

Department of Human Services
Bureau of Human Service Licensing

August 1, 2022

[REDACTED], SR. VICE PRESIDENT OF OPERATIONS/REGULATORY COMPLIANCE
[REDACTED]
[REDACTED]

RE: COUNTRY MEADOWS OF SOUTH
HILLS I
3560 WASHINGTON PIKE
BRIDGEVILLE, PA, 15017
LICENSE/COC#: 43066

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/08/2022, 06/09/2022, 06/10/2022 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

Facility Information

Name: *COUNTRY MEADOWS OF SOUTH HILLS I* License #: *43066* License Expiration: *09/11/2022*
Address: *3560 WASHINGTON PIKE, BRIDGEVILLE, PA 15017*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

[REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *09/20/2017* Issued By: *South Fayette Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *102* Waking Staff: *77*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *06/10/2022*

Inspection Dates and Department Representative

06/08/2022 - On-Site: [REDACTED]
06/09/2022 - On-Site: [REDACTED]
06/10/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *57*

Secured Dementia Care Unit

In Home: *Yes* Area: *Shadyside* Capacity: *50* Residents Served: *35*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *57*
Diagnosed with Mental Illness: *15* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *45* Have Physical Disability: *1*

Inspections / Reviews

06/08/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/07/2022*

Inspections / Reviews (*continued*)

07/08/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *07/11/2022*

07/12/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/18/2022*

08/01/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident’s designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident’s power of attorney for health care or health care proxy or a resident’s designated person, or if a court orders disclosure.

Description of Violation

On [redacted]/22 at [redacted] a.m., there were three resident care assignment sheets dated [redacted] 22 which included a list of residents and their care needs including a column with special diet notations and a column with special needs listed such as “glasses, walker, “do not use wipes”” setting on the lowest shelf in the unlocked cabinet above the dishwasher in the secure dementia care unit activities room. The list included the names of residents #1, #2 and #3.

Plan of Correction

Accept

- Care assignment sheets are to be used only by the caregiver assigned to those residents and should never be left out where others can see them.
- The Executive Director/ADON will ensure that assignment sheets are no longer being used or given to anyone effective 7/31/22. Instead caregivers will utilize Point Click Care/ Point of Care to access a resident’s care duties and dietary needs on the cell phones which only care staff have access.
- This insures no confidential resident information is left behind on paper for anyone to view.
- The Executive Director and nurses will ensure that no paper assignment sheets are being provided.
- During Campus ED and AED walk throughs, they will verify that the phones are being used consistently to provide care.
- The Director of Nursing or ED will pull a report weekly for the next 4 weeks, starting the week of 7/31/22 to monitor that the caregivers are signing off properly in Point of Care.

Completion Date: 07/07/2022

Document Submission

Implemented

Training Documentation attached.

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident’s designated person if any, if the resident agrees.

Description of Violation

Resident #1’s Resident contract completed on [redacted] was not signed by the resident.

Plan of Correction

Do Not Accept

- Effective 7/31/22 all managers have been informed that resident contracts must be signed by the resident.
- In the case where the resident refuses to sign or it causes undue stress to the particular resident then it will be noted on the contract that the resident refused or was not able to sign.
- On or before 7/31/22 the business office managers will review all current resident files and ensure all residents have signed their contract or it has been properly noted that the resident was not able to sign.

Completion Date: 07/07/2022

25b - Contract Signatures (continued)

Plan of Correction

Accept

Resident was presented with agreement by staff on [redacted] and refused to sign after it was brought to our attention by the inspector. It was noted on the contract that she refused to sign. POA [redacted] signed the contract on [redacted]. We will submit a copy of the contract where this is noted.

Completion Date: 07/11/2022

Document Submission

Implemented

Contract attached.

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

The bed enabler for the bed in room #29 had an uncovered, approximately 6 inch opening in the perimeter of the enabler. The cover for the enabler was setting on the small refrigerator in the resident's room.

REPEAT VIOLATION 7/21/21 et al

Plan of Correction

Accept

- On or before 7/31/22 all bed enablers including room 29, will be checked and secured if necessary for proper installation by our maintenance team and verified by the Campus ED, Building ED or DON.
- On or before 7/31/22 Non-slip mattress pads will be utilized for beds where the mattress slides away easily from the bed cane.
- Ongoing compliance will be monitored by adding a daily task into our Point of Care system to have our care staff check the bed enablers and alert the nurse immediately if they find a bed enabler not secure or a safety risk for the resident.
- The AED will have and document an in-service with all care staff on how to check to see if a bed cane is secure and has the proper covering. This will be completed by 7/31/22 and sign in sheets provided to DHS.

Completion Date: 07/07/2022

Document Submission

Implemented

documentation attached

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 6/8/22 at 10:50 a.m., there was a black plastic/resin chest/bin in the accessible, unattended Secure Dementia Care Unit (SDCU) courtyard near the Fox Chapel side of the home which contained a 50lb bag of Excel 50 Calcium Chlorite 94-97% pellets with warning label indicating: If swallowed, give water or milk to induce vomiting immediately; seek

82c - Locking Poisonous Materials (continued)

medical attention.

On 6/8/22 at 10:55 a.m., there was a large black plastic/resin bin on the covered patio located in the accessible, unattended SDCU courtyard near the right end of the building which contained two full, unopened 50lb bags and an approximately ¼ full opened bag of Excel 50 Calcium Chlorite 94-97% pellets with warning label indicating: If swallowed, give water or milk to induce vomiting immediately; seek medical attention.

On 6/8/22 at 11:45 a.m., there was a green plastic oval bin setting on the top shelf in the right side of the cupboard above the dishwasher in the unattended Activity Room kitchen on the SDCU with miscellaneous personal care item to include:
*One 1.75oz tube of Equate healing ointment with warning label: keep out of reach of children. If swallowed, get medical help or contact Poison Control Center right away.

* One nearly full 5.4oz tube of Crest plus Scope with warning: if more than used for brushing is accidentally swallowed, get medical help or contact PCC right away.

* Five 1.5oz bottles of Medline Roll On antiperspirant with warning: if accidentally swallowed, get medical help or contact a PCC right away.

Not all residents in the SDCU are assessed as able to safely use and avoid poisonous material to include resident #2.

Plan of Correction**Accept**

- The safety of our residents is our top priority.
- Locks were installed on 6/11/22 for all of our storage bins that hold our ice melt. When ice melt is needed, the maintenance team will unlock the bins, remove the needed amount of ice melt and lock the bin back up so no resident will have access to the ice melt.
- In the months where ice melt is not needed these bins will be stored in our garage that is locked and where the residents have no access. The Maintenance Director, Campus ED and AED will verify the bins remain locked during their daily walk throughs.
- In addition, on 6/11/22 the green plastic bin was removed and all potentially harmful and poisonous personal hygiene ointments, liquids, etc. have been stored in a locked cabinet where only our care staff has access.
- During Campus ED and AED walk throughs this will be checked throughout the day to ensure no harmful chemicals are left out where residents have access.
- The AED will hold and document an in-service with all care staff by 7/31/22 reviewing what items are considered poisonous or harmful to residents, what to do and who to contact if they find a hazardous item in a room or common area.

Completion Date: 07/07/2022

Document Submission**Implemented**

documentation attached.

85a - Sanitary Conditions**1. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED] at [REDACTED] a.m., the following unlabeled items were in a green plastic oval bin setting on the top shelf in the right side of the cupboard above the dishwasher in the Activity Room kitchen on the SDCU: a small black comb with

85a - Sanitary Conditions (continued)

long grey strands of hair attached to it, three additional combs, a toenail clipper and a nail file.

Plan of Correction**Accept**

- On 6/11/22 the green plastic bin was removed and all personal care items for the residents have been put in a locked cabinet in the resident's room.
- The AED will hold and document an in-service by 7/31/22 with all care staff to explain the importance of keeping these personal items separated by resident.
- The Campus ED and AED will conduct a daily walk through and address any issues immediately.

Completion Date: 07/07/2022

Document Submission**Implemented**

documentation attached

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 6/8/22 at 11:50 a.m., the emergency phone numbers posted on the phone in the activity room in the home's Secure Dementia Care Unit did not include the correct phone number for the personal care home complaint hotline.

Plan of Correction**Accept**

- All emergency telephone numbers have been updated and posted by all phones in the community on 6/9/2022.
- These numbers will be verified on a yearly basis by the Campus ED during the annual updates to the Emergency Preparedness Manual for the new year.
- The Country Meadows Director of Risk and Safety and the Campus ED will review and update the manual on or before 1/1/2023.

Completion Date: 07/07/2022

Document Submission**Implemented**

no further documentation required

103e - Left Overs**1. Requirements**

2600.

- 103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 6/8/22 at 12:40 p.m., there was an unlabeled, undated, and uncovered teal ceramic mug filled with an unidentified liquid that appeared to be thickened in the refrigerator side of the stainless steel refrigerator/freezer in the activity room on the Fox Chapel side of the building.

Plan of Correction**Accept**

- On 6/8/22 the liquid that was unlabeled, undated and uncovered in a mug was thrown out immediately.

103e - Left Overs (continued)

- The AED will hold and document an in-service with all care staff on proper storage of leftovers or refrigerated/frozen items in the common area refrigerated on or before 7/31/22.
- Ongoing the Campus ED and AED will conduct a daily walk through and will verify that there are no items in the refrigerator/freezer that are undated, uncovered or unlabeled.

Completion Date: 07/07/2022

Document Submission

documentation attached

Implemented

103f - Refrigerator/Freezer Temps**1. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 6/8/22 at 12:40 p.m., there was no thermometer in the refrigerator side of the stainless steel refrigerator/freezer in the activity room on the Fox Chapel side of the building.

Plan of Correction

- The missing thermometer for the refrigerator/freezer in the common area has been replaced on 6/8/22.
- All other thermometers were noted to be in place.
- Ongoing the Campus ED and AED will conduct a daily walk through and will verify that all refrigeration/freezer units have a working thermometer.

Completion Date: 07/07/2022

Document Submission

Documentation attached

Implemented

105g - Lint Removal and Duct Cleaning**1. Requirements**

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 6/8/22 at 12:10 p.m., there was approximately a 1/8" layer of lint in the filter of the stacked dryer on the left in the laundry room in the secure dementia care unit.

Plan of Correction

- Lint removal is a safety concern and we are constantly monitoring this and training our team.
- Our housekeeping supervisor will hold another in-service by 7/31/22 with all housekeepers on how to clean the lint trap for the different dryers we have and the importance of cleaning the lint trap after every use.
- On or before 7/31/22 [REDACTED] will also place signs on or near each dryer to remind staff to clean the lint trap after every use.
- Ongoing the Campus ED and/or AED will conduct a daily walk through and will verify that the lint traps are lint free.

Accept

105g - Lint Removal and Duct Cleaning (continued)

Completion Date: 07/07/2022

Document Submission

documentation attached.

Implemented

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

The home's fire drill conducted on 3/20/22 at 5:35 a.m., took 22 minutes and 25 seconds which exceeds the safe evacuation time of 15 minutes as established by a fire safety expert on 8/5/21.

Plan of Correction

Do Not Accept

- Effective immediately if there is a fire drill that exceeds the maximum time of 15 minutes for evacuation of all residents, the Maintenance Director, Campus Director and all other Department Heads present during the fire drill will immediately trouble shoot why the fire drill evacuation exceeded the allowed 15 minutes.
- Once the problem has been identified and resolved, another fire drill will take place within 3 days for the same building/time frame so that the evacuation of all residents falls within the allowed 15 minutes.
- This trouble-shooting/verification process will continue if the time allowed is exceeded.
- All fire drills since this one in March have been within the allotted time frame.
- On or before 7/31/22 the maintenance team will be retrained on fire drill procedures and documentation provided to DHS.

Completion Date: 07/07/2022

Plan of Correction

Directed

Per the state, if the time is over for evacuation, drill to be redone within the same month showing it was the corrected time. [REDACTED] was the state representative to give this information.

DIRECTED

within one calendar day of the receipt of the accepted plan of correction: The administrator shall audit the fire drill record monthly. If the home exceeds the fire safe evacuation time specified by the home's fire safety expert, the home shall add additional staff to each shift which ensures all residents are evacuated in accordance with Regulation 2600.132(d). 7/12/22 [REDACTED]

Completion Date: 07/11/2022

Document Submission

documentation attached.

Implemented

141b1 - Annual Medical Evaluation

1. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

141b1 - Annual Medical Evaluation (*continued*)**Description of Violation**

On 6/8/22 at 3:10 p.m., resident #4's annual medical evaluation (DME) completed [REDACTED] did not include a list of the resident's medications.

On 6/8/22 at 3:35 p.m., resident #5's annual DME completed [REDACTED] did not include a list of the resident's medications.

Plan of Correction**Accept**

- The medication list was to have been attached to the original DME.
- On 6/9/22 Resident #4 and #5 DME's have been updated to include a list of all resident medications.
- In addition, all other resident DME's have been reviewed on 6/9/22 to ensure they were completed properly and entirely.
- All new DME's will be reviewed by our Director of Nursing (DON), as well as our AED to insure all DME's are filled out properly before being filed away.

Completion Date: 07/07/2022

Document Submission**Implemented**

documentation attached

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 6/8/22 at 12:20 p.m., the menus posted in the secure dementia care unit were dated "Week One [May 29 thru June 4th]" and "Week Two [June 5th thru June 11th]."

On 6/8/22 at 12:35 p.m., the menus posted in the Fox Chapel side of the home were dated "Week One [May 29 thru June 4th]" and "Week Two [June 5th thru June 11th]."

Plan of Correction**Accept**

- This was corrected on 6/8/2022 during inspection.
- Our Director of Dining Services and Dining Services Manager for that building will ensure our current two week dining menus are posted in both dining areas of our building.
- The menus will be updated every Monday to reflect the current week and the next week of dining menus.
- The Campus ED and AED will verify this is happening on their daily walk throughs and address any issues immediately.

Completion Date: 07/07/2022

Document Submission**Implemented**

documentation attached.

224a - Preadmission Screen Form

1. Requirements

2600.

224a - Preadmission Screen Form (continued)

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

On 6/8/22 at 3:30 p.m., the preadmission screening completed on [redacted] for resident #5 did not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction

Accept

- The box stating that the residents needs can be met by the home was inadvertently over looked and not checked when the form was completed.
- The preadmission screening for resident #5 was fixed on [redacted] to note that the residents needs can be met by the services provided by the home.
- All other files were audited on 6/9/22 as well to ensure the preadmission screenings are complete.
- The Pre Admission Screenings will be reviewed by our Director of Nursing (DON), and/or our AED to ensure all preadmission screenings are filled out properly before being filed away.

Completion Date: 07/07/2022

Document Submission

Implemented

documentation 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 resides in the home's secure dementia care unit (SDCU). However, the resident's medical evaluations completed [redacted] did not indicate the need for the resident to be served in a [redacted]

Plan of Correction

Accept

- On 6/9/22 the DME for resident #2 was updated to reflect the resident does need to be served in a [redacted]
- All other DME's were audited on 6/9/22 to ensure this box was checked by their PCP if they require and are in our SDU.
- Ongoing all new DME's will be reviewed by our Director of Nursing (DON) and/or AED to ensure all DME's are filled out properly before being filed away.

Completion Date: 07/07/2022

Document Submission

Implemented

documentation attached.