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

January 30, 2023

[redacted], EXECUTIVE DIRECTOR
REBECCA RESIDENCE
[redacted]

RE: CONCORDIA AT REBECCA RESIDENCE
3746 CEDAR RIDGE ROAD
ALLISON PARK, PA, 15101
LICENSE/COC#: 43007

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/14/2022, 12/15/2022, 12/16/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CONCORDIA AT REBECCA RESIDENCE* **License #**: *43007* **License Expiration**: *03/08/2023*

Address: *3746 CEDAR RIDGE ROAD, ALLISON PARK, PA 15101*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *REBECCA RESIDENCE*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-1* **Date**: *10/04/1999* **Issued By**: *PA Dept of Health*

Type: *C-2 LP* **Date**: *07/13/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/16/2022*

Inspection Dates and Department Representative

12/14/2022 - On-Site: [redacted]
12/15/2022 - On-Site:
12/16/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*

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

Have Mobility Need: *11* **Have Physical Disability**: *1*

Inspections / Reviews

12/14/2022 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/13/2023*

Inspections / Reviews *(continued)*

01/19/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/27/2023*

01/30/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2023*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, whose first day of work was [redacted], began providing unsupervised direct care services on [redacted]. However, direct care staff person A did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

REPEAT VIOLATION 9/15/21 et. al.

Plan of Correction ***Accept [redacted] - 01/19/2023)***

Staff Person A was immediately removed from the direct care schedule on [redacted] An audit of employee files was initiated by Human Resources on 12/19 to identify any other discrepancies in documentation received by facility. Identified issues were remedied immediately. Administrator applied for waiver for 2600.54.a for staff person A on 12/20/22 to allow staff member to return to direct care services. Waiver was received on 1/5/23 attached hereto. Ongoing audits of HR files by Administrator or designee will commence on 12/20/22 weekly for 4 weeks and then monthly in perpetuity.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 01/30/2023)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On [redacted] at approximately [redacted] there was an unidentifiable yellow substance splattered on every interior surface of the Garden Unit country kitchen microwave, and there was an unidentifiable brown residue in an area measuring approximately three quarters of an inch wide by three inches long underneath the rotating glass dish.

REPEAT VIOLATION 9/15/21 et. al.

Plan of Correction ***Accept [redacted] - 01/19/2023)***

The microwave was immediately addressed by housekeeping in the presence of the surveyor. Administrator ordered microwave splash covers for all publicly used microwaves in Personal Care which were delivered 12/19/22 and immediately dispersed to the units. Facility microwave inspection for cleanliness was added to the Environmental Rounds Audit sheet. Beginning 12/20/22 Administrator or designee will complete Environmental Rounds Audits twice weekly for 2 weeks, weekly for 4 weeks and then monthly thereafter in perpetuity.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 01/30/2023)

88a - Surfaces

3. Requirements

2600.

88a Surfaces *(continued)*

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [redacted] at approximately [redacted] there was a drop ceiling tile in the first floor country kitchen that was dry but water damaged and stained brownish yellow in an area measuring approximately 5 inches long by two and one half inches at the widest point.

Plan of Correction ***Accept ([redacted] - 01/19/2023)***

The ceiling tile was immediately reported to maintenance department and remedied in the presence of the surveyor. Maintenance completed Environmental Round audit on 12/19/22 to identify any additional ceiling tiles that needed replaced and remedied any identified issues immediately. Staff was educated on the importance of regulation 2600.88a and process for addressing identified issues was reviewed on 12/21/22. Ceiling tile checks have been added to Environmental Rounds Audit which will be performed by Administrator or designee twice weekly for 2 weeks, weekly for 4 weeks and then monthly thereafter in perpetuity beginning 12/19/22.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 01/30/2023)

101j7 - Lighting/Operable Lamp

4. 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 [redacted] at approximately [redacted]. the lamp on the bedside table was out of reach from bedside in resident room [redacted] belonging to resident #1.

Plan of Correction ***Accept [redacted] - 01/19/2023)***

Resident #1 does not want to reposition furniture in her room to have an operable light at bedside. Administrator purchased a battery operated switch light which was installed on the headboard of resident's bed on 12/15/22 and evidence of which was presented to surveyor prior to exit. Administrator and designee completed room round audit on 12/19/22 to identify any additional residents without an operable light source at bedside and remedied any identified issues in the same manor. Staff was educated on the importance of regulation 2600.101j and process for addressing identified issues on 12/21/22. Room round audit sheet was updated to include assurance of operable light source at bedside. Beginning 12/20/22, room round audits will be completed on 10 chosen resident rooms without repeat by Administrator or designee weekly for 6 weeks and then each unit monthly thereafter in perpetuity.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented [redacted] - 01/30/2023)

132b - Safety Inspection/Fire Drill

5. 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

On [redacted] at approximately [redacted]. the home conducted a fire drill and safety inspection under the supervision

132b - Safety Inspection/Fire Drill (continued)

of a fire safety expert. However, the fire safety inspection conducted by a fire safety expert did not designate the specific fire safe areas or areas of refuge in writing and only indicated "Behind fire doors" on the fire safety inspection letter dated 7/12/22.

Plan of Correction ***Accept (- 01/19/2023)***

On 12/19/22 Administrator initiated attempts to obtain a different fire safety expert to inspect the facility, however was unable to find a willing participant. Administrator then contacted previous fire safety expert on 12/22/22 to communicate DHS expectations of the fire safety inspection and request an additional inspection to comply with regulation. Re-inspection was planned for 12/23/22 but was cancelled due to fire departments' need to respond urgently to an electrical fire in the area. Fire safety inspection was rescheduled for 1/14/22. An updated fire inspection letter detailing fire safe areas is attached. During future fire inspections, Administrator or designee will review fire inspection expectations and documentation needed with fire safety experts prior to annual inspection to ensure documentation meets requirements of the regulation.

Licensee's Proposed Overall Completion Date: *01/20/2023*

Implemented (- 01/30/2023)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's current medical evaluation is dated . However, the previous medical evaluation was completed on 2/18/21.

REPEAT VIOLATION 9/15/21 et. al.

Plan of Correction ***Accept - 01/19/2023)***

Resident uses an outside PCP and was evaluated by a medical professional on 7/2/21 and 2/3/22 and documentation of each was provided to the surveyor at exit. Both visits addressed all required items in the DHS provided DME form, however the form was not completed leading to the citation of 2600.141 b.1. Administrator met with Resident Care Coordinator on 12/19/22 to review process for monitoring DME timeframes and documentation completion. Facility recently switched Electronic Medical Record systems and the new system tracks due dates of state forms and alerts staff of due dates. On 12/19 and 12/20 RCC completed audit of DME scheduling in EMR to ensure due dates were programmed off of "evaluation date" time frame instead of "form completion date". Any identified issues were remedied immediately. RCC will begin to send DME form to outside practitioners to complete at every visit to ensure DHS required forms are kept up to date. Beginning 12/26/22 Administrator and RCC will meet daily to review upcoming DME due dates to ensure timeliness of DME completion.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented - 01/30/2023)