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

February 23, 2023

[redacted]
FDG CB OPCO LLC
[redacted]

RE: ATRIA AT CRANBERRY WOODS
3020 FAIRPORT LANE
CRANBERRY TOWNSHIP, PA, 16066
LICENSE/COC#: 45268

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/03/2023, 01/04/2023, 01/17/2023 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: *ATRIA AT CRANBERRY WOODS* **Licen e #**: *45268* **Licen e Expiration**: *04/13/2024*

Address: *3020 FAIRPORT LANE, CRANBERRY TOWNSHIP, PA 16066*

County: *BUTLER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *FDG CB OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *01/29/2021* **I ued By**: *Cranberry Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *75* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/25/2023*

Inspection Dates and Department Representative

01/03/2023 On Site [redacted]
01/04/2023 On Site
01/17/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *59*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Third Floor* **Capacity**: *41* **Residents Served**: *16*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *58*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *16*
Have Physical Disability: *0*

Inspections / Reviews

01/03/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/05/2023*

Inspections / Reviews *(continued)*

02/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/14/2023*

02/14/2023 - POC Submission

Submitted By: [redacted]*ro* **Date Submitted:** *02/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/15/2023*

02/23/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2023*

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

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

On 1/3/23, the contract, dated [redacted]/22, for resident #1, was not signed by the resident nor did it indicate the resident's inability to sign.

On 1/3/23, the contract, dated [redacted]/22, for resident #2, was not signed by the resident nor d it indicate the resident's inability to sign.

Plan of Correction ***Accept [redacted] - 02/13/2023)***

An audit was completed of all residents' contracts by the Community Business Director on 1/6/2023 to ensure that all contracts are signed by the resident in each place requiring signatures and/or an indication on why the resident was unable to sign the contract in each location. As of 1/6/2023, all resident contracts will be reviewed by the Executive Director and/or designee prior to being filed to ensure there is a resident signature and/or an indication in the resident's file on why the resident could not sign for the next 90 days to ensure compliance.
Both resident 1 and resident 2 contracts were completed with indication on why they could not be signed by 1/6/2023 by the Community Business Director

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented ([redacted] 02/23/2023)

41a - Complaint w/o Retailiation

2. Requirements

2600.
41.a. Upon admission, each resident and, if applicable, the resident's designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter. Retaliation includes discharge or transfer from the home.

Description of Violation

As of 1/3/23, resident #1, admitted [redacted]22, had not been educated on his/her resident rights or his/her right to lodge complaints without intimidation, retaliation, or threats of retaliation.

As of 1/3/23, resident #2, admitted [redacted]22, had not been educated on his/her resident rights or his/her right to lodge complaints without intimidation, retaliation, or threats of retaliation.

Plan of Correction ***Accept [redacted] - 02/13/2023)***

An audit was completed of all residents' contracts by the Community Business Director on 1/6/2023 to ensure that all contracts have resident signatures and/or an indication on why the resident was unable to sign the resident rights. As of 1/6/23 all resident contracts will be reviewed by the Executive Director and/or designee prior to being filed to ensure there is a resident signature and/or an indication on why the resident could not sign for the next 90 days to ensure compliance.
Both resident 1 and resident 2 contracts were completed with indication in the resident's file on why they could not

41a - Complaint w/o Retailiation (continued)

be signed by 1/6/2023 by the Community Business Director.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

85a Sanitary Conditions

3. Requirements

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

Description of Violation

On 1/3/23, at approximately 11:40 a.m., the 3rd floor microwave in the kitchenette, was found to have a dried food like substance on the interior of the microwave.

Plan of Correction ***Accept [redacted] 02/13/2023)***

The microwave on 3rd floor was immediately cleaned by the Life Guidance Director on 1/3/2023. The Microwave on the 3rd floor was added to the nightly cleaning schedule for night shift by Life Guidance Director as of 1/6/2023. As of 1/6/2023, the Life Guidance Director and/or designee will monitor it daily for 3 weeks and weekly thereafter to ensure compliance.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

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 1/3/23, the bedroom belonging to resident #3, did not have a source of light at bedside.

Plan of Correction ***Accept [redacted] 02/07/2023)***

Resident #3 lamp was located while surveyor was on the unit. Resident #3 relocates items and rearranges items. Maintenance Director installed a light on 1/6/2023 in [redacted] room that is on a timer that comes on at dusk and off at dawn to ensure that [redacted] had a light available for use. This light cannot be relocated as it is located out of reach of the resident. Pictures of light will be attached. As of 1/6/2023, to the Maintenance Director will ensure that a check of whether there is a working light present at bedside is added to the Cleaning Checklist as part of their cleaning routine weekly. If a working light is not present the, Staff person will put in a work order to ensure lamp is fixed or replaced.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

132a - Monthly Fire Drill

5. Requirements

2600.

132a - Monthly Fire Drill *(continued)*

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Multiple interviews indicate staff are being informed of upcoming fire drills during daily staff meetings; therefore, fire drills are announced to staff in advance.

Plan of Correction ***Accept [redacted] 02/13/2023)***

The Maintenance Director was educated by Executive Director on the requirement monthly fire drills are unannounced on 1/6/2023. Maintenance Director will schedule Drill dates and times to be reviewed prior to drill with Executive Director only to ensure no knowledge of the drill is known by staff starting 2/1/2023. Starting 2/1/2023, for the next 90 days, after an unannounced fire drill, the Executive Director will randomly select staff to confirm there was no prior knowledge of the date or time of drill.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

132c - Fire Drill Records

6. 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

As of 1/4/23, the home is licensed for 62 residents; 14 of which are residing in the secured dementia care unit. The fire drill records, for the following dates, did not contain an accurate number of residents participating nor an accurate number of residents in the home at the time of the fire drills:

Date & time	*# residents in the home*	*# residents evacuated*
12/17/21 5:40 a.m.	*68*	*4*
1/14/22 8:22 p.m.	*35*	*8*
2/21/22 6:40 a.m.	*37*	*6*
3/24/22 1:50 p.m.	*MC*	*6*
4/16/22 10:53	*8*	*8*
5/13/22 7:54 a.m.	*37*	*6*
6/8/22 4:16 p.m.	*16*	*16*
7/31/22 3:44 p.m.	*7*	*7*
8/31/22 12:33 p.m.	*7*	*7*
9/9/22 2:00 p.m.	*NA*	*0*
10/19/22 6:18 a.m.	*112*	*0*
11/15/22 4:45 p.m.	*16*	*16*

A fire drill was held on 4/16/22 at 10:53; however, the fire drill log did not indicate if this drill was AM or PM.

132c - Fire Drill Records (continued)

Plan of Correction ***Accept (JW - 02/13/2023)***

Technical assistance was provided by surveyor on 1/4/2023 on how to complete the fire drill documentation correctly with the Maintenance Director. As of 1/6/2023, Fire Drill documentation will be reviewed by Executive Director and/or designee monthly for the next 6 months to ensure compliance and quarterly thereafter.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented ([redacted] - 02/23/2023)

141a - Medical Evaluation

7. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

On 1/3/23, the medical evaluation for resident #4, dated [redacted]22, was blank in the areas of height, weight, pulse rate, blood pressure, and temperature.

Plan of Correction ***Accept [redacted] - 02/07/2023)***

Resident Services Director and/or designee will ensure completion of resident #4 DME per regulation by 2/5/2023.
The Resident Service Director (RSD)/ designee will complete an audit of all current resident DMEs by 2/15/2023, to ensure Medical Evaluations are fully completed by the physician. Any issues found during the audit were addressed immediately.
Regional Care Director will provide additional education to the Executive Director and Resident Services Director/ designee to ensure compliance with regulation 2600 141a to make sure DMEs are fully completed within the required timeframe according to regulation and Atria expectations. Regional Care Director will provide additional training to Executive Director and Resident Service Director/designee on move in process to ensure understanding of requirements for obtaining DME and DME completeness prior to move in by 2/15/2023.
Executive Director will be meeting with the Resident Services Director/designee weekly starting 2/6/2023 to review new resident DMEs for next 90 days to ensure any missing information is immediately addressed by requesting the physician to update the DME. Resident Services Director will be responsible to ensure continue compliance with regulation.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

141b1 - Annual Medical Evaluation

8. Requirements

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

Description of Violation

On 1/3/23, the medical evaluation for resident #5, dated [redacted]22, was blank in the areas of height, weight, pulse

141b1 - Annual Medical Evaluation (continued)

rate, blood pressure, and temperature.

Plan of Correction ***Accept [redacted] - 02/07/2023)***

Resident Services Director and/or designee will ensure completion of all information for resident # 5's DME per regulation by 2/5/2023.
The Resident Service Director and/or designee will complete an audit of all current resident DMEs by 2/15/2023, to ensure DMEs are complete. Any issues found during the audit were addressed immediately.
Regional Care Director will provide additional education to the Executive Director and Resident Services Director and/or designee to ensure compliance with regulation 2600 141b to make sure DMEs are completed fully and if not to follow up with the physician to complete, within the required timeframe (annually) according to regulation and Atria expectations by 2/15/2023.
Executive Director will be meeting with the Resident Services Director and/or designee weekly starting 2/6/2023 to review new DMEs for next 90 days to ensure compliance with regulation 2600 141b. Resident Services Director will be responsible to ensure continue compliance with regulation.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

162c - Menus Posted

9. 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 1/3/23, at approximately 11:00 a.m., the facility menus posted on the 2nd floor were not dated.

Plan of Correction ***Accept ([redacted] - 02/13/2023)***

Menu dates were added immediately in presence of surveyor on 1/3/2023 by the Executive Director. The new menu program was changed as of 2/1/2023, to show a date on the menu when printed to ensure compliance with regulation. Director of Culinary Services will ensure dates are present on the menus prior to posting them each week to ensure compliance starting 2/1/2023. As of 2/1/2023, Executive Director and/or designee will check all posted menus each week immediately after posting to ensure a date is shown for the next 90 days.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] - 02/23/2023)

191 - Resident Right to Refuse

10. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

As of 1/3/23, resident #1, admitted [redacted]/22, has not been educated to the resident's right to question or refuse medication if the resident believes that there may be a medication error.

191 - Resident Right to Refuse (continued)

As of 1/3/23, resident #2, admitted [redacted]/22, has not been educated to the resident's right to question or refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept [redacted] - 02/07/2023)***

An audit was completed of all residents' contracts by the Community Business Director on 1/6/2023 to ensure that all contracts have resident signatures and/or an indication on why the resident was unable to sign the resident rights and any without proper notification have been noted in the resident file. As of 1/6/2023, all resident contracts will be reviewed by the Executive Director and/or designee prior to being filed to ensure there is a resident signature and/or an indication on why the resident could not sign for the next 90 days to ensure compliance.
Both resident 1 and resident 2 contracts were completed with indication in resident's file on why they could not be signed by 1/6/2023.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented ([redacted] - 02/23/2023)

225a - Assessment 15 Days

11. 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.

Description of Violation

As of 1/3/23, the home uses their own Resident Assessment and Support Plan(RASP) that is not a comprehensive assessment and does not contain the same resident assessment information as the Department form. Multiple resident assessment needs are not included on the home's form, to include but not limited to: hallucinations, irritability, long term memory, and short term memory, for the following for residents RASP's:

Resident #2, dated [redacted]/22
Resident #3, dated [redacted]22
Resident #6, dated [redacted]/22

On 1/3/23, resident #2's RASP, dated [redacted]22, indicated a name of a PCP and a dentist under the formal support section and the daughter's name is under the informal support section; however, the required contact information is not included.

On 1/3/23, resident #3's RASP, dated [redacted]22, indicates this resident does not have a Primary Care Physician(PCP) under the formal support section and the informal supports do not include this resident's spouse and contact information; however, information regarding both formal and informal supports are on the resident's facesheet.

On 1/3/23, resident #4's RASP, dated [redacted]22, indicates a PCP under the formal support section; however, the required contact information is not included.

225a - Assessment 15 Days (continued)

Plan of Correction ***Accept (JW 02/13/2023)***

The Community's assessment tool was approved by the Department and the Waiver provided will be submitted as a part of the Implementation Documentation.
Resident Service Director and/or designee will ensure that the assessments for Resident #2, #3, and #4 have included contact information for formal and informal supports by 2/15/2023
The Resident Service Director and/or designee will complete an audit of all current resident assessments by 2/15/2023, to ensure contact information is entered for resident's formal and informal supports. Any issues found during the audit were addressed immediately
Regional Care Director will provide education to the Executive Director and Resident Service Director and/or designee by 2/15/2023 on the importance of ensuring resident assessments have included contact information for formal and informal supports.
Executive Director will meet with Resident Services Director and/or designee weekly starting 2/6/2023 for the next 90 days to review all new resident assessments to ensure they include contact information for all formal and informal supports.

Licensee's Proposed Overall Completion Date: *02/15/2023*

Implemented [redacted] 02/23/2023)