

Department of Human Services  
Bureau of Human Service Licensing

June 2, 2022

[REDACTED], DIRECTOR OF OPERATIONS  
TRANSITIONS HEALTHCARE WASHINGTON PA LLC  
90 HUMBERT LANE  
WASHINGTON, PA, 15301

RE: TRANSITIONS HEALTHCARE  
WASHINGTON PA  
90 HUMBERT LANE  
WASHINGTON, PA, 15301  
LICENSE/COC#: 44599

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 04/19/2022, 04/20/2022, 04/21/2022 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations 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: *TRANSITIONS HEALTHCARE WASHINGTON PA* License #: *44599* License Expiration: *07/22/2023*  
Address: *90 HUMBERT LANE, WASHINGTON, PA 15301*  
County: *WASHINGTON* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *TRANSITIONS HEALTHCARE WASHINGTON PA LLC*  
Address: *90 HUMBERT LANE, WASHINGTON, PA, 15301*  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-1* Date: *01/31/1985* Issued By: *Department of Health*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *30* Waking Staff: *23*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Complaint* Exit Conference Date: *04/21/2022*

**Inspection Dates and Department Representative**

04/19/2022 - On-Site: [REDACTED]  
04/20/2022 - On-Site: [REDACTED]  
04/21/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *48* Residents Served: *23*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *1*

**Number of Residents Who:**

Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *23*  
Diagnosed with Mental Illness: *5* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *7* Have Physical Disability: *0*

**Inspections / Reviews**

**04/19/2022 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/26/2022*

Inspections / Reviews (*continued*)

05/26/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *06/02/2022*

06/02/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *07/31/2022*

## 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 most recent quality management review was completed in April, 2020.*

## Plan of Correction

Accept

*The PCH Administrator received training on the Abaqis (quality assurance) platform on 5/23/22. The Quality Management Meeting will be facilitated by the Administrator and held monthly. Minutes will be entered into the Abaqis system. Monthly meeting will include discussion on reportable incident and conditions, complaint procedures, staff person training, licensing violations and plans of corrections, and resident council. Quality Management Meeting – First meeting held 5/26/22.*

**Completion Date:** 05/26/2022

## 42b - Abuse

## 1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

## Description of Violation

*Resident #2 indicates that staff person B, the home's administrator, frequently rubs resident #2's arms and back in a way that makes the resident feel "yucky". Resident #2 has asked staff person B to stop touching the resident on numerous occasions; however, staff person B states, "that's just the way I am."*

*In the beginning of [REDACTED], resident #5 was talking with staff person B in resident #5's bedroom. Resident #5 stated [REDACTED] was talking with staff person B about getting more frequent showers for [REDACTED], as well as resident #12, who is resident #5's [REDACTED] and [REDACTED] as resident #5. Staff person B asked resident #5 if resident #12 got a "whore bath". Resident #5 asked staff person B what a "whore bath" was and staff person B responded. "Like a whore. After they have sex, they have to wash themselves". Residents #5 and #12 were upset by staff person B's statements and did not feel comfortable talking to staff person B. Resident #12 indicated the inappropriate statements made [REDACTED] feel "mortified".*

*Resident #10 [REDACTED] resident #11. In the beginning of [REDACTED], staff person B entered resident #10 and #11's [REDACTED] and began asking resident #11 questions, such as, "Who is the President?", "When was your mother born?" and "When was your father born?" While staff person B was questioning resident #11, staff person B was winking at resident #10. Resident #10 states that resident #11 became visibly upset, because resident #11 was unable to answer the questions [REDACTED]; however, staff person B continued to ask the resident questions. Resident #10 stated that staff person B is aware of resident #11's [REDACTED] and believes staff person B was questioning resident #11 "as a game". After staff person B left [REDACTED] resident #10 indicated resident #11 was upset and on the verge of tears due to resident #11's inability to answer the questions asked by staff person B.*

**42b - Abuse (continued)**

In the beginning of [REDACTED] staff person C was outside of the [REDACTED] of residents #10 and #11 when staff person C observed staff person B pull the sheet off of resident #11 and say, "look at that fat ass". Staff person C stated staff person B then raised his voice and yelled at resident #11 to, "get out of bed."

Numerous residents and staff persons indicated that staff person B regularly discusses [REDACTED] personal sexual encounters [REDACTED] has with [REDACTED] partners. Residents and staff persons indicated these conversations make them feel uncomfortable.

**Plan of Correction****Directed**

Investigation was immediately initiated, Staff Person B, Nursing Home Administrator, was suspended and subsequently terminated on [REDACTED]. The Regional Clinical Nurse provided education and training on abuse identification and reporting on [REDACTED]. Staff also receive education on abuse upon hire, annually, and as needed thereafter. Department approved Abuse/Neglect training for staff will be completed by Protective Services on [REDACTED]. Documentation of training will be kept with the quality management meeting in Abaqis. The Regional Director of Operations/designee will interview 5 staff/residents monthly to ensure residents are free from abuse/neglect. Documentation of interviews will be kept with the monthly quality management meeting minutes. (DIRECTED: The monthly staff/resident interviews shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

On [REDACTED], [REDACTED] was notified via e mail of the immediate interim personal care home administrator. Interim administrator is a current employee of the personal care and has been employed since [REDACTED]. To ensure that the administrator does not violate any resident rights and residents are free from abuse/neglect, corporate oversight from the Regional Director of operations/designee will complete monthly visits to the facility and interview 5 staff/residents to ensure resident rights are protected. (DIRECTED: The monthly staff/resident interviews conducted by the Regional Director of Operations/Management designee shall begin within 5 calendar days of receipt of the plan of correction. Documentation of the interviews shall be kept. [REDACTED] 6/2/22).

The facility hotline number is posted at the bedside of each resident. The facility will conduct a quality management review and evaluation by [REDACTED]. The Administrator will place an increase emphasis on the plans of correction and take action to improve the quality of the resident rights. All new hires will have training completed within 40 scheduled working hours in accordance with 2600.65(b)(1) and 2600.65(b)(3). Training will also be completed annually in accordance with 2600.65(g)(3) and 2600.65(g)(4). (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 6/2/22).

**Completion Date:** 06/15/2022

**42h - Religion****1. Requirements**

2600.

42.h. A resident has the right to practice the religion or faith of the resident's choice, or not to practice any religion or faith.

## 42h - Religion (continued)

**Description of Violation**

Staff person B, the home's administrator, regularly talks to staff persons and residents about being [REDACTED]. Most recently, staff person B talked to residents about [REDACTED] during a resident council meeting. Numerous residents indicated they do not feel comfortable practicing their religion of choice, because staff person B regularly talks to residents and staff persons about [REDACTED].

**Plan of Correction****Directed**

Staff Person B was terminated on [REDACTED]. Resident Council meeting was held on [REDACTED] which included discussion with the residents on resident rights including the right to practice the religion or faith of choice, or not to practice any religion or faith. New hires will receive education and training on resident rights with their orientation program. Department approved training on Resident rights for staff, including residents' rights to practice religion, will be completed by the Area Ombudman on [REDACTED]. Documentation of training will be kept with the quality management meeting in Abaqis.

The Regional Director of Operations/designee will interview 5 staff/residents monthly to ensure residents rights are not violated. Documentation of interviews will be kept with the monthly quality management meeting minutes. (DIRECTED: The monthly staff/resident interviews shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

On [REDACTED] was notified via e mail of the immediate interim personal care home administrator. Interim administrator is a current employee of the personal care and has been employed since [REDACTED]. To ensure that the administrator does not violate any resident rights, corporate oversight from the Regional Director of operations/designee will complete monthly visits to the facility and interview 5 staff/residents to ensure resident rights are protected. (DIRECTED: The monthly staff/resident interviews conducted by the Regional Director of Operations/Management designee shall begin within 5 calendar days of receipt of the plan of correction. Documentation of the interviews shall be kept. [REDACTED] 6/2/22).

The facility hotline number has been posted at the bedside of each resident. The facility will conduct a quality management review and evaluation. by July 31, 2022. The Administrator will place an increase emphasis on the plans of correction and take action to improve the quality of the resident rights. All new hires will have training completed within 40 scheduled working hours in accordance with 2600.65(b)(1) and 2600.65(b)(3). Training will also be completed annually in accordance with 2600.65(g)(3) and 2600.65(g)(4). (DIRECTED: Documentation of the quality management reviews shall be kept. [REDACTED] 6/2/22).

**Completion Date:** 06/02/2022

## 57c - 2 Hours/Day

**1. Requirements**

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

**Description of Violation**

The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs.

On 4/9/22, there were 22 residents in the home, including [REDACTED], requiring a total minimum of 29 hours of direct care hours. On this day, only 28 hours of direct care staffing were provided.

## 57c - 2 Hours/Day (continued)

**Plan of Correction****Directed**

Facility cannot go back in hours. The clinical coordinator will calculate hours and adjust based on new admissions or change in mobility. Resident census and mobility calculation will be added to the schedule. Excel report created to track and monitor compliance.

Daily review of the schedule will be completed by the administrator to ensure adequate staffing coverage.

(DIRECTED: The daily review of staffing hours shall begin within 24 hours of receipt of the plan of correction. [REDACTED]

6/2/22). Staffing increases with an increase in census or change in mobility status of residents. The facility has contracted agency staff that will supplement the staffing needs. Substitute personnel when available from the skilled nursing unit who meet the direct care staff qualifications and training requirements will be utilized as needed. Staff training on 2hours/day will be completed on 6/1/22. Staffing will be discussed ongoing in the monthly Quality Mangement Meeting.

**Completion Date:** 06/02/2022

## 57d - Waking Hours

**1. Requirements**

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

**Description of Violation**

The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs.

On 4/9/22, there were 22 residents in the home, including [REDACTED], requiring a total minimum of 21.75 hours of direct care staffing during waking hours. On this day, only 20.5 hours of direct care staffing were provided during waking hours.

**Plan of Correction****Directed**

Facility cannot go back in hours. The clinical coordinator will calculate hours and adjust based on new admissions or change in mobility. Resident census and mobility calculation will be added to the schedule to ensure 75% of hours are during resident waking hours. Excel report initiated to track and monitor compliance. Daily review of the schedule will be completed by the administrator to ensure adequate staffing coverage during waking

hours. (DIRECTED: The daily review of staffing hours shall begin within 24 hours of receipt of the plan of correction.

[REDACTED] 6/2/22).

The facility has contracted agency staff that will supplement the staffing needs. Substitute personnel when available from the skilled nursing unit who meet the direct care staff qualifications and training requirements will be utilized as needed. Staff training on waking hours will be completed 6/1/22. The administrator will review/discuss staffing at the monthly quality management meeting.

**Completion Date:** 06/02/2022

## 60a - Staff/Support Plan

**1. Requirements**

60a - Staff/Support Plan (continued)

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

On 4/9/22, there were 22 residents in the home, including [redacted]. Of the [redacted] [redacted]

On 4/12/22, there were 23 residents in the home, including [redacted]. Of the [redacted] [redacted]

On 4/18/22, there were 23 residents in the home, including [redacted]. Of the [redacted] [redacted]

However, on 4/9/22, 4/12/22 and 4/18/22, there was only 1 staff person present in the home from approximately 11:00 PM through 7:00 AM, which is not adequate to safely evacuate all residents in the event of an emergency.

Plan of Correction

Directed

Facility cannot go back in hours. The clinical coordinator has been scheduling two staff members on 11-7 shift. Resident census and mobility calculation will be added to the schedule. Facility will have two staff on 11PM to 7 AM shift due to mobility needs of the residents. Excel report initiated to track and monitor compliance. Daily review of the schedule will be completed by the administrator to ensure adequate staffing coverage on nights. (DIRECTED: The daily review of staffing hours shall begin within 24 hours of receipt of the plan of correction. [redacted] 6/2/22).

The facility has contracted agency staff that will supplement the staffing needs. Substitute personnel when available from the skilled nursing unit who meet the direct care staff qualifications and training requirements will be utilized as needed.

Fire Drill will be conducted during sleeping hours to ensure all residents are evacuated within the time specified by the fire safety expert ( South Strabane Fire Chief). Drill will be completed 6/2/22.

Completion Date: 06/03/2022

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A was hired on [redacted]; however, did not receive orientation on any of the topics specified in 2600.65a.

## 65a - FS Orientation 1st Day (continued)

REPEAT VIOLATION: 6/9/2021, et. al.

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

Staff person A received orientation training on [REDACTED]. New hires will receive orientation on evacuation procedure, staff duties and responsibilities during fire drills, smoking safety procedures, location and use of fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services. New hire orientation will be discussed in the monthly quality management meeting to ensure compliance. Records reviewed and all current staff have received all the trainings specified in 2600.65(a). Record review completed on 5/23/22 by the Human Resources Director. Copies of the PCH orientation checklists are secured in the employee files. All newly hired staff persons will receive training on all the topics specified in 2600.65a prior to their first day of work during their new hire orientation. Newly hired staff will be scheduled and attend the orientation program provided by Human Resources. Once orientation has been completed, the newly hired staff will then be placed on the schedule. Staff training will be conducted by the Administrator/designee. Human Resources and the Administrator received re-education on the new hire training process. Re-education was completed on 5/31/22.

**Completion Date:** 05/31/2022

## 65b - Rights/Abuse 40 Hours

**1. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

Staff person A was hired on [REDACTED]; however, did not receive orientation on any of the topics specified in 2600.65b.

**Plan of Correction****Directed**

Staff person A received rights/abuse training on [REDACTED] (DIRECTED: Within 5 calendar days of receipt of the plan of correction: Staff person A shall receive training on all topics specified in 2600.65b. Documentation of the education shall be kept. [REDACTED] 6/2/22)

Orientation training packet has been revised. New hires will receive orientation on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents and conditions. Staff records reviewed by Human Resources and all current staff have received all the trainings specified in 2600.65(b) prior to working 40 hours. Record review completed on 5/23/22. All newly hired staff persons will receive training on all the topics specified in 2600.65a prior to working 40 hours. (DIRECTED: All newly-hired staff persons shall receive training on all topics specified in 2600.65b within 40 scheduled working hours. [REDACTED] 6/2/22). Newly hired staff will be scheduled and attend the orientation program provided by Human Resources. Staff training will be conducted by Human Resources and the Administrator. Human Resources and the Administrator received re-education on the new hire training process on 5/31/22. New hires will be discussed in the monthly quality management meeting

**Completion Date:** 06/01/2022

## 85a - Sanitary Conditions

## 1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On 4/21/22, there were no paper towels, mechanical air blower or other sanitary means of hand drying present in the following resident bathrooms:

- The [REDACTED] of residents #2 and #3
- The [REDACTED] of residents #6 and #7

**Plan of Correction****Directed**

Paper towel dispensers in [REDACTED] of residents #2 and #3 and [REDACTED] of resident #6 and #7 have been filled. Staff will refill dispensers as needed daily. Audit completed 5/31/22 and all bathrooms checked and each bathroom has a paper towel dispenser stocked. Staff education provided on restocking paper towels. Education completed 6/1/22. Administrator will complete walking rounds and monitor towel dispensers weekly to ensure paper towels are available in each resident room. Results of walking rounds will be discussed in the monthly quality management meeting. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

**Completion Date:** 06/02/2022

## 87 - Lighting

## 1. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

**Description of Violation**

On 4/20/22, no lighting was present at the evacuation route leading from the exit door next to bedroom #118.

**Plan of Correction****Directed**

Maintenance added a light in the ceiling of the evacuation route leading from the exit door next to room #118. All hallways, interior stairs, outside steps, outside doorways, porches, evacuation routes, outside walkways and fire exits have been checked and no other lighting concerns identified by the maintenance director. Maintenance Director will add a monthly lighting check into their preventative maintenance monitoring system (TELS). Results of monthly lighting check will be reviewed in the monthly quality management meeting. (DIRECTED: The monthly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

**Completion Date:** 05/31/2022

## 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.

**Description of Violation**

On 4/19/22, water damage and peeling paint were present on the ceiling and the left side of the wall of the corridor leading from the exit door next to bedroom #118.

**88a - Surfaces (continued)****Plan of Correction****Directed**

Water damage and peeling paint on the ceiling and the left side of the wall of the corridor leading from the exit door next to bedroom #118 has been repaired. No other areas have been identified. Maintenance checked all other floors, walls, ceilings, windows, doors and other surfaces to ensure they clean, in good repair and free of hazards. Maintenance will complete walking rounds monthly to identify any surface that needs repaired. (DIRECTED: The monthly monitoring shall begin within 5 calendar days of receipt of the plan of correction. ■ 6/2/22). Maintenance will discuss results of his walking rounds monthly in the quality management meeting, Staff will be trained on how to complete a work order when they identify an area that needs repaired. Request is entered into the TELs system. Training will be completed by 6/2/22.

**Completion Date:** 06/02/2022

**90b - Staff Communication****1. Requirements**

2600.

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

**Description of Violation**

On 4/19/22, 4/20/22 and 4/21/22, the home served 23 residents. According to multiple staff persons, the home has rechargeable walkie-talkies at the nurse's station; however, staff persons do not utilize these communication devices. The walkie-talkies were observed by an agent of the Department sitting unused at the nurses station the duration of the inspection.

**Plan of Correction****Directed**

Walkie Talkie communication system training completed on 5/18/22. Administrator provided the training. Administrator will complete walking rounds weekly and during rounds monitor use of the communication system. Results of rounding will be discussed in the the monthly quality management meeting. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. ■ 6/2/22).

**Completion Date:** 05/31/2022

**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 4/19/22, there were no emergency telephone numbers posted on or near the telephone in bedroom #131.

## 91 - Telephone Numbers (continued)

**Plan of Correction****Directed**

Emergency Telephone Number Listing was updated with pertinent required phone numbers and posted in bedroom #131. Updated listing has been posted in all bedrooms. All other phones were checked and have required numbers posted per 2600.91.

The administrator will complete walking rounds once a week to check and ensure postings of phone numbers are next to all phones. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

Staff training on phone number posting completed 6/1/22.

Results of walking rounds will be discussed at the monthly quality management meeting.

**Completion Date:** 06/01/2022

## 101j1 - Mattress Fire Retardant

**1. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

**Description of Violation**

Resident #5's [REDACTED] is supposed to move up and down; however, on 4/22/22, resident #5's [REDACTED] was inoperable.

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

Maintenance repaired the [REDACTED] for resident #5 and it is now functioning. No other bed was identified as in need of repair. Staff will notify maintenance for any [REDACTED] that do not function correctly. If a resident is ordered a [REDACTED], a nursing measure order will be added to the MAR to check functionality daily.

Maintenance Director checked other resident beds physically and all beds have an appropriate bed and frame. Staff training will be completed 6/1/22 on this requirement. Maintenance will discuss any concerns with beds in the monthly quality management meeting,

**Completion Date:** 06/02/2022

## 101j2 - Bedroom Chairs

**1. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

2. A chair for each resident that meets the resident's needs.

**Description of Violation**

On 4/21/22, there was only 1 chair present in the [REDACTED] of residents #2 and #3.

On 4/21/22, there was only 1 chair present in the [REDACTED] of residents #6 and #7.

101j2 - Bedroom Chairs (*continued*)**Plan of Correction****Directed**

Chairs have been added to [REDACTED] of residents #2 and #3 and in the [REDACTED] of residents #6 and #7. No other room identified with a missing chair. Administrator will complete walking rounds weekly to ensure each resident has a bedside chair. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

On 5/31/22 all other resident bedrooms were physically checked and each resident has a chair that meet their needs. Staff training on this requirement will be completed 6/1/22. Results of walking rounds will be discussed in the monthly Quality Management Meeting.

**Completion Date:** 06/02/2022

## 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 4/21/22, resident #6's bedside lamp was approximately 5' from the resident's bed and could not be turned on/off from bedside.

On 4/21/22, resident #7's bedside lamp was approximately 5' from the resident's bed and could not be turned on/off from bedside.

On 4/21/22, resident #8's bedside lamp was approximately 4' from the resident's bed and could not be turned on/off from bedside.

**Plan of Correction****Directed**

Battery operated bedside light was added to the night stands of resident #6, #7, and #8. Lights placed within 5 feet of each bedside. Lighting at bedside discussed in resident council on 5/23/22. Maintenance completed an audit of bedside lighting and additional lighting added to beds identified as needing a light. Bedside lights will be added to any other resident's bedside that is identified as needing a light.

The administrator will complete walking rounds weekly to ensure each resident bed has a operable light source that can be turned on from the bedside. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22). Staff training will be completed 6/1/22. Batteries available at the nursing station for replacement. Results of walking rounds on Bedside Lighting will be discussed in the monthly quality management meeting.

**Completion Date:** 06/02/2022

## 102i - Soap Dispenser

**1. Requirements**

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

**Description of Violation**

On 4/21/22, no soap was present in the soap dispenser in resident #1's bathroom.

On 4/21/22, there was an unlabeled bar of soap at the [REDACTED] of residents #2 and #3.

On 4/21/22, there was an unlabeled bar of soap at the [REDACTED] of residents #6 and #7.

**Plan of Correction****Directed**

Soap dispenser in resident #1 bathroom filled. Bar soap was removed from [REDACTED] of residents #2 and #3 and residents # 6 and #7. If a resident prefers bar soap, soap will be placed in a plastic soap container with the resident name labelled on it. Soap and dispensers discussed in the resident council meeting on 5/23/22. Audit of all bathrooms completed each bathroom has a soap dispenser and they are filled. No unlabelled bars of soap present. Staff education provided on use of soap dispenser and bar soaps being stored and labeled. Education completed 6/1/22. Administrator will monitor soap dispensers and bar soap usage weekly to ensure soap dispensers are filled and no unlabeled bar soap left in the bathroom. Results of walking rounds will be discussed in the monthly Quality Management Meeting. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

**Completion Date:** 06/02/2022

**102k - No Common Towel****1. Requirements**

2600.

102.k. Use of a common towel is prohibited.

**Description of Violation**

On 4/21/22, there were unlabeled, used towels present in the [REDACTED] of residents #2 and #3.

On 4/21/22, there were unlabeled, used towels present in the [REDACTED] of residents #6 and #7.

**Plan of Correction****Directed**

Each towel rack is labelled with the resident names placed on the wall to identify the resident the towels belong to. Each resident bathroom had this completed. Resident #2 #3 #6 and # 7 who were identified during survey have had their towel rack labeled with their name. Clinical Coordinator will monitor process and make sure new admissions have their towel rack labeled with their name. New process was reviewed in the 5/23/22 resident council meeting. The administrator will complete walking rounds weekly to ensure proper labeling of towel racks and each resident has individual towels for use. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22). Staff training on towel labeling and use completed 6/1/22. Results of walking rounds will be discussed in the monthly Quality Management Meeting.

## 102k - No Common Towel (continued)

Completion Date: 06/02/2022

## 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 4/20/22, the home and municipality's emergency procedures were not posted in a conspicuous and public place.

REPEAT VIOLATION: 6/9/2021, et. al.

## Plan of Correction

*Directed*

The home procedures are posted on the wall near the lobby. Red bifold folder is labeled emergency management guide. The Washington County Emergency Management has been contacted to obtain a copy of the municipality emergency procedures to post. Fire Chief providing plan on 6/2/22. Once the emergency procedures are obtained, a copy will be posed with the facilities plan. The Administrator will complete walking rounds weekly to ensure procedures are posted in the designated public place. Results of walking rounds will be discussed in the monthly Quality Management Meeting. (DIRECTED: The weekly monitoring shall begin within 5 calendar days of receipt of the plan of correction. [REDACTED] 6/2/22).

Completion Date: 06/03/2022

## 130e - Hearing Impairment

## 1. Requirements

2600.

130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

## Description of Violation

Resident #8 is [REDACTED] the fire alarm system; however, resident #8 [REDACTED] approved by a fire safety expert so resident #8 is [REDACTED].

## Plan of Correction

*Directed*

The facility reached out to [REDACTED] for recommendations on [REDACTED]. The [REDACTED] was identified as the appropriate choice. The [REDACTED] purchased 5/27/22. Once equipment arrives, it will be installed by the fire alarm expert vendor, ABCO. Staff and resident will be trained on the system once it is installed. (DIRECTED: The staff training shall be completed within 5 calendar days of installation of the system. Documentation of the education shall be kept. [REDACTED] 6/2/22). Fire chief will review the device during his onsite visit on 6/2/22. Device will be installed 6/8/22. Currently, staff notify resident #8 in the event of fire alarm activation and ensure evacuation. No other residents identified as [REDACTED].

**130e - Hearing Impairment (continued)**

*Any resident with a hearing impairment and cannot hear the alarm will have the silent alarm system purchased and installed. A direct observation of residents unable to hear fire alarm will be conducted to ensure appropriate resident response from the silent alarm system during monthly drills to monitor this process. Staff training on hearing impaired residents/fire alarm activation and assistance completed on 6/1/22. Results of drills will be discussed in the monthly Quality Management Meeting.*

**Completion Date:** 06/10/2022

**132b - Safety Inspection/Fire Drill****1. Requirements**

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

**Description of Violation**

*A fire safety inspection and fire drill conducted by a fire safety expert has not been completed within the past year.*

**Plan of Correction****Directed**

*Fire inspection and drill scheduled with the South Strabane Fire Chief for 6/2/22 at 10:00 AM. (DIRECTED: Documentation of the fire safety inspection and fire drill conducted by a fire safety expert shall be kept. [REDACTED] 6/2/22). Going forward, an annual inspection and drill will be scheduled by the maintenance director. Reminder will be entered into the preventative maintenance system, TELS. The annual fire safety inspection and drill conducted by a fire safety expert will be pre loaded in the preventative maintenance system (TELS) to reoccur annually in June. Results of drill will be discussed in the monthly Quality Management Meeting.*

**Completion Date:** 06/03/2022

**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.

**Description of Violation**

*The fire drill record for the fire drill conducted on 12/29/21 at 3:45 does not include if the fire drill was conducted in the AM or PM, the amount of time it took for evacuation in minutes and seconds, the number of residents present in the home at the time of the fire drill, the number of staff persons participating, the exit routes used, and whether the fire alarm or smoke detectors were operative.*

*The fire drill record for the fire drill conducted on 1/13/22 at 6:00 AM does not include the amount of time it took for evacuation in minutes and seconds, the number of residents present in the home at the time of the fire drill, the number of residents that were evacuated, the number of staff persons participating, the exit routes used, and whether the fire alarm or smoke detectors were operative.*

*The fire drill record for the fire drill conducted on 2/2/22 at 1:51 PM does not include the amount of time it took for*

**132c - Fire Drill Records (continued)**

evacuation in minutes and seconds, the number of residents that were evacuated and the exit routes used.

The fire drill record for the fire drill conducted on 2/25/22 at 3:30 PM does not include the amount of time it took for evacuation in minutes and seconds, the number of residents present in the home at the time of the fire drill, the number of residents that were evacuated, the number of staff persons participating, the exit routes used, and whether the fire alarm or smoke detectors were operative.

The fire drill record for the fire drill conducted on 3/30/22 at 5:00 PM does not include the amount of time it took for evacuation in minutes and seconds, the number of residents present in the home at the time of the fire drill, the number of residents that were evacuated, the number of staff persons participating, the exit routes used, and whether the fire alarm or smoke detectors were operative.

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

The facility cannot go back to previous drills. Maintenance Director trained on the correct procedure and documentation requirements on 5/23/22. Correct form was initiated and fire drill was completed on 5/12/22 using the DPW Fire Drill Record form. Fire Drills will be completed monthly going forward using the correct form to document the required information. The fire drill records will be taken to the monthly quality management meeting to review to ensure accuracy and completeness.

**Completion Date:** 05/31/2022

**221a - Program Activities****1. Requirements**

2600.

221.a. The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

**Description of Violation**

According to numerous staff persons and residents, the home does not have a program of activities designed to promote the active involvement of residents with families and the community.

**Plan of Correction****Directed**

Activity Calendar was implemented May 2022. Discussed activities in the resident council meeting on 5/23/22. Calendar initiated for each month based on feed back in resident council meeting. Calendar will be distributed to the residents and posted in the lobby and library area. Ad has been placed for a full time activity coordinator. The activity coordinator/designee will be responsible to ensure activities are conducted as scheduled. In the interim, the administrator is responsible for coordination of the resident activities. The administrator will monitor that activities are occurring as scheduled, and report/review in the the quality management team. (DIRECTED: Within 5 calendar days of receipt of the plan of correction: The monitoring of activities shall be conducted weekly for one month, then monthly thereafter. [REDACTED] 6/2/22).

**Completion Date:** 06/15/2022

**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.

225a - Assessment 15 Days (continued)

Description of Violation

Resident #1 was admitted to the home on [REDACTED] however, the resident's assessment was not completed until [REDACTED].

Plan of Correction

Directed

There has been no new admissions since survey. Chart audit completed and all current residents have an assessment completed. Going forward, new admission chart audits will be completed by the clinical coordinator. A new admission checklist will be implemented and used by the clinical coordinator. (DIRECTED: The new admission checklist shall be implemented within 5 calendar days of receipt of the plan of correction. A copy of the completed new admission checklist shall be kept in each resident's record. [REDACTED] 6/2/22). The clinical coordinator is responsible for resident assessment completion and received reeducation on timely completion of the 15 day assessment on 5/23/22. Results of chart audits will be reviewed in the quality management meeting .

Completion Date: 06/15/2022

225c - Additional Assessment

1. Requirements

2600.

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

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #7's most recent assessment, dated [REDACTED], indicates the resident is [REDACTED]; however, resident #7 requires the assistance of [REDACTED]

Resident #9's most recent assessment, dated [REDACTED] indicates the resident is [REDACTED]; however, resident #9 requires the assistance of [REDACTED]

Plan of Correction

Accept

Additional assessments were completed for residents #7 and #9 on 5/24/22. Current residents reviewed on 5/31/22 and one other resident identified as needing an additional assessment. Assessment will be completed by 6/15/22. Clinical Coordinator received re education on updating resident assessments as resident care needs change. Training was completed 5/23/22. The clinical coordinator is responsible for identifying resident changes and initiating additional assessments. Clinical Coordinator will review each resident monthly and initiate an additional assessment as appropriate. Additional Assessments will be discussed in the monthly Quality management Meeting.

Completion Date: 06/15/2022