plan of Correction **Accept**

Some of the residents that are hospice or that are considered fall risks have fall mats next to their beds. In order for them to fit securely the caregiver moved the nightstand away form the bed, to make sure they were all the way under the bed. ██ purchased wall lamps to either be attached to the headboard or the wall right next to the bed so this would not be an issue. Each resident will have a bedside lamp within arms reach of their bed to be able to be operated by resident. This resident is a fall risk so fall mats are being utilized and were pushed up closely to the bed. A push lamp attached to the wall was installed that is reachable by the resident and/or care staff. Please see pictures. All caregivers, housekeeping and maintenance staff were educated that all residents must have a lamp within arms reach on October 11-15th. Housekeeping will maintain and an audit log when they are cleaning the rooms to make sure there is a bedside lamp that is reachable and if not they will notify Environmental Services Director to be replaced/and or repaired. Please see attached weekly audit

Completion Date: *10/25/2021*

Document Submission **Implemented**

all residents must have a bedside operable lighting source. Most have end tables and lamps next to their beds. If they are a hospice resident or cannot reach the lamp then ██ have installed push lights on the wall right next to the beds. Please see audit tool that either Environmental services or housekeeping weekly audit.

162c - Menus Posted

1. **Requirements**

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 9/28/21, the only menu posted in a conspicuous and public place was dated 9/27/21 through 10/3/21.

Plan of Correction **Accept**

The Dining Services Director cooks on Sunday and Monday and previously would put out the new menu on Tuesday mornings. ██ now will print 4 weeks of menus, and post the current week and the following week's menu on Sunday afternoon while ██ is here, so they will be visible by Monday morning. The front desk concierge will verify posting on Sunday evening before ██ leaves for the day and sign the audit tool each Sunday. If the DSD is on vacation, ██ will leave the menus at the front desk and they will be responsible for posting. There will be current weeks menu and the following week's menus posted on each floor by the elevator and outside of the dining room and on the entryway of the first floor entry. The weeks go from Monday through Sunday. Please see attached audit tool. Dining staff and Concierge staff will all be educated by Sunday October 24th and Executive Director and DSD are responsible parties

Completion Date: *10/24/2021*

Document Submission **Implemented**

attached are pictures that show the placement of the menus each week and the concierge checks them every Sunday evening before they leave

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:

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

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is prescribed Oxycodone HCL 5mg tablet-Give 1 tablet by mouth every 4 hours as needed; however, the pharmacy label indicates, Oxycodone HCL 5mg capsule-Give 1 capsule by mouth twice daily as needed.

Resident #4 is prescribed Morphine Sulfate solution 20mg/ml-Give 0.25ml sublingually every 1 hour as needed; however, the pharmacy label indicates, Morphine Sulfate solution 20mg/ml-Give 0.25ml sublingually every 2 hours as needed.

Plan of Correction **Accept**

The medication was not checked against the order, MAR, and prescription label to make sure they all read the same. Upon receiving new medications, the med tech must log them in on a sheet designated for that resident and it shall have space to identify and verify the prescription, MAR, and label are the same. This shall be verified weekly in an audit performed on all medication carts weekly by Wellness Manager and Executive Director. All med-tech's were re-educated on the 5 rights of medicine administration for the prescribed dosage and instructions going forward.
A change order was placed on correct medication to reflect the accurate information. Please see the attached medication cart audit.

Completion Date: *10/27/2021*

Document Submission **Implemented**

A change order was submitted and corrected immediately. We developed a medication audit for our residents that we have implemented to verify labels against the MAR and physician orders

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.

Description of Violation

Resident #5 is prescribed Atropine Sulfate Solution 1%-Take 2 drops sublingually ever 1 hour as needed; however, on 9/29/21, this medication was not available in the home.

Plan of Correction **Accept**

Atropine Sulfate Solution 1% was delivered to resident for PRN usage. As prescribed in the 5 rights which was reviewed with Med Techs and management. When a medication is prescribed and is on the MAR inventory must be identified immediately in preparation to be used. Weekly checks on each Medication cart will be conducted to maintain accuracy and availability of the drug

Completion Date: *10/11/2021*

Document Submission **Implemented**

The medication was corrected immediately and we began educating our caregivers and med-techs. ██ instituted a weekly check of the carts to ensure that the medication that is prescribed matches the prescription and the label

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 #3's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.

Resident #5's preadmission screening form, dated [redacted] indicates that the needs of the resident cannot be met by the services provider by the home; however, resident #5 has been a resident at the home since [redacted]

Plan of Correction **Directed**

Initially the nurse had refused to take this resident because of behavior reasons. It was discovered [redacted] had a UTI and once treated [redacted] health and demeanor were much more agreeable. The Executive Director went out to re-assess resident and deemed the resident to be appropriate for admission. The prior pre-admission form should have been destroyed and a new one should have been written. Preadmission form was re-written and boxed off correctly to reflect that the home can meet the needs of the resident. A check off admission form has been created to make sure all of these admission documents are captured upon admission. (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on the new check off admission form to ensure preadmission screenings are completed in their entirety within 30 days prior to admission for all newly-admitted residents. Documentation of the education shall be kept. LM 10/26/21). Executive Director and wellness will be responsible within 48 hours to review and again in 72 hours to determine completeness. Please see admission checklist

DIRECTED: Within 3 days of receipt of the plan of correction: Resident #3's preadmission screening shall be updated to indicate the home can meet the resident's needs. The update shall include the date of the update and the initials of the staff person who completed the update. The completed preadmission screening shall be placed in resident #3's record. LM 10/26/21

Completion Date: *10/25/2021*

Document Submission **Implemented**

[redacted] have developed a plan for all new residents admission checklist.s. [redacted] use this to check all new admissions for required documents and then [redacted] also use this document to go back through our current resident charts to audit them as well and discuss in monthly QA meeting

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 #5 was admitted to the home on [redacted]; however, the resident's assessment was not completed until [redacted].

225a - Assessment 15 Days *(continued)*

Plan of Correction **Directed**

were not monitoring the assessments as closely as should have. delegated that function to the Wellness Director (LPN) who has resigned effective Nov 3, 2021 and did not have a check system in place to monitor the process. have just switched to a new system called Point Click Care in the last month and are still inputting .all of our paper Support Plans and Assessments. This system will alert you once the resident is inputted as to when the documents are due. Until we have it all of the plans uploaded we have developed a checklist to go on the front of all new admissions, and each form must be completed as are inputting this information into the system. (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on the new checklist to ensure resident assessments are completed in their entirety within 15 days of admission for all newly-admitted residents. Documentation of the education shall be kept. LM 10/26/21). The new folder will not be filed until it is checked within 15 days to make sure the assessment is complete and then that box can be checked off. Executive Director and Wellness Director and Manager will review 20% of charts each month to ensure all paperwork is complete in all charts of new and current residents to ensure all required documentation is completed within the time constraints set forth by the regulations of 15 days within of admission. They will be reviewed at the Monthly Quality meeting. Please see admissions checklist (this form will also be used for the 20% audits of all charts monthly)

DIRECTED: Within 10 days of receipt of the plan of correction: A designated staff person shall review all resident records to ensure each resident has an assessment completed in its entirety within 15 days of admission. LM 10/26/21

Completion Date: *10/28/2021*

Document Submission **Implemented**

when use the admission checklist, the checklist stays on the front of the chart until the RASP is completed and all documents have been obtained. They are not filed in the cabinet until complete. also enter the information into our new electronic system PCC to help prompt on any missing information and then finally the Executive Director reviews all document to make sure all boxes are checked appropriately and all information is included with the time constraints listed.

231b - Medical Evaluation

1. **Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident’s diagnosis of Alzheimer’s disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the home's secured dementia care unit (SDCU) on however, the resident’s medical evaluation, dated does not indicate the need for the resident to be served in the SDCU.

231b - Medical Evaluation *(continued)*

Plan of Correction **Directed**

Prior to admission to a secured dementia unit we will obtain the correct Medical Evaluation form showing the diagnosis of Dementia or Alzheimers disease and included on the admission checklist. (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on the new checklist to ensure medical evaluations for residents admitted to the home's secured dementia care unit are completed in their entirety, which includes the resident's diagnosis of Alzheimer's Disease or other dementia and the need for the resident to be served in the secured dementia care unit, within 60 days prior to admission. Documentation of the education shall be kept. LM 10/26/21). This Medical Evaluation form was updated by CNRP to reflect status of resident to show the need for ██ to be on a secured dementia unit.
Executive Director and Wellness Director and Manager will review each new admission within 48 hours to ensure proper documentation to comply with all medical evaluation regulations. Please see admission checklist to keep us in check for all the admission documents

DIRECTED: Within 10 days of receipt of the plan of correction: A designated staff person shall review all resident records to ensure medical evaluations for residents who currently reside in the home's secured dementia care unit are completed in their entirety, which includes the resident's diagnosis of Alzheimer's Disease or other dementia and the need for the resident to be served in the secured dementia care unit. LM 10/26/21

Completion Date: *10/25/2021*

Document Submission **Implemented**

██ have reviewed all of the current resident records to ensure the medical evaluations are correct and reflect the proper diagnosis and has all the correct boxes checked and is conclusive of the needed information. For all of ██ new residents, it is part of ██ new admission process to look for the items brought to our attention during the survey process

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 #4's cognitive preadmission screening, dated ██ does not indicate the resident's diagnosis. This section of the form is blank.

Resident #5's cognitive preadmission screening, dated ██ does not indicate the resident's diagnosis. This section of the form is blank.

231c - Preadmission Screening *(continued)*

Plan of Correction **Directed**

As part of the admission process, ███ have developed a checklist that ███ can utilize on each admission to ensure all of the requirement documentation has been obtained and within the timely manner. (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on the new checklist to ensure cognitive preadmission screenings for residents admitted to the home's secured dementia care unit are completed in their entirety within 72 hours prior to admission. Documentation of the education shall be kept. LM 10/26/21).
A written cognitive preadmission screening is required for each resident with a physician or assessment team (wellness team) within 72 hours of admission. (DIRECTED: A written cognitive preadmission screening is required for each resident admitted to the home's secured dementia care unit within 72 hours prior to admission. LM 10/26/21).
This shall be completed on every new admission within 48 hours and reviewed by the executive Director and Wellness Director and Wellness Manager for completeness of all necessary information according to 2600.231c. This has been corrected on this resident's chart. we This will also be part of the 20% chart audit monthly and discussed at QA each month. The admission checklist will be part of that audit

DIRECTED: Within 3 days of receipt of the plan of correction: Resident #4 and #5's cognitive preadmission screening shall be updated to indicate the resident's diagnoses. The update shall include the date of the update and the initials of the staff person who completed the update. The completed preadmission screening shall be placed in resident #4 and #5's record. LM 10/26/21

DIRECTED: Within 10 days of receipt of the plan of correction: A designated staff person shall review all resident records to ensure cognitive preadmission screenings for residents who currently reside in the home's secured dementia care unit are completed in their entirety within 72 hours prior to admission. LM 10/26/21

Completion Date: *10/25/2021*

Document Submission **Implemented**

The Executive Director is the designated staff person that has reviewed all charts in the Secured Dementia unit and is responsible for all new resident chart as well. Resident's 4 and 5 diagnosis has been updated to reflect the diagnosis of dementia and placed in the chart. this has been updated as of 10/29/2021

233c - Key-Locking Devices

1. **Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Repeat Violation

On 9/28/21, the directions to open the keypad locking devices were not posted at the the following exit doors in the home's SDCU:

- *The exit door to stairwell A*
- *The exit door at stairwell C*

REPEAT VIOLATION: 5/5/2021

233c - Key-Locking Devices *(continued)*

Plan of Correction **Accept**

The original citation on 5/5/21 required [redacted] to post a code next to the elevator and [redacted] did so complying with tag and request. Both of these doors were examined on that date and [redacted] did not receive any additional direction to add any additional directions. Please see original tag. On this survey when the surveyor identified the doors as needing additional instructions, they were immediately typed and posted for [redacted] to see within moments. Please see attached photos. Doors and exits on the secured memory care unit will be examined weekly to make sure the directions and codes are prominently displayed. There is a audit tool developed and will be maintained weekly by Environmental Services Director. All housekeeping and ESD were educated on October 1st, and 2nd of the regulation and compliance. ESD will turn in tool weekly to Executive Director.

Completion Date: *10/25/2021*

Document Submission **Implemented**

the codes were posted and it was corrected on 9/29/2021 while the surveyor was on the premises. [redacted] are maintaining it and an education was completed with staff to know it must remain there at all times and an audit was created to monitor it weekly.

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 #5 was admitted to the home's SDCU on [redacted] however, resident #5's initial support plan was not completed until [redacted]

Plan of Correction **Directed**

Within 72 hours of admission or 72 hours prior to admission all residents shall have an initial support plan. We have developed a checklist to make sure of the timeliness of each document and that it is correct. (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on the new checklist to ensure a support plan for residents admitted to the home's secured dementia care unit are completed in their entirety within 72 hours of admission, or within 72 hours prior to admission. Documentation of the education shall be kept. LM 10/26/21).

Executive Director, and Wellness Manager will review each new admission within 72 hours after admission to ensure adequate documents have been completed and are accurate in accordance with 2600.234.a we will be conducting a chart audit (20%) monthly to ensure all charts are correct and discussed in QA monthly

DIRECTED: Within 10 days of receipt of the plan of correction: A designated staff person shall review all resident records to ensure each resident who resides in the home's secured dementia care unit has a completed support plan, completed in its entirety within 72 hours of admission, or within 72 hours prior to admission. LM 10/26/21

Completion Date: *11/01/2021*

234a - Admission Support Plan *(continued)*

Document Submission **Implemented**

The Executive director has reviewed all support plans in the Secured Dementia unit and completed either the initial or the annual or change of condition to be in compliance with 2600.234. All support plans are up to date and the Wellness Manager will maintain the RASP until the new Wellness Director starts on December 1st, 2021