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

August 31, 2023

[REDACTED], ADMINISTRATOR
COMMUNITY HEALTHCARE PC OPERATOR, INC.
277 HOFFMAN AVENUE
WINDBER, PA, 15963

RE: WINDBER WOODS SENIOR LIVING & REHABILITATION CENTER
277 HOFFMAN AVENUE
WINDBER, PA, 15963
LICENSE/COC#: 33388

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/27/2023 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: *WINDBER WOODS SENIOR LIVING & REHABILITATION CENTER* **Licen e #**: *33388* **Licen e Expiration**: *08/23/2023*

Address: *277 HOFFMAN AVENUE, WINDBER, PA 15963*

County: *SOMERSET* **Region**: *CENTRAL*

Administrator

Name: **Phone** **Email**:

Legal Entity

Name: *COMMUNITY HEALTHCARE PC OPERATOR, INC.*
Address: *277 HOFFMAN AVENUE, WINDBER, PA, 15963*
Phone:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *07/15/1986* **I ued By**: *D L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/27/2023*

Inspection Dates and Department Representative

06/27/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

06/27/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/17/2023*

07/17/2023 - POC Submission

Submitted By: **Date Submitted**: *08/09/2023*
Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/25/2023*

Inspections / Reviews *(continued)*

07/27/2023 - POC Submission

Submitted By [redacted] **Date Submitted**: *08/09/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/22/2023*

08/31/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/09/2023*

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

65a - FS Orientation 1st Day

1. 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:

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person A, hired on [redacted] Staff Person B, hired on [redacted] Staff Person C, hired on [redacted], did not receive first day orientation on the following topics:

- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

- Smoke detectors and fire alarms.

- Telephone use and notification of emergency services.

Plan of Correction ***Accept ([redacted] - 07/27/2023)***

Staff Person A, B, and C were trained on 7-11-23 and 7-12-23 by the Administrator and Nurse Manager on the following topics:

-the designated meeting place outside the building or within the fire-safe area in the event of an actual fire

-Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable

-Smoke detectors and fire alarms

-Telephone use and notification of emergency services

All personal care staff will be retrained on the above topics by the Administrator or Nurse Manager by July 26, 2023

In order to ensure the deficient practice does not reoccur, a day one orientation checklist was developed by the Nurse Manager to ensure the required training is complete and was implemented on 7-11-23. The Human Resource Director or designee will audit the training checklist prior to the end of the first day of work to ensure compliance.

Any non-compliance issues will be submitted to the Quality Assurance Performance Improvement committee for review and revision if necessary. The next quality management meeting is scheduled on 7-20-2023

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented [redacted] - 08/31/2023)

65b - Rights/Abuse 40 Hours

2. 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:

2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours *(continued)*

Description of Violation

The following staff have completed their 40th scheduled work hour, however, they did not complete training in emergency medical plan and reporting of reportable incidents and conditions:
Staff Person A, hired on [redacted]
Staff Person B, hired on [redacted]
Staff Person C, hired on [redacted]

Plan of Correction ***Accept ([redacted] - 07/27/2023)***

-Staff A, B, and C were educated on 7-11-23 and 7-12-23 on the Emergency Medical Plan and reporting of reportable incidents and conditions by the Administrator and Nurse Manager
-All personal care staff will be retrained in the above topics by the Administrator and/or Nurse Manager by July 26, 2023
-In Order to prevent the deficient practice from reoccurring, an orientation checklist was developed by the Nurse manager to ensure all direct care staff persons, ancillary staff persons, substitute personnel and volunteers if applicable will have the training completed within 40 scheduled working hours. The checklist was implemented on 7-11-23.
-The training checklist will be audited by the Human Resource Director or Designee to ensure compliance is achieved. Any training found to be out of compliance will be submitted to the Quality Assurance Performance mprovement committee for review and revision as necessary. The next Quality management meeting is scheduled on 7-20-2023.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented ([redacted] - 08/31/2023)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person A did not receive the annual training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert for 2022.

Plan of Correction ***Accept ([redacted] - 07/27/2023)***

-Staff person A was educated on 7-11-23 on fire safety by a trained staff member.
-The training is currently part of annual education. Annual Emergency Preparedness/Fire Safety was completed by Staff person A on 11-12-22, however, the Individual personnel file was not provided to the surveyor to verify this record.
-In order to prevent this from reoccurring Education was provided to the Nurse manager by the Administrator that the employees individual education file should be provided during survey to verify education.
-All active personnel files were reviewed to ensure that annual education was completed and revealed 100% compliance.

65g - Annual Training Content (continued)

-All training needs will be addressed at the next Quality Management meeting on 7-20-23

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented ███ - 08/31/2023)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 6/27/23 at approximately 10:00am on the 3rd floor (called the Tulip floor), the white Whirlpool freezer temperature was 42 degrees Fahrenheit. Over 20 individual sized ice cream cups were observed, and they were not frozen and soft to touch. Staff then placed another thermometer in the freezer. This freezer was rechecked approximately 4:20pm and the freezer was at 10 degrees Fahrenheit.

On 6/27/23 at approximately 10:10am, the white refrigerator in the 2nd floor Rose lounge was observed to have no thermometer in the freezer section of the refrigerator.

Plan of Correction ***Accept ███ - 07/27/2023)***

-The individual sized ice cream cups were discarded on 6-27-2023.
-The freezer was adjusted on 6-27-23 and the temperature reached -2 degrees that evening, and the individual ice cream cups were replenished at that time by the Nurse manager.
-A thermometer was immediately placed in the freezer section of the white refrigerator on the 2nd floor Rose lounge on 6-27-2023 by the Nurse Manager.
-in order to prevent the deficient practice from reoccurring, education will be provided to all personal care staff by 7-22-2023 by the Administrator and/or Nurse manager indicating that food requiring refrigeration shall be stored at or below 40 degrees Fahrenheit. Frozen food shall be kept at or below 0 degrees Fahrenheit. Thermometers are required in refrigerators and freezers. Temperatures will be recorded on the refrigerator and Freezer log every evening starting 7-12-2023. If any refrigerator is found to be non-compliant all food will be discarded, once the desired temperatures are maintained the nourishments will be replenished.
The Refrigerator and Freezer log will be audited by the Administrator and/or Nurse manager for compliance. Temperature audits began on 7-12-2023. Any audit found to be non-compliant will be addressed with Quality Assurance Performance Improvement for review and revision as necessary. The next quality management meeting is scheduled on 7-20-2023.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented ███ - 08/31/2023)

132d - Evacuation

5. 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

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during fire drills occurring in February 2022 through May 2023.

Plan of Correction ***Accept (MD - 07/17/2023)***

-The safe evacuation time was completed on 10-24-22 by a fire safety expert but was not provided at the time of survey.
-In order to prevent the deficient practice from occurring again, in the absence of the administrator, the copy of the Fire Evacuation Time/Fire safe area designation form will be readily accessible in the Administrator's office to the Nurse manager. Education will be provided to the Nurse Manager in regard to the exact location.
Education along with weekly mock fire drills will be completed immediately over the next 2 weeks.
Monthly fire drills will continue, and evacuation times will be audited by the Administrator and/or Nurse manager to ensure compliance with safe evacuation times. If any evacuation time is found to be non-compliant weekly mock fire drills will be completed by the Administrator and'/or unit manage until 100% compliance is achieved.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented (MD - 08/31/2023)

185a - Implement Storage Procedures

6. 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

Resident #1 is prescribed [redacted] as needed for [redacted]. However, on 6/27/23, this medication was not available in the home.

Resident #3 has an order for blood sugar checks 4 times a day using a Prodigy Auto Code glucometer. On the following dates, the glucometer reading did not match what was recorded in the Medication Administration Record (MAR):
- On 6/6/23, Resident #3's 9:00am glucometer reading was [redacted]. The blood sugar reading as recorded in the MAR was [redacted]
- On 6/25/23, Resident #3's 1:00pm glucometer reading was [redacted] The blood sugar reading as recorded in the MAR was [redacted].

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (MD - 07/27/2023)***

The [redacted] were immediately obtained on 6-27-2023 and placed in the Medication cart by the Nurse Manager.
The Med Tech was educated 7-12-2023 by the Nurse manager to ensure that accurate transcription of glucometer readings is documented on the medication administration record.
To ensure the deficient practice does not recur, random audits will be completed by the Nurse manager or designee weekly x 4, then monthly x 2 to ensure the transcription is accurate.
Any audit found to be non-compliant will be addressed with the Quality Assurance Performance Improvement committee for review and revision as necessary. The next quality management meeting is scheduled on 7-20-2023.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented [redacted] - 08/31/2023)

227d - Support Plan Medical/Dental

7. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The resident assessment/support plan (RASP) for Resident #2, dated [redacted] indicates the resident has a need for occasional assistance when transferring in and out of bed. However, the RASP also reads that [redacted] is independent for turning/positioning in bed. Resident #2 has 4 quarter rails on [redacted] bed and states [redacted] uses one rail for positioning in bed and transferring in and out of bed. The resident's most recent RASP, dated [redacted], does not indicate the resident's need for and use of bed rails.

Plan of Correction ***Accept [redacted] - 07/27/2023)***

Resident #2's Resident Assessment/Support Plan (RASP) was updated on [redacted] to include assistance needed when transferring in and out of bed utilizing a bed rail as an enabler with occasional staff assistance as needed.
Audits were completed by the nurse manager on 7-12-2023 of all residents utilizing bed rails to ensure accurate documentation on the RASP's and revealed no other compliance issues with the level of assistance required.
Education was provided to the Nurse Manager by the Administrator on 7-12-2023 to ensure the level of assistance with bed rails is documented accurately.
Random audits will be completed with any new order for bed rails to ensure the level of assistance is documented accurately. The audits will start on 7-12-2023, will be completed weekly x 4, then monthly x 2 by the Administrator and/or Nurse manager. Any audit found to be non-compliant will be addressed with the Quality Assurance Performance Improvement committee for review and revision as necessary. The next Quality Management meeting is scheduled on 7-20-2023.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented [redacted] - 08/31/2023)

254a - Records Discharge/Active

8. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 6/27/23 at approximately 9:55am, the third-floor nurse's station (called the Tulip floor) was not locked, and no staff were visible. Resident charts were unlocked, unattended, and accessible in the nurse's station.

On 6/27/23 at approximately 10:05am, the medical records office was unlocked. The room contained resident medical records which were unlocked, unattended, and accessible.

Plan of Correction ***Accept - 07/27/2023)***

-The Tulip Nurses station door and the medical records office were immediately locked on 6-27-2023 by the Nurse Manager and remained locked when unattended.
-In order to prevent the deficient practice from reoccurring, the Nurse Manager and/or Administrator will educate all personal care staff and the medical records department that all areas containing confidential information should be ocked to prevent unauthorized access when unattended. Education will be completed by 7-22-2023.
-Random audits will be completed by the Nurse manager or designee to ensure all medical records areas are locked when unattended to ensure resident confidentiality and prevent unauthorized access. Audits will begin on 7-12-2023 and be completed weekly x4, then monthly x 2. Any audits found to be out of compliance will be taken to the Quality Assurance Improvement Committee for review and revision as necessary. The next Quality management meeting is scheduled on 7-20-2023.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented - 08/31/2023)