Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* **License #:** *44948* **License Expiration:** *05/29/2023*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*

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

Administrator

Name: [redacted] **Phone:** *412 430-4630* **Email:** [redacted]

Legal Entity

Name: *KJ BETHEL PARK LLC*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *12/13/2019* **Issued By:** *Municipality of Bethel Park*

Staffing Hours

Resident Support Staff: *68* **Total Daily Staff:** *256* **Waking Staff:** *192*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *12/28/2022*

Inspection Dates and Department Representative

12/28/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* **Residents Served:** *120*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st & 2nd Fl* **Capacity:** *40* **Residents Served:** *33*

Hospice

Current Residents: *19*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *120*

Diagnosed with Mental Illness: *2*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *68*

Have Physical Disability: *3*

Inspections / Reviews

12/28/2022 - Partial

Lead Inspector: [redacted] [redacted]**-Up Type:** *POC Submission* **Follow-Up Date:** *02/03/2023*

Inspections / Reviews *(continued)*

04/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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 12/28/22, at 11:20 a.m., and 2:05 p.m. there were the following unsecured, unattended and accessible documents on the third floor med cart by bedroom #350,to include:

** A binder labeled "Narc Book" room's 340 – 360, that contained lists of multiple residents prescribed narcotics to include, resident#1, #2, and #3.*

** Resident #4's BHS Laboratory order for CTS,*

** A urinal catch basin and under basin a prescription for resident #1 for Cefuroxime Axetil 500mg dated, 12/25/22.*

** A white piece of paper with the log on information and password for contract staff to log on to EMAR (PN: Bright.01 L: DNA-staffing PW:123123)*

On 12/28/22, at 11:40 a.m., there was a staff assignment sheet unsecured, unattended and accessible on a black leather sofa by bedroom [redacted] on the first floor. The document indicated a list of resident names, room numbers, assistive devices used, shower schedules, and comments/notes regarding residents and assistance given and needed for ambulating, toileting, eating and any additional comments, to include resident #1.

Plan of Correction ***Directed ([redacted]- 04/11/2023)***

• On 3/14/2023 Immediate action was taken by Health and Wellness Director to audit (Exhibit 1.A) all medication carts within the community to verify all documentation relating to resident private health information was either properly discarded or privately secured under lock and key residing with-in medication cart

• On 3/14/2023 Immediate action was taken by Personal Care Director designee to remove all Resident names from staff assignment sheets. (Exhibit 1.B)

• On 3/14/2023 An Audit (Exhibit 1.C) of all nurse's stations/med rooms was completed to verify compliance of all staff assignment sheets were discarded privately and properly

• On 3/14/2023 an education (Exhibit 1.D) for direct care staff was completed by Executive Director on Regulation 2600.17 and the list of related violations.

• An Audit (Exhibit 1.E) of medication carts by Health and Wellness Director to take place once daily for 4 weeks, followed by once weekly for 4 weeks, followed by once biweekly for 4 weeks. Ongoing measures to be discussed at monthly quality assurance meeting.

DIRECTED

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure resident information is maintained in a confidential manner. 4/10/23[redacted]

Directed Completion Date: *04/15/2023*

141b1 - Annual Medical Evaluation

2. Requirements

2600.

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

The annual medical evaluation for resident #1, signed by the physician on 8/1/22, does not have the date the in-person medical evaluation was completed. The medical evaluation does not include the resident's height, weight, pulse rate and blood pressure. These sections are blank.

REPEAT VIOLATION: 8/30/21

Plan of Correction ***Directed [redacted] - 04/11/2023)***

• On 3/14/2023 Immediate action was taken by Health and Wellness Director to update resident #1 Annual Medical Evaluation.

• On 3/15/2023 action taken by Health and Wellness director or Designee to Audit (Exhibit 2.A) all current and incoming resident Medical Evaluations for proper information and compliance.

• On 3/15/2023 An education (Exhibit 2.B) was provided to Health and Wellness Director by Executive Director on Regulation 2600.141.b.1

• An audit (Exhibit 2.C) of current resident medical evaluations and their accuracy to be completed by Health and Wellness Director or Designee for 2 residents twice weekly for 4 weeks, followed by 2 residents once weekly for 4 weeks, followed by 2 residents bi-weekly for 4 weeks. Ongoing measures to be discussed at monthly quality assurance meeting.

DIRECTED

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall review all newly completed. medical evaluations for accuracy and completeness. 4/10/23[redacted]

Directed Completion Date: *04/15/2023*

185a - Implement Storage Procedures

3. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 12/22/22, resident #1 was diagnosed with a [redacted] and prescribed Cefuroxime Axetil 500mg tablet, take one tablet by mouth twice daily for 7 days. (9:00 a.m. and 5:00 p.m.) Resident #1 uses their own pharmacy to fill prescriptions. The home faxes the order to the home's pharmacy first to be recorded on the homes electronic Medication Administration Record (MAR) or (EMAR). The order was to be faxed to resident #1's pharmacy to be filled on 12/22/22. However, staff neglected to fax the order to the resident's pharmacy, which delayed the administration of the medication. The home had to get an updated order, dated 12/25/22 to have filled. Resident #1's December 2022 medication Administration Record (MAR) indicated the resident was not administered the prescribed medication on 12/22/22, 12/23/22, 12/24/22 and 12/25/22 due to not being available in the home.

Plan of Correction ***Directed [redacted] - 04/11/2023)***

• On 3/16/2023 action was taken by Executive Director to report (Exhibit 3.A) errors to the PA Department of Human services, resident physician, and family regarding all listed medication administration errors.

• On 3/14/2023 immediate action by Health and Wellness Director was taken to Audit (Exhibit 3.B) Resident #1 Mar to check for further discrepancies

• Beginning 3/20/2023 Health and Wellness Director or Designee to observer medication pass for Resident #1 for one week (Exhibit 3.C). Observed report to be place in resident Chart.

185a - Implement Storage Procedures (continued)

• On 3/20/2023 All resident Mars Audited by Health and Wellness Director or Designee to ensure All required medications are in the building and ordered in advance appropriately.
• 3/16/2023 Education (Exhibit 3.D) Provided by Executive Director to Medtech Staff and Director of Wellness on updated Medication Storage Policy and Ordering/Reordering Policy (Exhibit 3.E)
• Med chart audit (Exhibit 3.F) to be performed by Health and Wellness Director or Designee, 3 times weekly for 4 weeks, followed by 1 time weekly for 4 weeks, followed by 1 time bi-weekly weekly for 4 weeks. Ongoing measures to be discussed at monthly quality assurance meeting.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit the homes; procedures for ordering medications monthly to ensure all medications are available for administration. 4/10/23[redacted]

Directed Completion Date: *04/15/2023*

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

On 12/22/22, resident #1 is prescribed Cefuroxime Axetil 500mg tablet, take one tablet by mouth twice daily for 7 days. (9:00 a.m. and 5:00 p.m.) to start administration on 12/22/22. However, based on the residents December 2022 MAR, the medication was not available or administered as prescribed from 12/22/22, 12/23/22, 12/24/22 and 12/25/22. The resident received the first administration of the medication on 12/26/22 at 9:00 a.m.

REPEAT VIOLATION: 8/24/22

Plan of Correction ***Directed*** [redacted] ***04/11/2023)***

• On 3/16/2023 action was taken by Executive Director to report (Exhibit 4.A) errors to the PA Department of Human services, resident physician, and family regarding all listed medication administration errors.
• On 03/15/2023 immediate action by Health and Wellness Director was taken to Audit (Exhibit 4.B) All resident Mars to ensure medications are ordered and in community for residents
• On 3/16/2023 Education provided by Executive Director to all Medication technicians on medication administration records policy (Exhibit 4.C)
• Medication Supervision Competency Checklist (Exhibit 4.D) to be completed by Health and Wellness Director or Designee twice weekly for 4 weeks, followed by once weekly for 4 weeks, followed by once bi-weekly for 4 weeks. Ongoing measures to be discussed at monthly quality assurance meeting.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall complete an audit of all resident medications monthly to ensure all prescribed medications are available in the home for administration. 4/10/23[redacted]

Directed Completion Date: *04/15/2023*

227c - Support Plan Revision

5. Requirements

227c - Support Plan Revision *(continued)*

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

The support plan, dated 5/17/22, for resident #1, does not address the frequency of the home's plan to address the following needs:

** Drinking- requires prompting/cueing.*

** Ambulating- requires moderate hands-on assist.*

** Personal hygiene- requires verbal reminders/prompts/cues.*

** Making/keeping appointments, caring for personal possession, and writing correspondence- requires physical assist.*

** Obtaining clean, season clothing-requires total physical assistance.*

** Vision- has severe vision impairment.*

** Hearing: mild impairment can hear with devices.*

Plan of Correction ***Directed [redacted]- 04/11/2023)***

• On 3/14/2023 Immediate action was taken by the Health and Wellness Director to update Resident #1's Support plan to accurately reflect care needs of resident and how the community plans to address needs listed

• On 3/14/2023 an Education (Exhibit 5.A) by the Executive Director provided to the Health and Wellness Director on Regulation 227.c and SLC Assisted living move in policy (Exhibit 5.B)

• On 3/20/2023 an audit (Exhibit 5.C) by Health and Wellness Director or Designee of all resident support plans preformed to determine accuracy and address any discrepancies.

• Support Plan Audit (Exhibit 5.D) to be performed by Health and Wellness Director or Designee for 4 residents weekly for 4 weeks, followed by 2 residents weekly for 4 weeks, followed by 1 resident weekly for 4 weeks. Ongoing measures to be discussed at monthly quality assurance meeting.

DIRECTED

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit all newly completed support plans for accuracy and completeness. 4/10/23[redacted]

Directed Completion Date: *04/15/2023*

227g -Support Plan Signatures

6. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation ***Withdrawn [redacted] - 04/11/2023)***

The support plan for resident #6, does not have the resident's signature and does not indicate if the resident participated in the development of the plan, was unable to participate, or if the resident refused to sign the support plan.