pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GRACEFUL CARE LIVING, LLC**
LEGAL ENTITY

To operate **GRACEFUL CARE LIVING**
NAME OF FACILITY OR AGENCY

Located at **211 GARNIER STREET, SHARPSBURG, PA 15215**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **52**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **April 9, 2024** until **October 9, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454671**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 9, 2024

[redacted]
Graceful Care Living LLC
[redacted]

RE: Graceful Care Living
211 Garnier Street
Sharpsburg, Pennsylvania 15215
License/COC #: 454671

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 30, 2023, August 31, 2023, and January 10, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 454670) dated July 18, 2023 – June 1, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 9, 2024 to October 9, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department

of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

[redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *GRACEFUL CARE LIVING* **License #:** *45467* **License Expiration:** *06/01/2024*

Address: *211 GARNIER STREET, SHARPSBURG, PA 15215*

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

Administrator

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

Legal Entity

Name: *GRACEFUL CARE LIVING, LLC*

[redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/07/1993* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *39* **Waking Staff:** *29*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *08/31/2023*

Inspection Dates and Department Representative

08/30/2023 - On-Site: [redacted]
08/31/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *52* **Residents Served:** *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *5* **Are 60 Years of Age or Older:** *30*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability:** *3*

Have Mobility Need: *7* **Have Physical Disability:** *8*

Inspections / Reviews

08/30/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/28/2023*

10/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/29/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/09/2023*

10/16/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/09/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/15/2023*

03/26/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/15/2023*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 8/30/23 at 9:30 AM, agents of the Department requested current staff and resident lists from staff person A; however, the lists were not provided to agents of the Department until 10:20 AM.

On 8/30/23 at 9:30 AM, agents of the Department requested access to staff and resident records from staff person A; however, the records were not provided to agents of the Department until 11:07 AM.

Plan of Correction ***Accept ([redacted] - 10/03/2023)***

The administrator/co-owner has addressed to managing partners that the administrator or a designee shall provide, upon request, immediate access to the home, the residents, and records to the agents of the department. The staff member listed in this violation is no longer employed by this legal entity, therefore, cannot be re-addressed on this violation. Moving forward, the administrator also clarified to the charge med tech of the day shift and the kitchen supervisor (who is DCS qualified) on 9/27/2023 that if the administrators/managing partners are not present upon the arrival and request of such information by the department, that the present staff person(s) are designated, permitted, and must retrieve any resident and/or employee files and other information that the department agent(s) request in an immediate manner. The locations of the requested documents have been shown to the designated staff persons. If for any reason the information is not easily found, the present med staff person is to immediately contact the administrator for direction/guidance in obtaining such information. Administrator has constructed a blue folder that is labeled "DHS inspection/survey information" which is in the lobby office in a black file holder on the ledge of the wall by the desk. that contains pertinent information that the department frequently requests and is accessible to the designated person(s) to immediately retrieve. The administrator will ensure that the information within the blue folder is updated per change of statistics. Please see the attached documentation that affirms designated person(s) are in place.

Licensee's Proposed Overall Completion Date: *09/27/2023*

Implemented ([redacted] - 03/26/2024)

42q - Compensation

2. Requirements

2600.
42.q. A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the home.

Description of Violation

On 8/30/23 at approximately 2:15 PM, resident #1 was observed sweeping the home's sidewalk, cleaning the grounds of the home and pulling weeds. Resident #1 also regularly takes out the trash and paints in areas of the home; however, resident #1 is not compensated in accordance with State and Federal labor laws for labor performed on behalf of the home.

Plan of Correction ***Directed [redacted] - 10/10/2023)***

Not a violation within accordance of 2600.42.q due to the resident voluntarily and without coercion performs tasks that the resident enjoys doing. The home's legal entity has a housekeeper, maintenance and auxiliary staff

42q - Compensation (continued)

members on payroll to perform such tasks. Upon discussion between Resident #1 and the administrator/co-owner of this legal entity on 9/19/2023 regarding sweeping, pulling weeds and taking out the trash, the resident stated that [redacted] performs these tasks because [redacted] "enjoys doing that stuff", "it passes time" so that [redacted] "doesn't get bored". Admin/co-owner also clarified to resident #1 that [redacted] does not have to pull weeds, sweep or take out the trash if [redacted] does not want to, [redacted] replied "I know". No resident including resident #1 has ever painted any area within or outside the home's property. Resident suffered a TBI in 1987 from injuries that were sustained in a serious automobile accident, which left the resident with various impairments that deemed the resident unable to maintain [redacted] employment in the maintenance field (as explained by administrator to on-site inspectors). Though [redacted] may feel that [redacted] is "working", [redacted] is not asked, forced, scheduled, or coerced in any way to perform any tasks (by the legal entity's managing partners/administration/staff) that would be of the legal entity's benefit. Per resident #1's support plan on page 12, under hobbies/interests/solitary activities, it is listed that [redacted] enjoys landscaping in relation to pulling weeds as [redacted] did at the previous facility that [redacted] resided. Resident #1 is also deemed that [redacted] only requires supervision in unfamiliar places. Safety and wellness is not at risk due to resident is not utilizing any form of equipment or sharp objects. This facility and it's legal entity is aware that a resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the home, but this is not the case. It is within [redacted] resident rights to do things that [redacted] enjoys at [redacted] leisure as long as his safety and wellness is not at risk per [redacted] support plan. Support plan was faxed to the department as requested on 9/13/2023 at 10:25 am. Resident was re-addressed on 10/3/2023 at 10:23am that [redacted] is not permitted to perform any tasks which include pulling weeds, sweeping, taking out trash or any other task [redacted] has previously performed due to the department guidelines. Resident understands that [redacted] is no longer permitted to perform such tasks. Staff was addressed on 10/6/2023 regarding redirecting resident from attempting to perform tasks and reporting to administration to readdress concerns with resident(s). Please see attached supporting documentation.

DIRECTED: Beginning on 10/20/23: The administrator/shift supervisor shall monitor the home daily to ensure no resident, including resident #1, is performing any tasks or work that are designated for staff persons, including yard work and sweeping, unless the residents are compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. If residents are working in the home, documentation of the work shall be kept, which includes the hours worked and amount compensated. [redacted] 10/16/23

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 03/26/2024)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 8/30/23 at 11:25 AM, there were no paper towels, mechanical hand dryer or other sanitary means to dry hands present in the shared jack-and-jill bathroom between bedrooms #401 and #402A.

On 8/30/23 at approximately 11:30 AM, there was brown and gray material splattered on the mirror, sink, and toilet in the shared jack-and-jill bathroom between bedroom #403 and #404A.

On 8/30/23, a thick layer of dust was covering the exhaust fan in the shared jack-and-jill bathroom between

85a - Sanitary Conditions (continued)

bedroom #405 and #406.

On 8/30/23, a thick layer of dust was covering the exhaust fan in the 4th floor common bathroom.

On 8/30/23 at 11:44 AM, there were 2 unlabeled toothbrushes present on the sink in the 4th floor common bathroom.

Plan of Correction ***Accept ([redacted] - 10/10/2023)***

The above violations were immediately corrected for on site inspectors to verify. Paper towels were replenished in the half bath between rooms 401 and 402, the dried shaving cream was cleaned from the surface of the mirror, sink and toilet in the half bathroom between rooms 403 and 404, the exhaust fans in the half bathroom between rooms 405 and 406 and in the 4th floor common bathroom were cleaned and all dust was removed, and the 2 Unlabeled toothbrushes that were present on the sink of the 4th floor common bathroom were discarded. A full time housekeeper is scheduled 5 days a week starting 9/4/2023. Staff was formally addressed directly by administrator with documentation on 10/6/2023 at an all staff meeting regarding sanitary conditions and the violations pertaining to in this report. This is to ensure that sanitary conditions shall be and are maintained. Moving forward, administration will perform 3x/week checks for the next 6 months, then once weekly thereafter to ensure that compliance of this regulation is being upheld and that future violations will not occur. The checks began on 9/21/2023 that is documented and attached. The items that are to be checked are listed on the attached checklist that include, but are not limited to: vents (clean/operable), lights, toilet paper, paper towels, trash, soap, cleanliness for floors 1-5. Please see attached documentation.

Licensee's Proposed Overall Completion Date: *10/03/2023*

Implemented [redacted] - 03/26/2024)

88a - Surfaces

5. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 8/30/23, there was an approximate 2" x 4" hole through the door jamb and the wall on the lower left corner of the external red door by the ramp to the 4th floor.

On 8/30/23, there were 3 holes in the dry wall near the fire panel. The holes measured approximately 4" x 4", 4" x 5" and 2' x 3'.

On 8/30/23, the door leading from the 1st floor to the smoking area is in disrepair. The door knob and locking mechanism is not present on the door, exposing a hole through the door, which is approximately 4" long x 2.5" wide.

On 8/30/23 at 12:32 PM, the door leading to the fire-safe near the home's chapel was propped open with a cinderblock. A sign on the door indicates, "Fire safe doors on Chapel (older side) of building are functional. They are kept open with brick stopper due to mechanical issue. In case of fire, the MED TECH assigned for that shift is designated to move brick and close door to secure fire safe area immediately once alarm is sounded."

88a - Surfaces (continued)

Plan of Correction ***Directed [redacted] - 10/10/2023)***

Plan to correct the above violations are as follows: the 2''x 4'' hole through the door jamb and the wall on the lower left corner of the external red door by the ramp to the 4th floor and the 3 holes in the drywall near the fire panel is set to be repaired by an independent contractor on 9/30/2023 and has been completed. Cosmetic painting is set to be completed for the door jamb and drywall by the fire alarm system box in the lobby by 11/1/2023. The door leading to the smoking area on the 1st floor is a fire retardant door that requires a custom installation, measurements were obtained and given to the door fabrication company and will be installed upon completion of the build and delivery to the facility, estimated delivery of the door is 10/16/2023. (DIRECTED: The new door leading from the 1st floor to the smoking area shall be installed by a qualified professional by 11/1/23. [redacted] 10/16/23). The cinderblock and the sign on the door were immediately removed from the fire-safe door for on-site inspectors to verify. Neither the sign nor the cinderblock served any purpose and was unnecessary due to the fire doors in this violation Additionally, the doors are wire connected to the facility fire alarm system, are magnetic and are fully operable without any manual assistance from staff. The doors are inspected annually and per need to ensure that they operate accordingly. An extension of this POC was requested by the administrator to the department on 9/26/2023 to complete and submit documentation of the the upcoming repairs, but only one additional day was granted. The above listed violations were a one-time repair and the monitoring of any discovered issues were addressed at the 10/6/2023 staff meeting and are included in the maintenance protocols. Administration has implemented 3x weekly checks for 6 months then weekly thereafter beginning on 9/21/2023, as already submitted that include, but are not limited to floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.. All supporting documentation of these repairs will be immediately submitted to the department upon completion.

DIRECTED: By 10/21/23: The administrator shall develop and implement a repair form for staff persons to submit to management for issues that need repaired or replaced to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. All staff persons shall be educated on the new form by 10/25/23. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 10/16/23

Directed Completion Date: *10/25/2023*

Not Implemented [redacted] - 03/26/2024)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 8/30/23, the light bulb and light fixture cover were missing from the light fixture in the ceiling of the 5th floor common bathroom.

On 8/30/23, the hinge was detached from the lower right door of the cabinet under the sink in the 4th floor living area.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Directed [redacted] - 10/10/2023)***

The light fixture and bulb on the ceiling of the 5th floor common bathroom is to be installed on 9/30/2023 and the hinge of the lower right door of the cabinet under the sink in the 4th floor living area was repaired 9/27/2023. Moving forward, administration will perform 3x/week checks for the next 6 months, then once weekly thereafter to ensure that all light fixtures, furniture and equipment must be operable, are in good repair, clean and free of hazards within the facility. Housekeeping, maintenance, auxiliary, and direct care staff have been re-addressed on immediately reporting to administration if any furniture/equipment is in need of repair. This is to ensure that compliance of this regulation is being upheld and that future violations will not occur. An extension of this POC was requested by the administrator to the department on 9/26/2023 to complete and submit documentation of the the upcoming repairs, but only one additional day was granted. These violations are completed, administrative weekly checks began on 9/21/2023 which include, but are not limited to furniture and equipment must be in good repair, clean and free of hazards. Maintenance reporting protocols were addressed to all staff on 10/6/2023. Please see provided attached documentation.

DIRECTED: By 10/21/23: The administrator shall develop and implement a repair form for staff persons to submit to management for issues that need repaired or replaced to ensure all furniture and equipment is in good repair, clean and free of hazards. All staff persons shall be educated on the new form by 10/25/23. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 10/16/23

Directed Completion Date: *10/25/2023*

Implemented [redacted] - 03/26/2024)

100a - Exterior - Free of Hazards

8. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The external wooden fire escape leading from the 3rd floor is in disrepair. Numerous wooden boards are rotten and no handrail is present on the left side of the landing from the 3rd floor emergency exit door. Residents who reside on this floor have been instructed not to use this exit in an emergency evacuation.

Plan of Correction ***Directed [redacted] - 10/10/2023)***

To clarify, the now legal entity does not own but leases the building from the previous legal entity owners. The residents who resided on the third floor of the facility were relocated to new rooms on 9/1/2023 to ensure safety per administration and the department. The third floor is not to be occupied by current or new admissions to the facility until total repairs have been made and the fire escape stemming from the third floor has been deemed safe by the appropriate agencies. On April 11, 2023, the facility's annual Fire Evacuation/Fire Safe Area Designation/Supervised Fire Drill and Safety inspection was conducted by the Sharpsburg Borough Code Enforcement Officer who is a member of the local fire department and a construction code official (as verified on the department required form for 2600.132(b)(d)) where the building and its exit routes were inspected, passed and the information on the form is valid for one year assigned by the Sharpsburg Borough Code Enforcement Officer. The absent handrail on the left side (against the building's brick structure) was not deemed necessary nor previously violated per the Sharpsburg Borough Code Enforcement Officer or the local fire department currently or in the past during annual inspections that the department requires. All required handrails are present on the structural fire escape and its stairwells.

100a - Exterior - Free of Hazards (continued)

Since the department regulation 2600.100 (a), does not specify that the absent handrail in the exact location on the landing of the fire escape of the third floor is considered a potential "hazard", the administration refers to the Sharpsburg Borough Code Enforcement Officer to deem hazards in relation to [redacted] expertise as a member of the local fire department and as a qualified construction code official. On June 1, 2023, the same Sharpsburg Borough Code Enforcement Officer issued the building owners (not the current legal entity owners) a letter stating that a structural engineer report with a PE stamp was to be provided within 30 days. According to the Sharpsburg Borough Code Enforcement Officer, this requested documentation was never provided by the building/previous legal entity owners. It also states "Do not use the deck unless extreme emergency only". This letter (attached) was forwarded to the new legal entity owners per request to rectify this violation. Managing partners of Graceful Care Living, LLC have met with the Sharpsburg Borough Code Enforcement Officer and a licensed contractor on several occasions most recently on 9/27/2023. It is determined per the Sharpsburg Borough Code Enforcement Officer that a structural engineer report with a PE stamp will be required for an architect to provide drawings to submit to the borough for approval. Once approved, a permit can be obtained to proceed with the structural repairs/replacement. This time frame is currently undeterminable, but the administration will provide the department documentation immediately upon receipt and keep the department updated on the status of the plans for the structural repairs. The current legal entity is doing due diligence in rectifying this violation as timely as possible. Please see the attached supporting documentation. The resident that occupied [redacted] was relocated to [redacted] the resident that resided in [redacted] was relocated to [redacted] and the resident that resided in [redacted] was relocated to [redacted] as well. In regard to the letter dated 6/1/2023, as stated above, the Sharpsburg Borough Code Enforcement Officer issued the building owners (not the current legal entity owners) a letter stating that a structural engineer report with a PE stamp was to be provided within 30 days. According to the Sharpsburg Borough Code Enforcement Officer, this requested documentation was never provided by the building/previous legal entity owners. The current legal entity owner and renters of the building are assuming full responsibility for rectifying this now-discovered violation and had a licensed structural engineer at the facility on 10/8/2023 to conduct a walk-through and assessment of the fire escape, [redacted] was reaching out to the borough code enforcement officer on 10/9/2023 to discuss projected structural modifications that meet the borough and county guidelines. The structural engineer will then submit a PE-stamped letter in order to obtain the required building permits. As stated by the structural engineer to the legal entity owners, this is a work in progress and definitive dates cannot be yet determined. The wooden structure will need to be fabricated and this process cannot be started until approval by the borough and county is granted. (It is likely per the structural engineer that the borough and county will require a metal fire escape, but this is yet to be determined). Legal entity owners are doing due diligence in rectifying this procedure as timely as possible and are providing the department with the requested information as it becomes available. Until all permits are obtained and work is completed and approved by the borough and county, legal entity owners shall keep the 3rd floor of the facility completely vacant of any current or new admissions to ensure safety. Being that the 3rd floor is unoccupied, there is no reason for the 3rd level of the fire escape to be utilized whatsoever. The administration will submit all documentation and updates throughout this renovation procedure immediately as it becomes available and appreciates the department's understanding.

DIRECTED: By 10/31/23: A structural engineer shall submit an engineer's report, which contains a PE stamp, to the Code Enforcement Officer with Borough of Sharpsburg for replacement of the home's external fire escape from the 3rd floor. Documentation of the engineer's report, as well as documentation of the submission to the Borough of Sharpsburg, shall be kept. Copies of all applicable building permits shall be kept. [redacted] 10/16/23

DIRECTED: By 11/30/23: The home's external fire escape leading from the 3rd floor shall be replaced in accordance with recommendations from the engineer and the local Code Enforcement Officer. These remedial renovations and alterations will include handrails in accordance with 2600.93(a) - Each ramp, interior stairway and outside steps

100a - Exterior - Free of Hazards (continued)

must have a well-secured handrail. [redacted] 10/16/23

DIRECTED: By 12/15/23: The home shall submit to the Department documentation of a new certificate of occupancy/fire safety approval, or written certification that a new certificate of occupancy/fire safety approval is not required in accordance with 2600.14(c). Pursuant to 2600.14(d) and effective 10/16/23, the Department hereby requests additional fire safety inspection(s) by the local Code Enforcement Officer upon completion of the remedial renovations and alterations of the external wooden fire escape leading from the 3rd floor. [redacted] 10/16/23

Directed Completion Date: *12/15/2023*

Not Implemented [redacted] - 03/26/2024)

101j7 - Lighting/Operable Lamp

9. 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 8/30/23, resident #2's bedside lamp was approximately 4 feet from resident #2's bed and could not be turned on/off at bedside.

On 8/30/23, no operable lamp or other source of lighting was present at resident #3's bedside.

REPEAT VIOLATION: 5/15/2023

Plan of Correction ***Directed ([redacted] - 10/10/2023)***

Wall-mounted bedside lights were installed by both resident #2 and resident #3's beds to correct this violation by 10/1/2023. This is to ensure that an operable lamp or other source of lighting can be turned on at the bedside. Administration will perform weekly checks on all light fixtures within the home to ensure that they are within reach and operable. Please see the attached documentation. An extension of this POC was requested by the administrator to the department on 9/26/2023 to complete and submit documentation of the upcoming repairs, but only one additional day was granted. The weekly checks began on 9/21/2023, which includes all bedside lights. Resident #3 was the repeat violation due to [redacted] chose to move the light. Daily checks are to be implemented on 10/10/2023-11/10/2023 to ensure lights remain operable and in place. (DIRECTED: The daily checks shall be conducted by the shift supervisor/administrator and shall include a daily check of each resident bedroom to ensure operable lighting is within reach of each resident's bed. Weekly checks of all resident bedrooms shall be conducted immediately following the daily checks. [redacted] 10/16/23). To rectify the regulation, the administration installed a wall-mounted light on residents #2 and #3's walls at the bedside to prevent future related violations. All staff was re-educated on operable lamps or other sources of lighting that can be turned on at the bedside must be present. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 10/16/23). Please see the attached documentation.

Directed Completion Date: *11/10/2023*

Implemented [redacted] - 03/26/2024)

102h - Toilet Paper

10. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 8/30/23 at 11:25 AM, no toilet paper was present at the toilet in the shared jack-and-jill bathroom between bedrooms #402A and #401.

On 8/30/23 at 12:22 PM, no toilet paper was present at the toilet in the 1st floor common bathroom.

Plan of Correction ***Accept [redacted] - 10/10/2023)***

This violation was immediately corrected for on site inspectors to verify. A full time housekeeper has since been scheduled on [redacted] 2023 for 5 days per week to ensure that toilet paper shall be provided for every toilet. Moving forward, the administration will perform 3x/week checks for the next 6 months (which began on 9/21/2023), then once weekly thereafter to ensure that compliance with this regulation is being upheld and that toilet paper shall be provided for every toilet. All staff was re-educated on 10/6/2023 that toilet paper shall be provided for every toilet. Please see the attached documentation.

Licensee's Proposed Overall Completion Date: *10/09/2023*

Implemented [redacted] - 03/26/2024)

103g - Storing Food

11. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 8/30/23 at 12:43 PM, an open and unsealed box of lasagna sheets were present in the upright basement freezer.

On 8/30/23 at 12:45 PM, an opened and unsealed bag of rice and a bag of flour were present on a shelf in the basement pantry.

On 8/30/23 at 12:57 PM, 2 open and unsealed bowls of ice cream and 1 open and unsealed bag of chicken were present in the upright kitchen Whirpool freezer.

Plan of Correction ***Directed [redacted] - 10/10/2023)***

These violations were immediately corrected for on site inspectors to verify. The packaging tape was replaced on the box of unopened lasagna sheets. The rice and flour (in the basement pantry), the 2 improperly sealed ice cream bowls and the unsealed bag of chicken were discarded into the trash. The kitchen staff members were re-addressed that all food (new or previously opened) must be sealed securely at all times. Administration will perform once weekly checks that began on 9/21/2023 to ensure that compliance of this regulation is being upheld. All staff was re-addressed by administrator that food shall be stored in closed or sealed containers, on several occasions, and again and documented on the 10/6/2023 all-staff meeting. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 10/16/23). Please see attached documentation.

Directed Completion Date: *10/16/2023*

Implemented [redacted] - 03/26/2024)

121a - Unobstructed Egress

12. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 8/30/23, the exit door leading from the kitchen to the courtyard required excessive force by an agent of the Department to open.

Plan of Correction ***Directed [redacted] - 10/10/2023)***

The kitchen door listed in this violation was corrected on 9/25/2023. A private contractor/handyman fully repaired the rear kitchen door so that it easily opens, and can be locked via the handle (which means that the door can be locked if needed by the lock on the handle, but is left unlocked to satisfy this regulation). (DIRECTED: By 10/19/23: The administrator shall ensure the locking mechanism is removed from the exit door leading from the kitchen to the courtyard to ensure the door is unlocked and unobstructed in accordance with 2600.121a. [redacted] 10/16/23). The administrator was only explaining to the department that because a lock is present on the handle, it remains unlocked and is completely operable. Please see attached supporting pictures of the repaired knob that is able to be locked and unlocked with ease. (There is also a video that demonstrates that the door can be easily opened and closed, but it would not upload). Please see the attached still photographs. Staff was re-educated on 10/6/2023 on 2600.121 (a).

DIRECTED: By 10/25/23: All staff persons shall be educated that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 10/16/23

Beginning on 10/20/23: The administrator/shift supervisor shall inspect the home daily to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. [redacted] 10/16/23

Directed Completion Date: *10/25/2023*

Not Implemented [redacted] - 03/26/2024)

144c2 - Smoking Area Distance

14. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

On 8/30/23 at 12:26 PM, a white sheet was present on a chair in the home's designated smoking area.

144c2 - Smoking Area Distance *(continued)*

Plan of Correction ***Directed [redacted] - 10/10/2023)***

This violation was an oversight and was immediately corrected for onsite inspectors to verify. The white sheet was removed from the area by a staff member. Moving forward, a member of the administration will conduct once-a-week checks that were implemented on 9/21/2023 to ensure that combustible or flammable materials are not present in the home's designated smoking areas to ensure safety and to prevent any future violations of this nature. All staff was re-educated on this violation at the 10/6/2023 staff meeting. Please see the attached documentation.

DIRECTED: By 10/25/23: The administrator shall educate all residents that combustible or flammable materials are not permitted in the home's designated smoking area. Documentation of the education shall be kept. [redacted] 10/16/23

Directed Completion Date: *10/25/2023*

Implemented [redacted] - 03/26/2024)

184a - Resident's Meds Labeled

15. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is prescribed Hydrocodone/APAP-5mg/325mg-Take1 tablet by mouth 2 times a day; however, resident #3's pharmacy label indicates Hydrocodone/APAP–5mg/325mg-Take 1 tablet by mouth 2 times a day as needed for pain.

Plan of Correction ***Directed ([redacted] - 10/10/2023)***

This violation was immediately corrected and on-site inspectors verified. A "change of direction, refer to chart" label was adhered to the medication card. All medication staff was re-addressed by the administrator on 10/6/2023 regarding this violation that they must compare each medication to the MAR to ensure that all orders are correct without discrepancy. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 10/16/23). Moving forward, administrator will continue to complete documented once weekly medication cart, MAR and physician order audits re-implemented 9/21/2023 to verify that all orders, prescription labels are in accordance with the MAR. (DIRECTED: The weekly audits conducted by the administrator shall include an audit of at least 5 residents per week.[redacted] 10/16/23). Please see attached documentation.

Directed Completion Date: *11/01/2023*

Not Implemented [redacted] - 03/26/2024)

185a - Implement Storage Procedures

16. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #4 is prescribed Hydroxyzine 25mg-Take 1 capsule by mouth every 8 hours as needed for anxiety; however, on 8/31/23, this medication was not available in the home for administration.

Plan of Correction ***Directed [redacted] - 10/10/2023)***

Upon verification that this medication was not present on the cart, Health Direct Pharmacy was immediately contacted on 8/31/2023 to supply the facility with this medication. HDP then notified the med staff that the prescription required a refill. Resident #4 was scheduled to see PCP on [redacted]/2023 to review this and other medications. It was then decided by resident #4 and PCP that this medication was to be discontinued due to resident #4 no longer requests this as needed medication under non use. (DIRECTED: By 10/19/23: Documentation from resident #4's prescriber discontinuing resident #4's Hydroxyzine shall be kept in resident #4's record. [redacted] 10/16/23). All medication staff was re-addressed by the administrator during the 10/6/2023 staff meeting regarding this violation that they must ensure that each medication ordered per residents must be available in the cart per MD order. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 10/16/23). A policy was developed, submitted to the department and has implemented procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. This violation was an oversight that was corrected. Moving forward, administrator will continue to complete documented once weekly medication cart (POC documentation effective 9/21/2023), MAR and physician order audits to verify that all medication orders are available within the medication cart. (DIRECTED: The weekly audits conducted by the administrator shall include an audit of at least 5 residents per week. [redacted] 10/16/23). Please see attached documentation.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 03/26/2024)

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

Facility Information

Name: *GRACEFUL CARE LIVING* **License #:** *45467* **License Expiration:** *06/01/2024*

Address: *211 GARNIER STREET, SHARPSBURG, PA 15215*

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

Administrator

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

Legal Entity

Name: *GRACEFUL CARE LIVING, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/07/1993* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *40* **Waking Staff:** *30*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *01/10/2024*

Inspection Dates and Department Representative

01/10/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *52* **Residents Served:** *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older:** *29*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability:** *2*

Have Mobility Need: *7* **Have Physical Disability:** *6*

Inspections / Reviews

01/10/2024 - Partial

Lead [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/07/2024*

02/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/26/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/23/2024*

02/27/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/26/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/10/2024*

03/26/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/26/2024*

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

121a - Unobstructed Egress

1. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

A locking mechanism was present on the door knob of the exit door leading from the kitchen to the courtyard.

A locking mechanism was present on the door knob of the exit door by the ramp to the 4th floor. Also, this exit door required excessive force by an agent of the Department to open.

Plan of Correction ***Directed [redacted] - 02/27/2024)***

The knobs to both the kitchen door and the exit door near the ramp of the 4th floor ramp (is to be replaced by 2/15/2024) with a knob that does not have a locking mechanism. This was done to comply with 2600.121(a) where stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Administrator performed a walk through of the entire facility on 2/21/2024 to ensure that to comply with 2600.121(a) where stairways, hallways, doorways, passageways and egress routes from rooms and from the building were unlocked and unobstructed. Once weekly checks are to be completed by administrator (implemented on 2/21/2024) for 6 months to comply with 2600.121(a) where stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed and documentation will be kept on file within the home. Please see attached documentation.

DIRECTED: By 3/10/24: All staff persons shall be trained that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of the staff education shall be kept in accordance with 2600.65. [redacted] 2/27/24

Proposed Overall Completion Date: 02/23/2024

Directed Completion Date: *03/10/2024*

Not Implemented [redacted] - 03/26/2024)

133.1 - Exit Signs

2. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

There was no exit sign at the exit door by the ramp to the 4th floor. On 1/10/24, 33 residents resided in the home.

Plan of Correction ***Accept[redacted] - 02/27/2024)***

An exit sign was placed in clear view on the exit door by the ramp to the 4th floor on 2/6/2024 by the administrator. This was done to comply with 2600.133.1 where signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits. Administrator performed a walk through of the entire facility on 2/21/2024 to ensure that to comply with 2600.133.1 that signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exit doors. Once weekly checks are to be completed by administrator (implemented on 2/21/2024) for 6 months to comply with 2600.133.1 that signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exit doors. All related

133.1 - Exit Signs (continued)

documentation will be kept on file within the home. Please see attached documentation.

Licensee's Proposed Overall Completion Date: *02/23/2024*

Not Implemented [redacted] - 03/26/2024)

184a - Resident's Meds Labeled

3. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #1 is prescribed Trazadone 50 mg tablet–Take 1 tablet by mouth at bedtime, as well as Trazadone 50 mg tablet-Take 1 tablet by mouth at bedtime as needed for insomnia. However, resident #1's pharmacy label only indicates Trazadone 50 mg–Take 1 tablet by mouth at bedtime.

Plan of Correction ***Directed [redacted] - 02/27/2024)***

This violation was a duplicate order that was corrected in a timely manner. On 1/12/2024, the resident's MD/CRNP reviewed the scheduled and as needed order and determined that the as needed order was to be immediately discontinued. Please see attached documentation. Moving forward, administrator and designated med trained supervisors will continue to perform documented weekly Med Cart and MAR audits (that were implemented and began on 9/21/2023) indefinitely on ***all residents*** *to ensure that the original container for prescription medications shall be labeled with a pharmacy label with the correct prescribed dosage and instructions for administration or a "change of direction, refer to chart" label will be properly adhered to the medication so that the label and MAR are in coordination. All related documentation is to be kept within the resident file for verification. Administrator re-addressed to all med staff on 2/21/2024 at a meeting that all medication changes must be both compared to the pharmacy label and the MAR to ensure accuracy. A 'change of direction, refer to chart' label is to be adhered to the pharmacy label of the medication on hand. Administrator is currently coordinating with [redacted] from Medi HH in scheduling a refresher and re-certification medication training that is department approved within the next 14 days and the documentation is to be kept on file in accordance with 2600.65(i). (DIRECTED: The staff education conducted by Medi Home Health shall be completed by 3/8/24. [redacted] 2/27/24).*

Proposed Overall Completion Date: 02/23/2024

Directed Completion Date: *03/08/2024*

Not Implemented ([redacted] - 03/26/2024)

187d - Follow Prescriber's Orders

4. Requirements

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

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

Resident #2 is prescribed Senna 8.6 mg/50 mg tablet–Take 1 tablet by mouth at bedtime; however, this medication was not administered to resident #2 daily from 1/7/24 through 1/9/24, because the medication was not available in the home for administration.

Plan of Correction ***Directed [redacted] - 02/27/2024)***

The resident's MD/CRNP was notified immediately and the resident was evaluated on 1/12/2024 regarding this medication. The MD/CRNP determined that this medication is to be discontinued due to it was ordered by a previous hospice service and was no longer necessary. Please see attached documentation. Moving forward, administrator and designated med trained supervisors will continue to perform documented once weekly Med Cart and MAR audits (implemented on 9/21/2023) indefinity on ***all residents*** *to ensure that the home shall follow the directions of the prescriber and that all ordered medications are to be available in the home per MD order. Administrator re-addressed to all med staff on 2/21/2024 at a meeting that all medications ordered must be available within the home at all times. Administrator also addressed that all medications must be reordered when a 5-day or less supply is present within the medication container to prevent depletion of the ordered medication. Administrator is currently coordinating with [redacted] from Medi HH in scheduling a refresher and re-certification medication training that is department approved within the next 14 days and the documentation is to be kept on file in accordance with 2600.65(i). (DIRECTED: The staff education conducted by Medi Home Health shall be completed by 3/8/24. [redacted] 2/27/24).*

Proposed Overall Completion Date: 02/23/2024

Directed Completion Date: *03/08/2024*

Not Implemented [redacted]/26/2024)