

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

April 26, 2023

[REDACTED]
GRAND AT FAYETTE LLC
[REDACTED]

RE: GRAND AT FAYETTE D/B/A
COUNTRY CARE MANOR
205 COLDREN ROAD
FAYETTE CITY, PA, 15438
LICENSE/COC#: 44959

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/07/2023, 02/08/2023 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: GRAND AT FAYETTE D/B/A COUNTRY CARE MANOR License #: 44959 License Expiration: 05/15/2023
 Address: 205 COLDREN ROAD, FAYETTE CITY, PA 15438
 County: FAYETTE Region: WESTERN

Administrator

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

Legal Entity

Name: GRAND AT FAYETTE LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C 2 LP Date: 03/12/1993 Issued By: Dept L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 35 Waking Staff: 26

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint Exit Conference Date: 02/08/2023

Inspection Dates and Department Representative

02/07/2023 On Site [REDACTED]
 02/08/2023 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 75 Residents Served: 25

Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:

Hospice
 Current Residents: 12

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 25
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 10 Have Physical Disability: 0

Inspections / Reviews

02/07/2023 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/05/2023

03/28/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/14/2023
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/31/2023

Inspections / Reviews (*continued*)

04/10/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/14/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/17/2023

04/26/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/14/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

42s - Privacy

2. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 2/7/23 at 9:41 a.m., common bathroom #7, which is equipped with 3 bathroom stalls with no locks on their doors and a shower with a shower curtain, was unlocked from the hallway, and a female resident was using the toilet in the unlocked stall nearest the hallway door.

On 2/8/23 at 2:29 p.m., resident #2 was observed from the hallway using the toilet in the 3rd stall from the unlocked hallway door, and the stall door was held open by the resident's wheelchair.

Plan of Correction**Directed** [REDACTED] **04/10/2023)**

We respectfully disagree with this violation. The room had a lock to ensure privacy which the resident chose not to employ.

What: Residents routinely use this rest room due to its proximity to the community common areas. The individual stall doors will have privacy locks installed.

Who: Maintenance Director, or contractor.

When: By April 5, 2023

How: Professional installation

Ongoing: Maintenance Director, or designee will check that the door's operation as outlined to ensure that it is working properly.

DIRECTED

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall have latches placed on each of the toilet stalls. cited in the violation. If the shower is in use the main door(s) to the area shall be latched or locked to provide privacy. 4/10/23 [REDACTED]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff on the requirements of Regulation 2600.42(s) and the home's steps to ensure privacy. Documentation of education shall be kept. 4/10/23 [REDACTED]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall complete weekly checks of the area to ensure resident privacy is maintained. 4/10/23 JK

Directed Completion Date: 04/05/2023

Implemented [REDACTED] **- 04/26/2023)**

44g - Telephone Number

3. Requirements

2600.

44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

44g - Telephone Number (continued)

Description of Violation

On 2/7/23, the telephone number of the Department's personal care home regional office was not posted in a conspicuous and public place in the home.

Plan of Correction

Accepted [redacted] - 03/24/2023)

What: Upon notification of this violation the home placed the number in common areas of the home. This was verified during the inspection by the licensing representative.

Who: Community staff

When: 2/7/2023

How: A sign with the phone number was placed as outlined.

Ongoing: The Executive Director, or designee, will check that all required phone numbers are in place at least monthly.

Licensee's Proposed Overall Completion Date: 03/08/2023

Implemented [redacted] - 04/26/2023)

65a - FS Orientation 1st Day

5. 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:

- 4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- 6. Smoke detectors and fire alarms.

Description of Violation

The following staff persons did not receive orientation on the following topics: smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, smoke detectors and fire alarms:

- staff person A, date of hire [redacted] /19
- staff person B, date of hire [redacted] /21
- staff person C, date of hire [redacted] /22
- staff person D, date of hire [redacted] /22

In addition, direct care staff person B was hired on [redacted] /21; however, the the staff person did not receive training in evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location, the designated meeting place outside the building, and the location and use of fire extinguishers until [redacted] 22.

REPEAT VIOLATION: 2/14/2022 et al.

Plan of Correction

Accepted [redacted] - 04/10/2023)

What: The community will utilize the attached orientation checklist for all staff. This orientation will be completed prior to working with residents. In an effort to keep the training records consistent, all current staff, in addition to any new staff, will complete the orientation training using the attached form. This training record will include this most recent training date and will replace any prior orientation training the staff received.

Who: Hiring supervisor, or designee will ensure completion of the required orientation before the new staff person is scheduled for work with the residents. The Executive Director, or designee will check all new hire paperwork before the new staff person works with residents.

65a - FS Orientation 1st Day (continued)

When: Next new hire, current staff will complete this training by 4/5/2023

How: Verbal and written training materials proctored by the hiring supervisor. Senior staff will be receive the orientation training by the corporate consultant.

Ongoing: See "what" above

Licensee's Proposed Overall Completion Date: 04/05/2023

Implemented () - 04/26/2023)

65b - Rights/Abuse 40 Hours

6. 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 B, hired [redacted]/21, completed [redacted] 40th scheduled work hour; however, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions until [redacted]/22.

REPEAT VIOLATION: 2/14/2022 et al.

Plan of Correction

Accept () - 04/10/2023)

What: This gap in compliance was self identified and corrected prior to this inspection. Since the orientation deadline had expired this document could not be updated. The community will utilize the attached orientation checklist for all staff. This orientation will be completed prior to working with residents. An audit of all staff records showed that there were no other training need ng updated at the writing of this report.

Who: Hiring supervisor, or designee will ensure completion of the required orientation before the new staff person is scheduled for work with the residents. The Executive Director, or designee will check all new hire paperwork before the new staff person works with residents.

When: Next new hire

How: Verbal and written training materials proctored by the hiring supervisor

When: Next new hire

Ongoing: See "what" above

Licensee's Proposed Overall Completion Date: 03/31/2023

Implemented () - 04/26/2023)

65i - Training Record

7. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i - Training Record (continued)

Description of Violation

The home's record of direct care staff training does not include the length for the courses on safe management techniques, fire safety, and end of life care.

Plan of Correction

Accepted [REDACTED] - 03/24/2023)

What: This gap in compliance was previously self identified and in an effort to properly document training time for all direct care staff, the community had already begun using the BHSL training record. The Executive Director, or designee will review all staff training records to ensure that all items required in 2600.65(i) is available and accurate.

Who: Staff's Supervisor

When: Ongoing

How: Immediately following any staff training, the trainer will document all items as outlined in 2600.65(i) on the BHSL training form.

Ongoing: Executive Director, or designee, will review all prior quarter's training records at least quarterly to ensure that the training records identified herein are complete and in compliance.

Licensee's Proposed Overall Completion Date: 03/06/2023

Implemented [REDACTED] 04/26/2023)

82a - Poisonous Materials

8. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 2/7/23 at 9:59 a.m., there was a 1/3 full, unlabeled, clear, plastic 32oz. spray bottle containing a purple liquid with [REDACTED] handwritten in black ink on the front, sitting on the kitchen counter to the left of the sink. Original product labeling at the home says, "If swallowed: call a poison control center or doctor immediately."

Plan of Correction

Accepted [REDACTED] 03/24/2023)

What: This mislabeled product was disposed of and verified by the licensing representative. A complete review of all hazardous materials in the home was conducted. No other such incorrectly labeled hazardous materials were found.

Who: Community staff

When: 2/7/2023

How: Community areas were inspected by community staff.

Ongoing: The Maintenance Director, or designee, will inspect all areas of the community at least monthly to ensure that all hazardous materials are properly labeled and stored.

Licensee's Proposed Overall Completion Date: 03/31/2023

Implemented [REDACTED] - 04/26/2023)

82b - Poisonous Material Storage

9. Requirements

2600.

82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

82b - Poisonous Material Storage (continued)

Description of Violation

On 2/7/23 at 9:59 a.m., there was a 7.5oz. opened bag of [redacted] potato chips, 1/3 full, stored among a bottle of [redacted] and a nearly empty bottle of [redacted] on the kitchen counter to the left of the sink, with product labeling indicating, "If swallowed: call a poison control center or doctor immediately."

Plan of Correction

Accept [redacted] - 03/24/2023)

What: During a random community inspection by the Executive Director on the day of the inspection, the bag of chips noted was found in an employee only area and placed in the kitchen for removal. This was not an item intended for resident consumption. Staff will be retrained on the proper storage of food, those items intended for resident consumption, and chemicals to ensure proper resident food safety and compliance with this regulation.

Who: Executive Director, or designee

When: By 3/31/2022

How: In person, verbal training, including identification of storage areas to store food for resident consumption.

Ongoing: The Executive Director, or designee will inspect all areas where food, intended for resident consumption, is stored to ensure that all such items are stored according to this regulation.

Licensee's Proposed Overall Completion Date: 03/31/2023

Implemented [redacted] - 04/26/2023)

126a - Furnace Inspection

10. Requirements

2600.

126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

There is no documentation of an inspection of the home's electric furnace.

Plan of Correction

Accept [redacted] - 04/10/2023)

What: The installing vendor was contacted and will be scheduling an inspection as soon as their schedule permits.

Who: Contracted consultant contacted the vendor

When: March 4, 2023

How: Phone

Ongoing: The community will ensure that the unit will be inspected at least annually from the date of the pending inspection.

Licensee's Proposed Overall Completion Date: 03/31/2023

Implemented [redacted] - 04/26/2023)

132d - Evacuation

12. Requirements

2600.

132d - Evacuation (continued)

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

During the fire drill on 12/12/22 at 4:15 p.m., residents did not evacuate the building to a public thoroughfare, and the home's fire safety inspection letter, dated 3/23/22, indicates, "There are no internal areas of refuge in your building therefore during a fire or simulation all residents must evacuate to the exterior of the building."

Plan of Correction**Accept [REDACTED] 04/10/2023)**

What: The community has completed fire drills consistently according to regulations since the acceptance of the 2/12/2022 LIS in March of 2022. That said, the fire drill in question was completed well within the evacuation time but the staff failed to have the residents completely exit the community as is required since there is no area of refuge inside the community. Retraining of senior staff will be completed to ensure understanding of this regulation which requires evacuation of the building proper during said drills.

Who: [REDACTED] Contracted Consultant

When: Training will be completed by 3/31/2023

How: Zoom Video/Conference Call

Ongoing: The Executive Director, or designee, will review all planning and resulting fire drill records to ensure they were completed including evacuation to the exterior of the community's building. This will include interviews with staff who conduct such drills when the Executive Director is not in attendance during the drill.

Licensee's Proposed Overall Completion Date: 03/31/2023

Implemented [REDACTED] - 04/26/2023)