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

November 7, 2023

[redacted], CHIEF EXECUTIVE OFFICER
MERCY LIFE CENTER CORPORATION
[redacted]

RE: OUTLOOK MANOR
3560 OUTLOOK DRIVE
WEST MIFFLIN, PA, 15122
LICENSE/COC#: 43008

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/26/2023 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: *OUTLOOK MANOR* **License #**: *43008* **License Expiration**: *06/09/2024*

Address: *3560 OUTLOOK DRIVE, WEST MIFFLIN, PA 15122*

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

Administrator

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

Legal Entity

Name: *MERCY LIFE CENTER CORPORATION*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/15/1986* **Issued By**: *PA Dept of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *12* **Waking Staff**: *9*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/26/2023*

Inspection Dates and Department Representative

09/26/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *12* **Residents Served**: *11*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10* **Are 60 Years of Age or Older**: *6*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *1* **Have Physical Disability**: *2*

Inspections / Reviews

09/26/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/14/2023*

10/10/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/06/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/17/2023*

Inspections / Reviews *(continued)*

10/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/06/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/03/2023*

11/07/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/06/2023*

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

20b8 - Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home holds money for several residents to include residents #1, #2 and #3. However, an itemized account of financial transactions made on the residents' behalfs has not been provided to the residents and/or their designated persons on a quarterly basis.

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

The home maintains both quarterly account audits and itemized transaction logs for all residents at the home who use the homes safe. These transaction logs are signed/dated by the home's administrator/designated staff and the resident at time of each deposit or withdrawal. Residents actively review this at the time of each transaction. Both forms were available and reviewed during the inspection, however copies were not provided to residents/designated persons previously. On 10/5/23 the home's administrator met with each of the residents and provided them with a copy of the quarterly account audit from 2021/move-in through the last audit in August of 2023. The information on the forms, and expectation document will be provided to them every three months or on request. Each resident as told to expect the next account audit of monies in the safe in November 2023. On 10/5/23 copies of these statements were emailed to guardians of two residents with an explanation and review of what to expect moving forward. A note is placed in the resident record for each resident on 10/5/23. The homes administrator and/or designated staff will complete the quarterly review of the cash box and share this documentation with the home's residents and their designated persons in November. All tasks will be completed by the last business day of the months November/February/May/August, as verified by the home's administrator. See attached transaction logs, quarterly account audits, and emails to guardians, and documentation of resident review.

Licensee's Proposed Overall Completion Date: *10/06/2023*

Implemented ([redacted] - 11/07/2023)

85e - Trash Outside Home

2. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 10:30 a.m., there was an uncovered large round trash can outside of the side exit near room #11 that was approximately one-third full of trash to include a large amount of cigarette butts.

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

The trash can was left after yard clean-up for a resident picnic. The trash can was emptied and placed back in storage on 9/26/23. On 9/27/23 regulation 2600.85e was reviewed with daylight direct care staff who will monitor the back yard daily. On 9/28/23 the homes administrator reviewed this regulation with the home's contracted cleaner. On 10/5/23 the home's administrator ordered a new trash can for the yard. The new trash can will be placed when it is delivered, and it will be monitored by cleaning staff daily as part of trash removal. See purchase request for new trash can, and photo of area free of trash can and trash.

85e - Trash Outside Home *(continued)*

Licensee's Proposed Overall Completion Date: *10/19/2023*

Implemented [redacted] - 11/07/2023)

130e - Hearing Impairment

3. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #1 is deaf and unable to hear the fire alarm system when it is activated. However, the home does not have a signaling device approved by a fire safety expert and tested to ensure that resident #1 will be alerted in the event of a fire.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The home has had a system in place which consisted of a sonic relay obtained from Center for Deaf and Hearing, with a manual button on Resident #1's bedroom door. This was in-place and inspected by a fire safety expert on 4/10/23, however the sonic relay was not present on 9/26/23. After reviewing the set-up and testing it was determined the home's administrator and staff had not caught the missing equipment due to manually activating the system before opening the door. On 9/27/23 the homes administrator placed a request with Barrier Systems the fire safety provider to have a technician evaluate Resident #1's needs and the fire system in the building. On 10/2/23 the technician made a site visit and spoke to the home's administrator and planned to research options.

The new signaling system is scheduled to be installed on 11/1/23 by Barrier Systems. ABCO Fire Protection is scheduled to inspect the system on 11/3/23. All staff will be trained on the signal systems operation and testing by 11/10/23. See attached service requests and update on request. Documentation of system installation, inspection and approval, and staff training will be submitted by 11/13/23

Licensee's Proposed Overall Completion Date: *11/13/2023*

Implemented ([redacted] - 11/07/2023)

141b1 - Annual Medical Evaluation

4. Requirements

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

Description of Violation

The annual medical evaluation (DME) for resident #2 was completed on [redacted]. However, the resident's previous DME was completed [redacted].

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Resident #2 had a DME appointment scheduled within the approved timeframe, however the PCP's office canceled the appointment the day of. Due to the Christmas and New Year's holidays, the appointment could not be scheduled until 1/6/23. On 9/27/23 the homes administrator and registered nurse reviewed the current DME dates for all residents to ensure timeliness. Beginning on 9/27/23 the home updated the DME scheduling process to schedule 50 weeks from the previous evaluation to ensure timeliness. See attached list of target DME dates for both the current

141b1 - Annual Medical Evaluation (continued)

and upcoming year for all current residents. The homes RN and Administrator will maintain and review both the tracking tool and the DME/RASP documents monthly to ensure timely compliance.

Licensee's Proposed Overall Completion Date: *10/23/2023*

Implemented [redacted] - 11/07/2023)

171b5 - First Aid Kit

5. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

At approximately 11:30 a.m., the first aid kits in both the large and small vans did not include thermometers.

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

The home's administrator placed thermometers in the first aid kits for both the large and small van during the audit on 9/26/23. The ensure ongoing compliance, the complete first aid kits with thermometers, were sealed with initialed/dated paper tape on 9/27/23 by the home's administrator. Evening direct care staff will check for the removal of the tape seal monthly. If the kits have been opened or appear damaged evening staff will audit the kit and inform the home's administrator of missing items and they will be replaced.

Licensee's Proposed Overall Completion Date: *10/06/2023*

Implemented ([redacted] - 11/07/2023)

225c - Additional Assessment

6. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent annual assessment was completed [redacted]. The resident's previous assessment was completed [redacted].

Plan of Correction ***Accept [redacted] - 10/27/2023)***

This RASP was signed upon the completion of Resident #2's DME appointment which was completed on [redacted] On [redacted] the home's administrator reviewed the dates of all current RASPs and documented this on a tracking tool. Beginning on [redacted] to ensure timely completion of the RASP the homes administrator and RN will maintain a tracker of RASP due dates, Beginning [redacted] the homes administrator and nurse will schedule DME appointments to target a date 50 weeks out from the previous appointment to ensure this is available for the RASP completion by the stated deadline for timely completion. Beginning on [redacted] If the DME appointment cannot be completed to inform the RASP, a RASP will still be completed and reviewed prior to the due date by the home's administrator. A updated RASP will be made when the DME is completed. The homes RN and Administrator will maintain and review both the tracking tool and the DME/RASP documents to ensure compliance. This will be reviewed by the home's administrator and RN on a monthly basis.

225c - Additional Assessment *(continued)*

Licensee's Proposed Overall Completion Date: *10/23/2023*

Implemented ([redacted] - 11/07/2023)