

Department of Human Services
Bureau of Human Service Licensing

August 2, 2022

[REDACTED], OWNER
[REDACTED]
[REDACTED]

RE: THE FOUNTAINS AT INDIANA
2720 WEST PIKE ROAD
INDIANA, PA, 15701
LICENSE/COC#: 45298

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/04/2022, 04/05/2022 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: *THE FOUNTAINS AT INDIANA* License #: *45298* License Expiration: *07/01/2022*
Address: *2720 WEST PIKE ROAD, INDIANA, PA 15701*
County: *INDIANA* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

[REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *06/01/2021* Issued By: *White TWP of Indiana County*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *24* Waking Staff: *18*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *04/05/2022*

Inspection Dates and Department Representative

04/04/2022 - On-Site: [REDACTED]
04/05/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* Residents Served: *12*

Secured Dementia Care Unit

In Home: *Yes* Area: *The Gardens* Capacity: *22* Residents Served: *12*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *12*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *12* Have Physical Disability: *0*

Inspections / Reviews

04/04/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/02/2022*

Inspections / Reviews (*continued*)

06/22/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/24/2022*

07/01/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/08/2022*

08/02/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

26b - Quality Management Plan Content

1. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review dated 2021, did not address licensing violations and plans of correction.

Plan of Correction

Accept

Licensing inspections were printed out for 6/11/21 and 9/9/21. These licensing violations and plans of correction were both reviewed with staff on 4/28/21. Staff were also instructed as to where to locate the licensing inspections that are posted in the facility. To maintain compliance with 2600.26b, a copy of the most recent licensing inspection will be attached to the Quality Management Review that is done annually. Ongoing, The Administrator will review the most recent licensing violations and corrections with all staff during the annual Quality Management Review.

Completion Date: 04/28/2022

Document Submission

Implemented

Licensing inspections were printed out for 6/11/21 and 9/9/21. These licensing violations and plans of correction were both reviewed with staff on 4/28/21. Staff were also instructed as to where to locate the licensing inspections that are posted in the facility. To maintain compliance with 2600.26b, a copy of the most recent licensing inspection will be attached to the Quality Management Review that is done annually. Ongoing, The Administrator will review the most recent licensing violations and corrections with all staff during the annual Quality Management Review.

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.

Description of Violation

The home's staffing schedule indicates that only 1 staff person routinely works on the 11:00 pm.-7:00 am. shift. However, resident #1 requires a 2-person assist in transferring with a mechanical device for safety. The home's staffing is inadequate to meet the evacuation needs of resident #1.

Plan of Correction

Accept

on [REDACTED]/22 staffing was added to the schedule to support the needs of resident # 1 for care and mobility. This increase in staffing was maintained. The resident was under hospice care and passed away [REDACTED]/22. The death was expected and uneventful. All admissions and change of status in conditions will be reviewed immediately by the administrator or designee and staffing will be based on the mobility needs of the resident that is admitted or has a change in condition to ensure compliance with 2600.60 a please see attached schedule.

Completion Date: 04/05/2022

Document Submission

Implemented

on [REDACTED] 22 staffing was added to the schedule to support the needs of resident # 1 for care and mobility. This

60a - Staff/Support Plan (continued)

increase in staffing was maintained. The resident was under hospice care and passed away [REDACTED] 22. The death was expected and uneventful. All admissions and change of status in conditions will be reviewed immediately by the administrator or designee and staffing will be based on the mobility needs of the resident that is admitted or has a change in condition to ensure compliance with 2600.60 a please see attached schedule.

66a - Staff Training Plan**1. Requirements**

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2022.

Plan of Correction

The Administrator has created the staff training plan as of 4/25/22. The staff training plan documentation sheets were downloaded from the DHS website and placed in a binder for each staff member. January through April trainings will be completed by May 15th and then trainings will be held each month. The administrator or designee will audit the staff training plan and the documentation sheets monthly to ensure all trainings are completed and documented. The administrator will create a new training plan for 2023 in December of 2022. Please see attached training plan.

Accept

Completion Date: 05/15/2022

Document Submission

The Administrator has created the staff training plan as of 4/25/22. The staff training plan documentation sheets were downloaded from the DHS website and placed in a binder for each staff member. January through April trainings will be completed by May 15th and then trainings will be held each month. The administrator or designee will audit the staff training plan and the documentation sheets monthly to ensure all trainings are completed and documented. The administrator will create a new training plan for 2023 in December of 2022. Please see attached training plan.

Implemented**82c - Locking Poisonous Materials****1. Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 4/4/21, a box of denture tabs, with a manufacturer's label indicating "call Poison Control if swallowed", was unlocked, unattended, and accessible to residents on the bathroom sink counter and a container of disinfectant wipes and a can of disinfectant spray, with a manufacturer's label indicating "call Poison Control for treatment" was unlocked, unattended, and accessible to residents sitting on the shelf in the closet in bedroom #130.

Not all the residents of the home, including resident #2, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Plan of Correction

Accept

These items were removed immediately at the time of inspection. They were placed into a lock box inside the resident's closet. All residents have a secure locking box in their closet for all the hygiene products or poisonous materials. On 4/6/22 all resident rooms were audited to make sure all poisonous materials are locked in each resident's lock box so no resident would be able to obtain a poisonous material. Staff will monitor resident rooms daily while providing care to ensure that all poisonous materials remain locked up. These measures will assist with compliance of regulation 2600.82 c

Completion Date: 04/06/2022

Document Submission

Implemented

These items were removed immediately at the time of inspection. They were placed into a lock box inside the resident's closet. All residents have a secure locking box in their closet for all the hygiene products or poisonous materials. On 4/6/22 all resident rooms were audited to make sure all poisonous materials are locked in each resident's lock box so no resident would be able to obtain a poisonous material. Staff will monitor resident rooms daily while providing care to ensure that all poisonous materials remain locked up. These measures will assist with compliance of regulation 2600.82 c

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 4/4/22, there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in kitchenette area.

Plan of Correction

Accept

This was fixed at the time of inspection. A telephone list of the required numbers was placed beside the phone in the kitchenette area. On 4/6/22 staff audited all phone areas in the facility to ensure that all phones had the emergency telephone numbers posted by them. The administrator, designee and staff will audit phone areas daily to ensure that all phones have the emergency numbers beside them. If any phone is missing the emergency phone list, a new list will be immediately placed by the phone. A daily walk-through check list has been created so that the administrator or designee is able to audit the emergency phone list in place daily.

Completion Date: 04/06/2022

Document Submission

Implemented

This was fixed at the time of inspection. A telephone list of the required numbers was placed beside the phone in the kitchenette area. On 4/6/22 staff audited all phone areas in the facility to ensure that all phones had the emergency telephone numbers posted by them. The administrator, designee and staff will audit phone areas daily to ensure that all phones have the emergency numbers beside them. If any phone is missing the emergency phone list, a new list will be immediately placed by the phone. A daily walk-through check list has been created so that the administrator or designee is able to audit the emergency phone list in place daily.

103d - Storing Food Off Floor

1. Requirements

2600.

103d - Storing Food Off Floor (continued)

103.d. Food shall be stored off the floor.

Description of Violation

On 4/4/22, at approximately 10:50 am., 12 five-gallon jugs of water were stored on the floor in the upstairs right side storage room.

Plan of Correction**Accept**

on 4/6/22 all 12 five-gallon jugs were placed on the shelving in the upstairs storage area by staff. The administrator or designee will check the upstairs storage area on a daily walk through of the facility to ensure that the water remains on the shelving and is not on the floor, maintaining compliance with 2600.103d . A daily walk-through check list has been created so that the administrator or designee is able to audit the water remaining on the shelving.

Completion Date: 04/06/2022

Document Submission**Implemented**

on 4/6/22 all 12 five-gallon jugs were placed on the shelving in the upstairs storage area by staff. The administrator or designee will check the upstairs storage area on a daily walk through of the facility to ensure that the water remains on the shelving and is not on the floor, maintaining compliance with 2600.103d . A daily walk-through check list has been created so that the administrator or designee is able to audit the water remaining on the shelving.

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 4/4/22, the local municipality's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction**Accept**

This was fixed at the time of inspection. The administrator placed a new Emergency procedures plan from the local municipalities on the required postings bulletin board. It had been posted previously and must have been removed. The administrator or designee will monitor that it stays on the bulletin board during a daily walk through of the facility. If it has been removed or not there, then the administrator or designee will replace it immediately with a new copy. A daily walk-through check list has been created so that the administrator or designee is able to audit the posted Municipality's Emergency Procedures and ensure that it is posted.

Completion Date: 04/04/2022

Document Submission**Implemented**

This was fixed at the time of inspection. The administrator placed a new Emergency procedures plan from the local municipalities on the required postings bulletin board. It had been posted previously and must have been removed. The administrator or designee will monitor that it stays on the bulletin board during a daily walk through of the facility. If it has been removed or not there, then the administrator or designee will replace it immediately with a new copy. A daily walk-through check list has been created so that the administrator or designee is able to audit the posted Municipality's Emergency Procedures and ensure that it is posted.

133.1 - Exit Signs

1. Requirements

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

There is no exit sign over the sliding glass exit door in the dining room. On 4/14/22, the home served 12 residents.

Plan of Correction**Accept**

The sliding glass door in the dining room is not an exit and leads to a solarium and then to an enclosed patio. At the exit conference it was suggested by the surveyor to post a "not an emergency exit sign on the sliding glass doors" This sign was placed on 4/7/22. please see attached picture. This area is not an exit or and emergency exit to the outside of the building.

Completion Date: 04/07/2022

Document Submission**Implemented**

The sliding glass door in the dining room is not an exit and leads to a solarium and then to an enclosed patio. At the exit conference it was suggested by the surveyor to post a "not an emergency exit sign on the sliding glass doors" This sign was placed on 4/7/22. please see attached picture. This area is not an exit or and emergency exit to the outside of the building.

133.2 - Exit Signs Direction**1. Requirements**

2600.

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

The entrances into hallways 100 and 200 from the dining room, did not have a direct visual line to all exits. There are no signs marking the line of travel to the exits. On 4/4/22, the home served 12 residents.

Plan of Correction**Accept**

on 4/8/22 new signs have been placed in the 100 and 200 hallways distinguishing the line of travel to the exits. These hallways had signs previously, but they were not visible from the dining room, they were only visible in the hallways. please see the attached pictures. The new signs will be monitored to ensure placement and maintain compliance with the regulation during a daily walkthrough by the administrator or designee.

Completion Date: 06/23/2022

Document Submission**Implemented**

on 4/8/22 new signs have been placed in the 100 and 200 hallways distinguishing the line of travel to the exits. These hallways had signs previously, but they were not visible from the dining room, they were only visible in the hallways. please see the attached pictures. The new signs will be monitored to ensure placement and maintain compliance with the regulation during a daily walkthrough by the administrator or designee.

133.3 - Exit Signs Letter Size**1. Requirements**

133.3 - Exit Signs Letter Size (continued)

2600.

133.3. Exit Signs - The following requirements apply for a home serving nine or more residents: Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

Description of Violation

The letters on the exit sign next to the emergency exit door in 100 hallway are only 1 inch high. On 4/4/22, the home served 12 residents.

Plan of Correction**Accept**

On 4/8/22 a new sign was placed by the emergency door in the 100 hallway that has letters at least 6" high. Please see the attached picture. The administrator or designee will do a daily walkthrough of the facility and will look at the emergency door in the 100 hallway and monitor placement to maintain compliance with the regulation.

Completion Date: 06/23/2022

Document Submission**Implemented**

On 4/8/22 a new sign was placed by the emergency door in the 100 hallway that has letters at least 6" high. Please see the attached picture. The administrator or designee will do a daily walkthrough of the facility and will look at the emergency door in the 100 hallway and monitor placement to maintain compliance with the regulation.

141a 1-10 Medical Evaluation Information**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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

On 4/4/22, the medical evaluation for resident #1, dated [REDACTED], did not include dietary needs and indicated "see attachment" for the medication regimen. There was no attachment.

On 4/4/22, the medical evaluation for resident #3, dated [REDACTED], did not include the ability to self-administer medications. This section was blank.

Plan of Correction**Accept**

On 4/7/22 the medical evaluation for resident #1 was updated with the dietary needs. On [REDACTED] the medical evaluation for resident #3 was updated to state that the resident cannot self-administer medications. Both updates were ordered and confirmed by the MD by a phone call and verbal order. All resident charts are currently being

141a 1-10 Medical Evaluation Information (continued)

audited to ensure that all medical evaluations are completely filled out. Upon admission the administrator will review all admission documentation to ensure that all required information is documented. A second review will be done by the designee as a double check to ensure all required information is documented.

Completion Date: 04/07/2022

Document Submission**Implemented**

On [REDACTED] the medical evaluation for resident #1 was updated with the dietary needs. On [REDACTED] the medical evaluation for resident #3 was updated to state that the resident cannot self-administer medications. Both updates were ordered and confirmed by the MD by a phone call and verbal order. All resident charts are currently being audited to ensure that all medical evaluations are completely filled out. Upon admission the administrator will review all admission documentation to ensure that all required information is documented. A second review will be done by the designee as a double check to ensure all required information is documented.

162c - Menu 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 4/4/22, the home's menus were not dated, therefore, unable to determine if the current and upcoming weeks menus were posted.

Plan of Correction**Accept**

This was fixed at the time of inspection and the dates were placed on the menu that was posted. The administrator or designee will monitor during a daily walk through of the facility that the menu is posted for the week with the dates on each day of the menu. If there are no dates on the menu, then the administrator or designee will notify the dietary department to get the dates on the menu. The administrator verbally relayed to dietary that all menus must have the daily dates on them. A daily walk-through check list has been created so that the administrator or designee is able to audit the menu with dates in place daily.

Completion Date: 04/04/2022

Document Submission**Implemented**

This was fixed at the time of inspection and the dates were placed on the menu that was posted. The administrator or designee will monitor during a daily walk through of the facility that the menu is posted for the week with the dates on each day of the menu. If there are no dates on the menu, then the administrator or designee will notify the dietary department to get the dates on the menu. The administrator verbally relayed to dietary that all menus must have the daily dates on them. A daily walk-through check list has been created so that the administrator or designee is able to audit the menu with dates in place daily.

221c - Post Activity Calendar**1. Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

On 4/4/22, the home does not have a current weekly activity calendar posted in a public and conspicuous place in the home.

221c - Post Activity Calendar (continued)

Plan of Correction**Accept**

The activities director had a medical emergency and was not able to produce the activity calendar to be posted. The activity calendar was retrieved from the activities director on 4/7/22 and the activities calendar was posted in the dining room area for all residents and families to see. Each resident was given a calendar as well to keep in their room for reference. The administrator will require that the activity calendar is sent to the administrator on the 28th of each month to post for the next month. The administrator will then post the activities calendar if the activity director had not done so. The activities director otherwise will be responsible for posting the activity calendar on the last day of the month for the following month. The administrator or designee will monitor the activity calendar posting on a daily walk through of the facility. A daily walk-through check list has been created so that the administrator or designee is able to audit the activity calendar in place daily.

Completion Date: 04/07/2022

Document Submission**Implemented**

The activities director had a medical emergency and was not able to produce the activity calendar to be posted. The activity calendar was retrieved from the activities director on 4/7/22 and the activities calendar was posted in the dining room area for all residents and families to see. Each resident was given a calendar as well to keep in their room for reference. The administrator will require that the activity calendar is sent to the administrator on the 28th of each month to post for the next month. The administrator will then post the activities calendar if the activity director had not done so. The activities director otherwise will be responsible for posting the activity calendar on the last day of the month for the following month. The administrator or designee will monitor the activity calendar posting on a daily walk through of the facility. A daily walk-through check list has been created so that the administrator or designee is able to audit the activity calendar in place daily.

231e - No Objection Statement

1. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. On 4/4/21, the home had no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction**Accept**

The resident record has been updated with a statement of no objection to the admission in the resident's chart. The statement was signed by the POA and the resident. All resident records will be audited to make sure each resident has a statement signed that includes both the signature or mark of the resident and the POA. This will be completed by 5/2/22. All new admissions will have a form that has been created for the no objection statement that includes a place for both the resident and the POA to sign. The administrator or designee will be responsible for obtaining the resident signature or mark and the POA signature at the time of admission.

Completion Date: 05/02/2022

Document Submission**Implemented**

The resident record has been updated with a statement of no objection to the admission in the resident's chart. The statement was signed by the POA and the resident. All resident records will be audited to make sure each resident has a statement signed that includes both the signature or mark of the resident and the POA. This will be

231e - No Objection Statement (continued)

completed by 5/2/22. All new admissions will have a form that has been created for the no objection statement that includes a place for both the resident and the POA to sign. The administrator or designee will be responsible for obtaining the resident signature or mark and the POA signature at the time of admission.