Department of Human Services
Bureau of Human Service Licensing

June 3, 2022

[redacted], PCHA

RE: REDSTONE HIGHLANDS
4949 CLINE HOLLOW ROAD
MURRYSVILLE, PA, 15668
LICENSE/COC#: 44338

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/11/2022, 04/12/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

Facility Information

Name: *REDSTONE HIGHLANDS* **License #**: *44338* **License Expiration**: *06/20/2023*

Address: *4949 CLINE HOLLOW ROAD, MURRYSVILLE, PA 15668*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: *Norma Skillings* **Phone**: *7247339494* **Email**: *nskillings@redstone.org*

Legal Entity

Name: *REDSTONE PRESBYTERIAN SENIORCARE*

Address: *6 GARDEN CENTER DRIVE, GREENSBURG, PA, 15601*

Phone: *7247339494* **Email**: *nskillings@redstone.org*

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/24/2010* **Issued By**: *Municipality of Murrysville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *80* **Waking Staff**: *60*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/12/2022*

Inspection Dates and Department Representative

04/11/2022 - On-Site: Scott Klein

04/12/2022 - On-Site: Scott Klein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Terrace* **Capacity**: *20* **Residents Served**: *19*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *37* **Have Physical Disability**: *0*

Inspections / Reviews

04/11/2022 - Full

Lead Inspector: *Scott Klein* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/30/2022*

Inspections / Reviews *(continued)*

04/26/2022 - POC Submission

Reviewer: *Jon Kimberland* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/29/2022*

05/25/2022 - POC Submission

Reviewer: *Jon Kimberland* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/27/2022*

06/03/2022 - Document Submission

Reviewer: *Jon Kimberland* **Follow-Up Type**: *Not Required*

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/11/22 at approximately 11:52 a.m. in the home's Country Kitchen combination refrigerator and freezer, underneath the fruit and vegetable drawers, a brown liquid of unknown origin is dried and is stuck to the bottom of the refrigerator.

On 4/11/22 at approximately 12:45 p.m. in the home's main kitchen, the ice cream freezer has unidentifiable bits of debris along the top rim of the freezer, multiple scoops of ice cream outside of the containers in the basin of the freezer, and what appears to be partially melted ice cream stuck to the sides of the freezer walls.

Plan of Correction ***Do Not Accept***

Plan of Correction
The Director of dining will implement a weekly cleaning system to ensure that cleanliness is maintained at all times with all refrigerated and freezer equipment. An inspection verification log has been put in place as of 04/15/22 and will continue for a 3 month period checking bi-weekly to ensure the new system is compliant. The inspection log will be signed off once inspected by the Campus Director, Dining Director/Manager, and initialed by the PCHA. Please see attachment # 1.
Completion Date: 07/29/22

Completion Date: *07/29/2022*

Plan of Correction ***Accept***

Plan of Correction
There was brown liquid of unknown origin found in the country kitchen and bits of debris along with scoops of ice cream in the main kitchen's ice cream freezer. Per sanitary regulation 2600.85a both areas were immediately cleaned on 4/1/22. Moving forward the Director of dining will implement a weekly cleaning system to ensure that cleanliness is maintained at all times with all refrigerated and freezer equipment. An inspection verification log has been put in place as of 04/15/22 and will continue for a 3 month period checking bi-weekly to ensure the new system is compliant. The inspection log will be signed off once inspected by the Campus Director, Dining Director/Manager, and initialed by the PCHA. The staff was educated on regulations concerning sanitary conditions and reporting unsanitary conditions to appropriate persons. Please see attachment # 1.
Completion Date: 07/22/22

Completion Date: *07/22/2022*

Document Submission ***Implemented***

see attached

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records *(continued)*

Description of Violation

On 12/31/21 at 6:01 a.m. the home conducted a fire drill. However, the fire drill log does not indicate the number of residents in the home at the time the alarm sounded or the number of residents evacuated, those areas are blank.

Plan of Correction ***Accept***

Plan of Correction
The fire drill record document that is in place was verified by the inspector to be a compliant document, therefor we will continue the use of this document. Immediately after each fire drill the fire safety expert will meet with the PCHA to review that all documentation is completed and in compliance. The PCHA will initial off on the form for each fire drill. The document will be submitted for a 3 month period ending 07/31/2022. The PCHA will then continue to be involved with each fire drill and initial off on each event. Please see attachment # 2
Completed Date: 07/31/22

Completion Date: *07/31/2022*

Document Submission ***Implemented***

See attached

132d - Evacuation

1. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 1/23/22 at 1:54 p.m. the home conducted a fire drill. However, the fire drill log indicates there were 42 residents at the time the alarm was sounded and that 41 residents were evacuated to a public thoroughfare, or to a fire safe area designated in writing within the past year by a fire safety expert.

Plan of Correction ***Do Not Accept***

Plan of Correction
Moving forward in the event a resident is not able to be moved a written request will be submitted along with all documentation for approval prior to the fire drill. If this should be a true event and prior approval is not obtained a state reportable will be submitted immediately and available for review.
Completion date: 12/31/22

Completion Date: *12/31/2022*

Plan of Correction ***Accept***

Plan of Correction
On 1/23/22 the evacuation records showed 41 out of 42 residents being evacuated. One resident was not evacuated during the fire drill due to being COVID positive and in isolation. Regulation2600.132.d states that all residents shall be moved to a public thoroughfare or designated fire safety area. Moving forward to avoid having this happen again a written submission will be sent to the Regional Director for approval to leave a resident in place. Should there be a true event and prior approval was not obtained we will submit an immediate State Reportable. The Administrator will review the fire drill record to ensure all residents are evacuated during the fire drills.

132d - Evacuation (continued)

Completion date: 07/22/22

Completion Date: *07/22/2022*

Document Submission ***Implemented***

see attached

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

Resident #1's medical evaluation, dated 6/3/21, does not indicate the resident's height or weight. These sections were blamk.

Plan of Correction ***Do Not Accept***

Plan of Correction
A Resident Admission Tracking document has been created to ensure all documentation is present and correct on all DME's. This document will be used for all admissions with a start date of 04/21/22. This document will be submitted for a 3 month period with an ending date of 07/22/22. The PCHA will document and track all admissions, initialing off once completed. Please see attachment # 3.
Completion Date: 07/22/22

Completion Date: *07/22/2022*

Plan of Correction ***Accept***

Plan of Correction
On 6/23/21 the medical evaluation form was not fully completed. The height and weight of the resident was not documented on the form. The nursing staff was immediately educated to ensure the medical evaluation form will be completed in its entirety with in the acceptable time frame. A Resident Admission Tracking document has been created to ensure all documentation is present and correct on all DME's. This document will be used for all admissions with a start date of 04/21/22. This document will be submitted for a 3 month period with an ending date of 07/22/22. The PCHA will document and track all admissions, initialing off once completed. Resident #1 medical evaluation was corrected with the permission of the doctor. The Administrator will review all DME's for correctness and completeness. Please see attachment # 3.
Completion Date: 07/22/22

141a 1-10 Medical Evaluation Information (continued)

Completion Date: *07/22/2022*

Document Submission ***Implemented***

see attached

see attached

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 is ordered Lantus SoloStar Solution Pen-Injector 100 UNIT/ML (Insulin Glargine) Inject 35 unit subcutaneously at bedtime. However, on 4/2/22 at 9:00 p.m., the medication was held without orders by the physician and the resident was not administered 35 units of Lantus insulin.

Plan of Correction ***Do Not Accept***

Plan of Correction
A Medication Administration Audit has been created for monitoring accuracy of Medication administration. This document will start on 04/12/22 with an end date of 07/22/22. A weekly audit will be conducted randomly choosing 2 residents and completing a full audit of the MAR. The Audit will consist of checking the Mar, any discrepancies, and explanation of discrepancies followed by Action taken to correct any issues. The PCHA/Nurse will initial after completing the audit in the box marked chart auditor. Please see attachment # 4.
Completion date: 07/22/22

Completion Date: *07/22/2022*

Plan of Correction ***Accept***

Plan of Correction
Resident #1 was ordered Lantus SoloStar Solution Pen-Injector 100 UNIT/ML (Insulin Glargine) inject 35 unit subcutaneously at bedtime. The nurse did not obtain orders from the PCP before with holding the insulin. All medication that is withheld should only be done so with a doctor's order. The nurse was educated and the incident documented. Moving forward a Medication Administration Audit has been created for monitoring accuracy of Medication administration. This document will start on 04/12/22 with an end date of 07/22/22. A weekly audit will be conducted randomly choosing 2 residents and completing a full audit of the MAR. The Audit will consist of checking the Mar, any discrepancies, and explanation of discrepancies followed by Action taken to correct any issues. The PCHA/Nurse will initial after completing the audit in the box marked chart auditor. A State Reportable was submitted as part of this plan of correction. The physician was notified on 04/13/22 and the resident was notified on 04/02/22 for the omission. New orders were obtained from the physician. Please see attachment # 4.
Completion date: 07/22/22

Completion Date: *07/22/2022*

Document Submission ***Implemented***

see attached
see attached

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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on 2/15/22. However, the resident's medical evaluation was completed on 9/20/21.

Resident #2's was admitted to the Secure Dementia Care Unit (SDCU) on 2/15/22. However, the resident's medical evaluation, dated 9/20/21, does not indicate the resident's weight or temperature.

Repeat Violation; 3/25/21

Plan of Correction ***Accept***

Plan of Correction
A Resident Admission Tracking document has been created to ensure all documentation is present and correct on all DME's. This document will be used for all admissions with a start date of 04/21/22. This document will be submitted for a 3 month period with an ending date of 07/22/22. The PCHA will document and track all admissions, initialing off once completed. The document will ensure that the PCHA is tracking the correct time line of the DME dated no later than 60 days prior to admission for a memory care unit. Please see attachment # 3.
Completed Date: 07/22/22

Completion Date: *07/22/2022*

Document Submission ***Implemented***

see attached

see attached

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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on 2/15/22. However, the resident's admission support plan, dated 2/25/22, was not developed, implemented, and documented in resident #2's record within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit.

Plan of Correction ***Accept***

Plan of Correction
A Resident Admission Tracking Document was created and implemented on 4/21/22. This document will track the time line of the admission process tracking admission date and the date when the RASP is completed. Each

234a - Admission Support Plan (continued)

admission will be tracked for a 3 month period ending date of 07/22/22 to ensure compliance of each new admission with the PCHA initialing to show completion. The PCHA will initial off once the RASP is completed. Please see attachment # 3.
Completion Date: 07/22/22

Completion Date: *07/22/2022*

Document Submission ***Implemented***

see attached

see attached