pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ROCHESTER VILLA OPCO LLC**
LEGAL ENTITY

To operate **THE VILLAS AT ROCHESTER**
NAME OF FACILITY OR AGENCY

Located at **174 VIRGINIA AVENUE, ROCHESTER, PA 15074**
(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 **105** (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 **October 4,** **2024** until **April 4,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452791**

ISSUING OFFICER

Juliet Marsala
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: OCTOBER 4, 2024

[redacted]
Rochester Villa OPCO LLC
174 Virginia Avenue
Rochester, Pennsylvania 15074

RE: The Villas at Rochester
License/COC #: 452791

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on January 30, 2024, January 31, 2024 and June 11, 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), the Department hereby REVOKES your certificate of compliance (license number 45279) dated April 25, 2024 to April 25, 2025 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) ; (4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 4, 2024 to April 4, 2025.

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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	X	Fine Per resident Per day	=	Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
132c	III	28		$3		$84	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST 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 FIRST 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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE VILLAS AT ROCHESTER* **License #:** *45279* **License Expiration:** *04/25/2024*

Address: *174 VIRGINIA AVENUE, ROCHESTER, PA 15074*

County: *BEAVER* **Region:** *WESTERN*

Administrator

[redacted]

Legal Entity

Name: *ROCHESTER VILLA OPCO LLC*

Address: *174 VIRGINIA AVENUE, ROCHESTER, PA, 15074*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/05/1995* **Issued By:** *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *27* **Waking Staff:** *20*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *01/31/2024*

Inspection Dates and Department Representative

01/30/2024 - On-Site: [redacted]

01/31/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *105* **Residents Served:** *26*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older:** *23*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability:** *2*

Have Mobility Need: *1* **Have Physical Disability:** *0*

Inspections / Reviews

01/30/2024 - Full

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

03/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/11/2024*

03/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/15/2024*

09/06/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 1/30/24, at approximately 10:30 a.m., the licensing inspection summary, dated 1/4/23, was not posted in a public or conspicuous location in the home.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. A copy of the personal care license was placed in the lobby of the facility along with a current license inspection summary in a conspicuous place labeled at the front desk by the Administrative Assistant on 1/30/24.
2. PCHA will be educated by facility Executive Director on posting requirements in Pennsylvania by 3/8/24.
3. PCHA or designee will audit that the license and most recent annual survey results are posted in a conspicuous place weekly x3 and monthly x2 starting 3/4/24 until 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

20b8 - Quarterly Account

2. 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

Quarterly statements are not being provided to multiple residents, including resident #1.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1- Quarterly statements for quarter 4 was provided to resident #1 on 2/23/24 by the business office manager.
2. Business office manager will provide all residents with their quarterly statements for last quarter of 2023 by 3/30/24.
3- PCHA or designee will complete an audit quarterly x1 to ensure all residents with accounts received quarterly itemized statement of accounts with financial transactions completed by 4/30/24.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 09/06/2024)

25a - Written Contract and Review

3. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

25a - Written Contract and Review *(continued)*

Description of Violation

Resident #1 was admitted to the home on [redacted]/23; however, the contract does not indicate a month, day, or year the contract will take effect.

Resident #2 was admitted to the home on [redacted]/2020; however, the home does not have a contract. REPEAT VIOLATION 1/4/23 ET AL

Plan of Correction ***Accept[redacted] - 03/04/2024)***

1. Resident #1 contract updated and signed by PCHA and resident to include effective date of 2/1/24 on 2/1/24. Resident #2 contract received by Administrator on 2/1/24.
2. PCHA or designee will complete a whole house audit to ensure all residents have a signed contract with effective dates. Any missing or undated contracts will be complete by 3/15/24.
4. PCHA or designee will complete an audit of all new admissions beginning 3/4/24 until 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented[redacted] - 09/06/2024)

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1 was admitted to the home on [redacted]23; however, there is not a signed statement indicating the resident received a copy of the resident's rights and complaint procedures.

Resident #2 was admitted to the home on [redacted]/2020; however, there is not a signed statement indicating the resident received a copy of the resident's rights and complaint procedures.

Plan of Correction ***Accept[redacted] - 03/04/2024)***

1. Resident #1 received a copy of the signed contract on [redacted]/23 including residents rights and complaint procedures by Administrator. Resident #2 received a copy of the residents right and complaint procedures by the PCHA on February 1st, 2024.
2. An initial whole house audit will be completed by PCHA for any missing residents rights and complaints acknowledgments by 3/15/24.
3. PCHA or designee, will complete audits of all newly completed contracts and admissions, including documentation of residents rights and complaint procedure acknowledgements starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented[redacted] - 09/06/2024)

41e - Signed Statement *(continued)*

63a - First Aid/CPR Training

5. [redacted]

On 1/31/24, the home was serving 26 personal care residents; requiring a minimal of one staff person who is certified in [redacted]

1/19/24, none of the staff working from 7:00 a.m.-7:00 p.m. were trained in First Aid.

[redacted] *staff members was completed on 2/26/24 by a qualified professional consultant.*

2. PCHA updated schedule on 2/27/24 to ensure amount of trained staff are scheduled each shift. [redacted]

65d - Initial Direct Care Training

6. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.

65d - Initial Direct Care Training *(continued)*

x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted]3/22, did not successfully complete the Department-approved direct care training course or pass the competency test. However, this staff person provided unsupervised ADL services on 1/7/24, 1/9/24, 1/10/24, 1/11/24, and 1/12/24.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Direct Care staff Person A completed Department approved direct care training course and passed competency test via Temple University online training on 1/16/24.
2. An initial whole house audit will be completed on all staff to ensure department-approved direct care training course is complete and certificate has been received by 3/30/24.
3. PCHA or designee will audit all new applicants for department approved direct care training certificates beginning 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A, hired [redacted]/22, did not complete any of the 12 annual training hours required for the 2023 training year.

Direct care staff person B, hired [redacted]/22, did not complete any of the 12 annual training hours required for the 2023 training year.

Plan of Correction ***Accept ([redacted] - 03/04/2024)***

1. PCHA completed a whole house staff audit for confirmation of 12 hour training on 2/23/24.
3. Based on audit results, staff will be trained by PCHA or designee as needed to meet regulation requirements for unmet 2023 training topics by 3/30/24.
4. PCHA or designee will complete audits of 15% of staff monthly x2 months to ensure that 12-hour training is being completed as scheduled starting on 3/4/24 and completed by 5/15/2024.

65e - 12 Hours Annual Training (continued)

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A, hired [redacted]22, did not receive any of the required training topics in the 2023 training year.

Direct care staff person B, hired [redacted]/22, did not receive any of the required training topics in the 2023 training year.

Plan of Correction ***Accept [redacted]/04/2024)***

1. Direct care staff persons A and B are scheduled for education on topics from 2600.65f on 3/15/24.
2. PCHA or designee will complete audit of all staff to ensure training topics for 2600.65f are completed by 4/30/24.
3. Schedule of 2024 Training Plan will be completed and include required topics of 2600.65f by 4/30/24.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 09/06/2024)

65g - Annual Training Content

9. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

65g - Annual Training Content *(continued)*

Description of Violation

Staff person A, hired [redacted]/22, did not receive any of the required training topics in the 2023 training year.

Staff person B, hired [redacted]/22, did not receive any of the required training topics in the 2023 training year.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Direct care staff persons A and B are scheduled for education on topics from 2600.65g on 3/15/24.
2. PCHA or designee will complete audit of all staff to ensure training topics of 2600.65g are completed by 4/30/24.
3. Schedule of 2024 Training Plan will be completed and include required topics of 2600.65g by 4/30/24.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 09/06/2024)

6[redacted]

[redacted]

82a - Poisonous Materials

11. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 1/30/24, at approximately 12:00 p.m., an 800ml spray bottle, identified as cleaning solution, was not stored in the original labeled container, in the trash can room of the main kitchen.

On 1/30/24, at approximately 12:40 p.m., 3 spray bottles, in a cabinet in the linen room, on the first floor, identified by staff as cleaning and disinfectant solutions, was not stored in the original labeled containers:
800ml spray bottle, containing orange liquid
800ml spray bottle, containing blue liquid

82a - Poisonous Materials (continued)

800ml bottle containing a white solution and labeled "Snap Back"

On 1/30/24, at approximately 1:10 p.m., a clear spray bottle ¾ filled with a green liquid, identified by staff as disinfectant cleaner, was not stored in the original labeled container, in a cabinet in the kitchenette of the Renaissance unit.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. All unlabeled containers without original label, were removed from all units of the personal care home including the main kitchen, linen room, and kitchenette of the Renaissance unit by Housekeeping staff and PCA on 1/30/24.
2. PCHA or designee will complete an initial audit of unlabeled containers without original labels and remove containers from PCH by 3/1/24. PCHA or designee will educate Housekeeping staff and PCH staff on keeping poisonous materials in the original, labeled containers by 3/30/24.
4. PCHA or designee will complete audits of PCH to ensure no unlabeled containers are present weekly x3 and monthly x2. starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 1/30/24, at approximately 11:40 a.m., an activated and negative COVID-19 test was sitting on the shelf in the event centers serving table room, on the first floor, unattended and not in a sanitary manner.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Activated negative COVID-19 test was removed and properly disposed of by DHS surveyor and Food service director on 1/30/24.
2. All staff will be educated on COVID-19 testing location including proper disposal of COVID-19 testing materials by PCHA or designee by 3/30/24.
3. PCHA or designee will audit the sanitation of the event center weekly x3 weeks and monthly x2 months starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024* **Not Implemented [redacted] 6/2024)**

85d - Trash Receptacles

13. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/30/24, at approximately 11:15 a.m., two tall trash cans and three 55-gallon trash cans, in the main kitchen of the home, ½ full to ¾ full of trash and debris, did not have lids that completely covered the trash cans.

REPEAT VIOLATION 1/4/23 ET AL

85d - Trash Receptacles (continued)

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Trash cans noted during survey have been covered by Food service director on 2/1/24.
2. Food service director or designee will complete education will all dietary staff regarding covered trash policy by 3/30/24.
3. Food service director will complete audits of all trash cans weekly x3 and monthly x2 starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

86b - Bathroom

14. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 1/30/24, at approximately 1:20 p.m., each of the common use and private bathrooms, in the Renaissance unit, did not have an operable window and the exhaust fan for ventilation is inoperable, to include:

Common use bathrooms near bedrooms 236 and 242
Private bathrooms in bedrooms 230 and 241

REPEAT VIOLATION 1/4/23 ET AL

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Maintenance director or assistant manager will assess operability of common use and private bathroom exhaust ventilation in bedrooms 230 and 241 by 3/15/24.
2. If non-operable, maintenance director or assistant manager will complete work in order to have exhaust fans function. If unable to be repaired, maintenance director or designee will submit a waiver request based on non-possibility of ventilation by 4/30/24
3. Maintenance director or designee will complete audits on 15% of rooms weekly x3 weeks and monthly x2 months to ensure compliance starting 3/4/24 and completed 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

95 - Furniture and Equipment

15. Requirements

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

Description of Violation

The home's medication administration records (MAR) are recorded on an electronic EMAR system that requires wifi connection at times staff are recording the administration of medication. On 1/5/24, the home's

95 - Furniture and Equipment (continued)

information technology department instructed both the legal entity as well as staff person C, the home's [redacted] the home needed a second floor full wireless overhaul; the floor all personal care residents are presently residing. On multiple dates and times, the home's wifi was not sufficient to operate the EMAR system, to include the following:
1/12/24 at 5:00 p.m.
1/14/24 at 9:00 p.m.
1/25/24 at 5:00 p.m., 6:00 p.m., and 9:00 p.m.
1/30/24 at 9:00 p.m.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Additional IT equipment was purchased by Executive Director for the personal care unit on 2/20/24.
2. PCHA or designee will consult IT company on upgrading Wi-Fi functionality on the second floor where the personal care unit resides by 4/30/24.
3. PCHA or designee will audit Wi-Fi functionality x2 weeks starting on 4/30/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

100a - Exterior - Free of Hazards

16. 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

On 1/30/24, at approximately 11:00 a.m., a large amount of brush and tree limbs, measuring approximately 15 x 10 yards, was outside the emergency exit door in the Woodbridge unit.

On 1/30/24, at approximately 1:30 p.m., brush, tree limbs, and debris, measuring 10 yard x 10 yard, outside the Renaissance unit emergency exit door, in the upper parking lot.

Plan of Correction ***Accep [redacted]***

Renaissance Unit by Maintenance staff on 3/1/24.
2. Maintenance staff or designee will remove brush, tree limbs and debris from facility grounds by 3/30/24.
2. PCHA or designee will audit that all emergency exits are free of brush, tree limbs, and debris weekly x3 and monthly x2 months starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

101j7 - Lighting/Operable Lamp

17. 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.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

On 1/30/24, the bed belonging to resident #1, did not have a source of light that can be turned on/off from bedside as the lamp was approximately 3 feet away from the residents bed.

On 1/30/24, the bed belonging to resident #3, did not have a source of light that can be turned on/off from bedside as the lamp was approximately 3 feet away from the residents bed.

On 1/30/24, the bed belonging to resident #4, did not have a source of light that can be turned on/off from bedside as the lamp was approximately 3 feet away from the residents bed.

REPEAT VIOLATION 1/4/23 ET AL

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Resident # 1, 3, & 4, now have access to a source of light that can be turned on and off at bedside, access to a light source provided by Administrator on 1/31/24.
2. Whole house audit will be completed by PCHA or designee for sources of light that can be turned on and off at the bedside by 3/1/24.
3. PCHA or designee will complete audits on 15% of rooms weekly x3 weeks and monthly x2 to ensure compliance with lighting regulation starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Not Implemented [redacted] 9/6/2024)

103c - Food Protected

18. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 1/30/24, at approximately 11:30 a.m., a 25lb bag containing breaded chicken nuggets were opened with the approximately 20-25 nuggets spilled onto the chest freezer floor, in the event center's serving table room on the first floor.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Open bag of chicken nuggets including the ones spilled onto the chest freezer bottom were removed and discarded by Dietary staff on 1/31/24.
2. Food Service director will be educated by the PCHA or designee on proper storage of food items to prevent contamination while being stored, prepared, transported and served by 3/15/24. Kitchen staff will be educated by the Food service director or designee on proper storage of food items to prevent contamination while be stored, prepared, transported and served by 3/30/24.
3. Food service director or designee will complete audits of stored food items weekly x3 and monthly x2 starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

103f - Refrigerator/Freezer Temps

19. 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 1/30/24, at approximately 11:30 a.m., the chest freezer, in the event centers serving table room on the first floor, did not have a thermometer.

On 1/30/24, at approximately 12:15 p.m., the walk-in refrigerator, in the main kitchen, did not have a thermometer.

On 1/30/24, at approximately 12:20 p.m., the temperature in the walk-in freezer, in the main kitchen, measured 21.0 degrees Fahrenheit.

Plan of Correction ***Accept[redacted] - 03/04/2024)***

1. A thermometer was placed in the main kitchen walk-in refrigerator by the Food service director on 1/31/24. The chest freezer was removed from service by Food service director on 1/31/24.
2. Food service director or designee will educate staff on proper food storage temperature for walk-in freezers and refrigerators including completion of daily temperature logs by 3/30/24.
3. Food service director or designee will audit the main kitchen walk-in refrigerator and walk-in freezer for a thermometer and that temperature logs are complete and are at required temperature weekly x3 and monthly x2 starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024* Not Implemented [redacted] 9/6/2024)

103g - Storing Food

20. Requirements

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

Description of Violation

On 1/30/24, at approximately 12:05 p.m., there was a 50 lb bag of rice with a 15 inch cut in the center of the bag, opened and unsealed.

Plan of Correction ***Accept[redacted] 03/04/2024)***

1. Open rice bag with 15 inch cut was discarded by Food Service director on 1/30/24.
2. Food service director or designee will educate dietary staff on storage of food in closed or sealed containers by 3/30/24.
3. FSD or designee will complete audits of food storage weekly x3 weeks and monthly x2 months starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

103i - Outdated Food

21. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

On 1/30/24, at approximately 11:20 a.m., three eggs inside a Styrofoam bowl, in the reach in cooler near the dishwashing area, were covered with green and white mold.

On 1/30/24, at approximately 1:00 p.m., the underside of a stack of sliced cheese and an uncovered container containing chocolate was covered with green mold in the kitchenette refrigerator on the Renaissance Unit.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. The 3 eggs inside of the Styrofoam bowl located in the reach-in cooler near dishwashing area of main kitchen were discarded by Food Service director on 1/30/24. Sliced cheese with mold on underside and open container of chocolate with mold found in the kitchenette of Renaissance unit was discarded by PCA on 1/30/24.
2. PCHA and FSD will educate staff on dating food items placed in refrigerators and discarding in a timely manner by 3/30/24.
3. PCHA or designee will complete audits of refrigerators on the Renaissance unit weekly x3 and monthly x2 starting 3/4/24 and completed by 5/15/24. FSD or designee will complete audits of the refrigerators in main kitchen weekly x3 and monthly x2 to ensure items are dated and discarded in a timely manner starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024* **Not Implemented [redacted] 9/6/2024)**

121a - Unobstructed Egress

22. 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 1/30/24, at approximately 10:40 a.m., two metal chains with locks were observed on the emergency exit gates in the courtyard, located on the first floor.

On 1/30/24, at approximately 10:40 a.m., the emergency exit door, near bedroom #210, in the Victorian Unit was equipped with a keypad locking system; however, the code was not posted and the staff did not know the pass code to unlock and open the door.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Two metal chains and locks were removed on 1/30/24 from the emergency exit gates in the courtyard by Maintenance staff. Codes for emergency exit doors near room 210 were changed by Maintenance staff on 2/2/24
2. Maintenance staff or designee will check all emergency exit door codes to ensure that they are correct and operating by 3/1/24..
2. PCHA or designee will audit staff knowledge for verification of staff's awareness to codes of locked doors within the PCH weekly x3 and monthly x2, starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024* **Not Implemented [redacted] 9/6/2024)**

123b - Emergency Procedures Posted

23. Requirements

123b - Emergency Procedures Posted *(continued)*

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 1/31/24, the home did not have a copy of the emergency preparedness plan for the municipality, in which the home is located, posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Administrative Assistant requested emergency preparedness plan for the municipality on 1/31/24.
2. PCHA or designee will post emergency preparedness plan in a conspicuous public place in the home by 4/1/24.
3. PCHA or designee will complete audits to ensure placement of plan weekly x2 weeks starting on 4/30/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

126a - Furnace Inspection

24. 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

On 1/30/24, the home had two fossil fuel burning devices in the basement of the home. However, the home had no documentation of the last time the furnace was inspected.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Maintenance staff contacted [redacted]) and scheduled inspection of furnaces on 3/1/24.
2. Furnaces will be inspected on 3/11/24 by [redacted].
3. PCHA or designee will educate Maintenance Director on importance of completing annual furnace inspection by 3/15/24. PCHA or designee will schedule inspection of furnaces to be completed by 4/30/24. Annual furnace inspection will be added to Quarterly QAPI for review by Executive Director beginning 4/18/24.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 09/06/2024)

132a - Monthly Fire Drill

25. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not conducted in March, April, May, June, July August, or September 2023.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. A fire drill was performed on 2/29/24 by Maintenance staff and PCH staff.
2. PCHA or designee will educate Maintenance department and PCH staff on completing monthly fire drills per DHS regulation by 3/1/24.

132a - Monthly Fire Drill (continued)

3. PCHA or designee will complete audits monthly x3 months to ensure fire drills are performed routinely starting 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

132b - Safety Inspection/Fire Drill

26. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

There was no fire safety inspection and fire drill conducted by a fire safety expert completed in 2023.

Plan of Correction ***[redacted] 03/04/2024)***

1. Maintenance staff contacted a fire safety expert and are awaiting a return call to schedule a fire safety inspection on 3/1/24.

2. PCHA or designee will have a fire safety inspection and drill completed by a fire safety expert by 3/30/24.

3. PCHA or designee will educate Maintenance Director on scheduling fire safety inspection by 3/15/24. Annual Fire Safety Expert inspection will be added to Quarterly QAPI for review by Executive Director beginning 4/18/24.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 09/06/2024)

132c - Fire Drill Records

27. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's monthly fire drill records, for the following dates, did not indicate the amount of evacuation time for the following drills: 1/16/23, 2/17/23, 10/31/23, 11/29/23, 12/29/23, and 1/17/24.

The home's monthly fire drill records, for the following dates and times, did not indicate the evacuation route, as this section was left blank: 1/31/23 3:15 p.m., 11/29/23 6:30 a.m., 12/29/23 2:47 p.m., and 1/17/24 3:37 p.m.

REPEAT VIOLATION 1/4/23 ET AL

Plan of Correction ***Accept[redacted] 03/04/2024)***

1. PCHA interviewed PCH staff and completed missing documentation on fire drill records on 3/1/24.

2. PCHA will educate Maintenance Department and PCH staff on required documentation of fire drills including emergency exit routes used and amount of evacuation time to be completed by 3/30/24.

2. PCHA or designee will audit fire drills monthly x3 months to ensure all required documentation is in place starting 3/4/24 and completed by 5/15/24. Fire drill documentation will be added to Quarterly QAPI for review by

132c - Fire Drill Records (continued)

Executive Director beginning 4/18/23.

Licensee's Proposed Overall Completion Date: *05/15/2024* **Not Implemented [redacted] 9/6/2024)**

132d - Evacuation

28. Requirements

2600.
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 designated evacuation time from a fire safety expert. The home exceeded the maximum evacuation time of 2 minutes 30 seconds for fire drills conducted on the following dates and times:

Date	*Start Time*	*End Time*	*Estimated Evacuation Time*
1/16/23	*7:32:30 a.m.*	*7:36 a.m.*	*3 minutes, 30 seconds*
2/17/23	*3:15 p.m.*	*3:20 p.m.*	*5 minutes*
10/31/23	*3:15 p.m.*	*3:20 p.m.*	*5 minutes*
11/29/23	*6:30 a.m.*	*6:35 a.m.*	*5 minutes*
12/29/23	*2:47 p.m.*	*2:52 p.m.*	*5 minutes*
1/17/24	*3:37p*	*no end time*	*unable to determine*

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Maintenance staff contacted a fire safety expert and are awaiting a return call to schedule a fire safety inspection on 3/1/24.
2. A designated evacuation time will be received from a fire safety expert by 3/30/24. PCHA or designee will educate PCH staff on the importance of evacuating residents to a safe area within the designated evacuation time by 3/30/24.
3. PCHA or designee will complete audits to ensure that evacuations are within designated evacuation times x3 months to be completed starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024* **Not Implemented [redacted] 9/6/2024)**

132e - Fire Drill Sleeping Hours

29. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The only sleeping hour fire drill in the last 12 months was held on 11/29/23 at 6:30 a.m.

Plan of Correction ***Accept [redacted] 03/04/2024)***

1. A sleeping hour fire drill was performed on 2/29/24 at 11:07pm by Maintenance staff and PCH staff.
2. PCHA or designee will educate staff on fire drills and times they should occur by 3/15/24.
3. PCHA will schedule for fire drills to be completed including 1 sleeping hour drill every six months completed by

132e - Fire Drill Sleeping Hours (continued)

3/30/24. Sleeping hour fire drill will be added to Quarterly QAPI for review by Executive Director beginning 4/18/24.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] 09/06/2024)

184a - Resident's Meds Labeled

30. 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 #5 is prescribed Novolog Subcutaneous Flexpen injected per sliding scale three time per day 0- 150= 1 unit, 151-200=2 units, 201-250= 3 units, 251-300= 4 units, 301-350= 5 units, and 351-400= 6 units; however, there was no pharmacy label with the medication and no refer to MAR sticker.

On 1/31/24, resident #1 is prescribed Coumadin 2mg, take ½ tablet by mouth every Tuesday and Friday; however, the pharmacy label on the medication indicates give 1 ½ tablet by mouth every Tuesday and Friday.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Resident #5's Flexpen had a sticker placed to refer to MAR by Adminsitrator on 1/31/24 and Resident #1's Coumadin tablets had a sticker placed to refer to MAR by Administrator on 1/31/24.
2. PCHA or designee will educate Med Techs on Medication labels by 3/8/24.
3. PCHA will complete audits of 15% of residents medication labels weekly x3 and monthly x2 starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

187b - Date/Time of Medication Admin.

31. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

The home's medication administration records (MAR) are recorded on an electronic EMAR system the requires wifi connection at times staff are recording the administration of medication. On 1/5/24, the home's information technology department instructed both the legal entity as well as staff person C, the home's Administrator, the home needed a second floor full wireless overhaul; the floor all personal care residents are presently residing. As a result, multiple medications for multiple residents, to include the following, were not recorded anywhere at the time of administration:

187b - Date/Time of Medication Admin. (continued)

Resident #5, Rosuvastatin Calcium 10mg, 1 tablet by mouth at bedtime at 9:00 p.m. on 1/14/24, 1/25/24, and 1/30/24.

Resident #5, Novolog Flexpen 100 units/ml, 0-150= 1 unit, 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, 251-300= 5 units, 351-400= 6 units at 5:00 p.m. on 1/12/24, 1/25/24.

Resident #1, Lidocaine External patch 4%, applied topically at bedtime at 9:00 p.m. on 1/25/24.

Resident #1, Tramadol HCL 50 mg, 1 tablet by mouth at bedtime at 9:00 p.m. on 1/25/24

Resident #1, Flonase Allergy Relief nasal suspension 50 mcg, 1 spray in both nostrils two times per day at 6:00 p.m. on 1/25/24.

Resident #1, Metoprolol tartrate 25 mg, 1 tablet by mouth two time daily at 9:00 p.m. on 1/25/24.

Resident #1, Lactaid fast acting oral 9000 units, 1 tablet by mouth three time per day at 6:00 p.m. on 1.25.24.

REPEAT VIOLATION 1/4/23 ET AL

Plan of Correction ***Accept [redacted] - 03/07/2024)***

1. PCHA printed paper MAR for Month of January 2024 for Resident #5 and had Med Tech assigned those shifts complete documentation for 1/12. 1/14, and 1/25 on 3/5/24. PCHA printed MAR for Month of January 2024 for Resident #1 and had Med Tech assigned those shifts complete documentation for 1/14 and 1/25 on 3/5/24.
2. PCHA will educate all Med Tech's on medication administration and documentation policy by 3/8/24. PCHA will audit all MAR's for missing documentation and have completed by Med Tech by 3/8/24.
2. PCHA or designee will complete audits on 15% of residents MAR's for documentation weekly x3 weeks and monthly x2 months starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

191 - Resident Right to Refuse

32. Requirements

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

Description of Violation

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

191 - Resident Right to Refuse *(continued)*

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. On 2/1/24, resident #3 was educated by the Administrator on [redacted] right to question or refuse medications if the resident believes that there may be a medication error and a signed document was placed in resident's chart.
2. PCHA or designee will complete audit of all charts to ensure all residents have been educated on their right to question or refuse medications by 3/15/24.
3. PCHA will complete audits of new admissions charts to ensure they have received education on right to refuse medications starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] 09/06/2024)

224a - Preadmission Screen Form

33. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3 was admitted [redacted]/23; however, there was no preadmission screening completed for the resident.

Resident #2 was admitted [redacted] 2020; however, there was no preadmission screening completed for the resident.

Plan of Correction ***Accept [redacted] - 03/04/2024)***

1. Preadmission screenings were completed by Administrator on 2/27/24 for resident #2 and #3.
2. PCHA or designee will complete audit of all charts and complete preadmission screenings per DHS by 3/30/24. PCHA or designee will educate Admissions Director on process of admission to PCH by 3/20/24.
3. PCHA will complete audits of new admissions charts to ensure preadmission screenings are completed and filed in resident's chart starting on 3/4/24 and completed by 5/15/24.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented [redacted] - 09/06/2024)

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

Facility Information

Name: *THE VILLAS AT ROCHESTER* **License #:** *45279* **License Expiration:** *04/25/2025*

Address: *174 VIRGINIA AVENUE, ROCHESTER, PA 15074*

County: *BEAVER* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *ROCHESTER VILLA OPCO LLC*

Address: *174 VIRGINIA AVENUE, ROCHESTER, PA, 15074*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/05/1995* **Issued By:** *Dept L & I*

Staffing Hours

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

Inspection Information

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

Reason: *Incident, Monitoring* **Exit Conference Date:** *06/11/2024*

Inspection Dates and Department Representative

06/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *105* **Residents Served:** *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *19* **Are 60 Years of Age or Older:** *25*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability:** *4*

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

Inspections / Reviews

06/11/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/08/2024*

Inspections / Reviews *(continued)*

07/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/04/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/05/2024*

09/06/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/04/2024*

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

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

At 10:15 a.m., the chest freezer, in the food prep serving line room, of the main kitchen contained 2-3 inches of still clear water across the bottom of the floor of the freezer which had a strong foul moldy smell.

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. Water was removed from chest freezer on 6/12/24 by the Food Service Director. The chest freezer was removed from the facility by the Plant Operations Director on 7/5/24.
2. The Food Service Director will be educated by PCHA on sanitary conditions by 7/15/24. The Food Service Director will educate dietary staff on sanitary conditions by 7/19/24.
3. PCHA will complete audits for sanitary conditions of food prep serving line room of main kitchen weekly x3 then monthly x2 starting 7/8/24 and completed by 9/5/24.

Not Implemented [redacted] 9/6/2024)

Licensee's Proposed Overall Completion Date: *09/05/2024*

101j7 - Lighting/Operable Lamp

2. 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

The bed belonging to resident #1, does not have a source of light that can be turned on/off from bedside as the lamp did not contain a lightbulb.

The bed belonging to resident #2, does not have a source of light that can be turned on/off from bedside as the lamp exceeded 4.5 feet from the residents bed.

REPEAT VIOLATION: 1/4/23 et al

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. A light bulb was placed in resident #1's lamp by Director of Plant Operations on 6/11/24. Resident #2's lamp was moved from in front of his window to bedside by PCHA on 6/12/24.
2. PCHA will educate MT's and PCA's by 7/15/24 that all residents are required to have a light source at their bedside.
3. PCHA will complete audits for a bedside light source weekly x3 then monthly x2 starting 7/8/24 and completed by 9/5/24.

Not Implemented [redacted] 9/6/2024)

Licensee's Proposed Overall Completion Date: *09/05/2024*

103f - Refrigerator/Freezer Temps

3. 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.

103f - Refrigerator/Freezer Temps *(continued)*

Description of Violation

At 10:45 a.m. and 10:50 a.m., the freezer section of the white upright refrigerator/freezer in the kitchenette of the Renaissance area of the home measured 10 degrees Fahrenheit.

At 10:19 a.m. and 10:25 a.m. the temperature of the walk in freezer in the main kitchen measured 12 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. Items, in the Renaissance kitchen freezer, were adjusted by DHS staff while on unit on 6/11/24 so that the door would close properly, the temperature was rechecked at 6:00pm by PCHA and read -10 degrees. Main kitchens walk in freezer's inside thermometer read temperature of -10 degrees, they do not use the thermometer on the outside of the freezer, per Food Service Director on afternoon check on 6/11/24.
2. PCHA will educate PCA's and MT's on proper refrigerator and freezer temps by 7/19/24. Food Service Director will educate dietary staff on refrigerator and freezer temps by 7/19/24.
3. PCHA will complete audits of refrigerator and freezer temps in the facility weekly x3 then monthly x2 starting on 7/8/24 and completed by 9/5/24.

Licensee's Proposed Overall Completion Date: *09/05/2024* **Not Implemented [redacted] 9/6/2024)**

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 10:15 a.m., a small 10oz Styrofoam bowl with a pureed texture food product was stored in the serving line drop cooler; however, the food product was covered with a grey hair like moldy substance.

Plan of Correction ***Accept[redacted] - 07/17/2024)***

1. Styrofoam bowl with pureed texture food product was disposed of by Food Service Director on 6/11/24.
2. The Food Service Director will educate dietary staff on outdated or spoiled food by 7/15/24.
3. PCHA will complete audits of the serving line drop cooler weekly x3 then monthly x2 starting on 7/8/24 and completed by 9/5/24.

Licensee's Proposed Overall Completion Date: *09/05/2024* **Not Implemented [redacted] 9/6/2024)**

121a - Unobstructed Egress

5. 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

The magnetic exit keypad operated lock was on the gates in the courtyard, located on the second floor; however, the number/passcode to operate the magnetic locking system was not posted on or near the exits.

The magnetic exit keypad operated lock was on the emergency exit door near the elevators; however, the number/passcode to operate the magnetic locking system was not posted on or near the exits. Additionally, this door

121a - Unobstructed Egress (continued)

is restricted by a push button controlled behind the front desk; however, staff does not continuously man the front desk.

The magnetic exit keypad operated lock was on the emergency exit door which exits to the 2nd floor Victorian courtyard emergency exit door, located on the first floor. However, the number/passcode to operate the magnetic locking system was not posted on or near the exits.

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. PCHA verbally alerted Villa residents of the codes on Victorian Fire Exit door and Courtyard gate on 6/12/24. PCHA alerted residents on 6/12/24 that the Courtyard door is always locked, except when an alarm is activated, but that it can be unlocked by the receptionist. Facility staff provided residents with disclosure of codes and door operation on 7/5/24.
2. PCHA updated PCH contract on 7/5/24 to include a disclosure of the codes of Victorian Fire exit and Courtayrd gate and description of how the Courtyard door is operated.
3. PCHA will audit new admissions contracts to ensure they include disclosure x2 months, starting on 7/5/24 and completed by 9/5/24.

Licensee's Proposed Overall Completion Date: *09/05/2024*

Not Implemented [redacted] 9/6/2024)

123c - Evacuation Diagrams

6. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home serves 28 residents, however the emergency evacuation diagram on the first floor of the home does not include all corridors and line of travel to exit doors to include the corridor and emergency exit doors near the elevator on the first near the Victorian area of the home.

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. Evacuation routes were updated to include all corridors and line of travel to exit doors by Plant Operations Director on 7/5/24.
2. Plant Operations Director will be educated by PCHA on requirement of evacuation routes being posted by 7/12/24.
3. PCHA will complete audits of posted evacuation routes weekly x3 then monthly x2 starting on 7/8/24 and completed by 9/5/24.

Licensee's Proposed Overall Completion Date: *09/05/2024*

Implemented [redacted] 09/06/2024)

132c - Fire Drill Records

7. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records *(continued)*

Description of Violation

~~*The fire drill record, for the fire drill conducted on 3/29/24, indicates "NA" as the exit route used. Additionally, the fire drill log indicates 25 residents were present in the home; however, only 23 [redacted] in this drill.*~~

The fire drill record, for the fire drill conducted on 4/30/24, indicates 23 residents were present in the home at the time of the fire drill; however, it does not indicate how many residents evacuated. A [redacted]

The fire drill record, for the fire drill conduced on 5/12/24, does not indicate the exit route used.

REPEAT VIOLATION 1/4/23 et al

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. Fire Drill record for 3/29/24 had an error occur when transferring information from one form to another, that error was corrected by PCHA on 7/2/24. Fire Drill record for 4/30/24 updated on 7/2/24 by PCHA to include number of residents evacuated. Fire Drill record for 5/12/24 updated by PCHA on 7/2/24 to include the evacuation route used.
2. PCHA educated by Executive Director on evacuating all residents to a designated safe area for all fire drills on 7/1/24. PCHA will educate all MT's and PCA's on evacuating residents for all fire drills by 7/12/24.
3. PCHA will complete audits of fire drill records monthly x3 starting on 7/1/24 and completed by 8/31/24.

Licensee's Proposed Overall Completion Date: *08/31/2024* **Not [redacted]/6/2024)**

132d - Evacuation

8. Requirements

2600.
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 did not have a safe evacuation time designated in writing by a fire safety expert until 5/13/24. The home exceeded an evacuation time of 2 minutes 30 seconds for fire drills conducted at the following dates and times:
Fire drill Evacuation Time
2/29/24 23:07:00 3 minutes
3/29/24 14:05:00 4 minutes 5 seconds
5/12/24 23:00 11 minutes

The home conducted a fire drill, on 2/29/24 at 23:07:00, in which the residents did not evacuate the entire building or to a fire-safe area as the home did not have a fire safe area designed in writing by a fire safety expert within the past 12 months. The home documented on the fire drill logs the home "just closed door to resident rooms. Evacuation Route- stayed in room with fire safe doors closed". A written fire safe area designation, completed 5/13/24, indicates the only fire safe area is the lobby area between the fire doors.

132d - Evacuation (continued)

The home conducted a fire drill, on 3/29/24 at 14:05:00; however, only 23 or the 25 residents participated in the drill.

The home conducted a fire drill, on 4/30/24 at 3:35:00, in which the residents did not evacuate the entire building or to a fire-safe area as the home did not have a fire safe area designed in writing by a fire safety expert within the past 12 months. The home documented on the fire drill logs the home indicate the residents evacuated to: "stay in place".

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. Maintenance staff contacted Fire Chief to ask for a revisit to reassess designated fire safe areas on 7/5/24.
2. PCA's and MT's will be educated by PCHA on designated safe areas and the amount of time allowed to evacuate by 7/12/24.
3. PCHA will complete audits of evacuations to designated safe areas and evacuation times monthly x3 starting on 7/1/24 and completed by 8/31/24.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Not Implemented [redacted] 9/6/2024)

185a - Implement Storage Procedures

9. 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

[redacted]

Resident #3 is prescribed Hydrocodone-Acetaminophen 5mg-325mg tablet by mouth four times per day for chronic pain. However, from 6:00 p.m. on 6/9/24 to 1:00 p.m. on 6/11/24 the medication was not available in the home to administer the medication to the resident.

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. PCHA contacted pharmacy on 6/11/24 to inquire about delivery of Hydrocodone-Acetaminophen for Resident #3.
2. PCHA educated MT's on proper procedure of refilling controlled substances on 7/3/24.
3. PCHA will complete audits of stock of prescribed controlled substances weekly x3 then monthly x2 starting on 7/1/24 and completed by 9/5/24.

Licensee's Proposed Overall Completion Date: *09/05/2024*

[redacted]

187d - Follow Prescriber's Orders

10. Requirements

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

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

Description of Violation

Resident #4 is prescribed Losartan-HCTZ 100mg-12.6mg, by mouth one time per day; however, on 5/7/24 and 5/8/24 the medication was not available in the home to be administered.

Resident #4 is prescribed Meloxicam 7.5mg, 1 tablet by mouth one time per day; however, on 5/7/24 and 5/8/24 the medication was not available in the home to be administered.

Resident #4 is prescribed 250mg Saccharomyces Boulardii capsule by mouth twice per day per day. However, on 5/29/24 at 6:00 p.m. the medication was not available in the home to be administered.

Resident #3 is prescribed Hydrocodone-Acetaminophen 5mg-325mg tablet by mouth four times per day for chronic pain. However, from 6:00 p.m. on 6/9/24 to 1:00 p.m. on 6/11/24 the resident was not administered the medication.

Plan of Correction ***Accept [redacted] - 07/17/2024)***

1. PCHA completed an audit of any missing medications on 6/12/24.
2. PCHA will educate MT's on the proper process of re-ordering medications by 7/3/24.. MT's were trained by a trainer on 7/3/24.
3. PCHA will complete audits of MAR's for missed doses weekly x3 then monthly x2 starting on 7/1/24 and completed by 9/5/24.

Licensee's Proposed Overall Completion Date: *09/05/2024*

Not Implemented [redacted] - 09/06/2024)