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

June 25, 2024

[REDACTED], VICE PRESIDENT
JUNIPER VILLAGE AT MONROEVILLE LLC
2589 MOSSIDE BOULEVARD
MONROEVILLE, PA, 15146

RE: JUNIPER VILLAGE AT MONROEVILLE
2589 MOSSIDE BOULEVARD
MONROEVILLE, PA, 15146
LICENSE/COC#: 45263

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/15/2024 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: *JUNIPER VILLAGE AT MONROEVILLE* **License #**: *45263* **License Expiration**: *07/12/2024*

Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA 15146*

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

Administrator

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

Legal Entity

Name: *JUNIPER VILLAGE AT MONROEVILLE LLC*

Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA, 15146*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/14/1997* **Issued By**: *L & I*

Type: *I-2* **Date**: *05/30/1997* **Issued By**: *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *02/15/2024*

Inspection Dates and Department Representative

02/15/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *126* **Residents Served**: *69*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st floor* **Capacity**: *21* **Residents Served**: *16*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

02/15/2024 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/17/2024*

03/18/2024 - POC Submission

Submitted By: **Date Submitted**: *03/17/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2024*

Inspections / Reviews *(continued)*

06/12/2024 POC Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *04/15/2024*

Follow Up Type: *Bypass Document Submission*

06/25/2024 Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *06/12/2024*

Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at approximately [redacted] resident #1 was seated in a wheelchair just outside the dining room, when direct care staff person A asked the resident if he/she was ready to go to their room. Staff interviews and witness statements indicated resident #1 began yelling and screaming at direct care staff person A to "get away, get away from me". Direct care staff person B approached to assist with resident #1, who then reportedly began screaming/yelling, "he put his dick in my ass" then continued to yell out, "he fucked me in the ass" and "he stuck his dick in my ass", directing the sexual abuse allegations towards direct care staff person A and then laughed. The incident was witnessed multiple residents and staff to include direct care staff persons A, B, and C. However, the home did not report the allegations of sexual abuse to the local Area Agency on Aging until 2/7/24, at approximately 4:00 p.m.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

Education on incident reporting and reportable events immediately started on 2/15/24 verbally to leadership team, team leads, and med techs (responsible staff for initiating incident reports). All staff to be educated by 2/22/24.

Education on abuse policy and what constitutes abuse immediately started on 2/15/24 verbally to leadership team, team leads, and med techs (responsible staff for initiating incident reports). All staff to be re-educated by 3/21/24

DOW to report to ED immediately all reportable events and document on the incident reporting log immediately x 3 months. On 5/15/24 log to be reviewed for accuracy and if all reporting accurate will then follow company policies and procedures.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Implemented [redacted] - 06/25/2024)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at approximately [redacted] resident #1 was seated just outside the dining room, when direct care staff person A asked the resident if he/she was ready to go to their room. Staff interviews and witness statements indicated resident #1 began yelling and screaming at direct care staff person A to "get away, get away from me". Direct care staff person B approached to assist with resident #1, who then reportedly began screaming/yelling, "he put his dick in my ass" then continued to yell out, "he fucked me in the ass" and "he stuck his dick in my ass", directing the sexual abuse allegations towards direct care staff person A and then laughed stating not wanting direct care staff person A to escort resident #1 to the room. The incident was witnessed by direct care staff persons A, B, C, as well as other staff and residents in the dining room. However, the home did not report the allegations of sexual abuse to the Department until 2/7/24, at approximately 5:00 p.m.

16c Written Incident Report *(continued)*

Plan of Correction ***Accept - 03/18/2024)***

Education on incident reporting and reportable events immediately started on 2/15/24 verbally to leadership team, team leads, and med techs (responsible staff for initiating incident reports). All staff to be educated by 2/22/24. Education on abuse policy and what constitutes abuse immediately started on 2/15/24 verbally to leadership team, team leads, and med techs (responsible staff for initiating incident reports). All staff to be re educated by 3/21/24 DOW to report to ED immediately all reportable events and document on the incident reporting log immediately x 3 months. On 5/15/24 log to be reviewed for accuracy and if all reporting accurate will then follow company policies and procedures.
Completion date 3/21/24

Licensee's Proposed Overall Completion Date: *03/21/2024*

Implemented (- 06/25/2024)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

On , direct care staff person G was assigned to provide direct care services to residents during the overnight shift (11:00 p.m. to 7:00 a.m.) on the 3rd floor, was found sleeping on , at approximately . by a hospice aide and at by direct care staff person E, working . Interviews indicated on , during the daylight rounds at multiple residents were found with their briefs to be soaked through to the mattress indicating that their care needs were not met as indicated in their assessments and support plans during the overnight shift, to include:
** resident #2's significant change assessment and support plan, dated indicates resident # requires total physical assistance for toileting and bladder management, as well as extensive supervision in the community. The staff/hospice will provide physical assistance and hygienic needs for toileting and bladder management, as well as surrounding incontinence related products and hygiene needs. The summary and determination indicate the resident requires total assist with all ADL's.*
** Resident #3's assessment and support plan, dated , indicates the resident requires prompting/cueing for toileting and staff will provide physical assistance and hygienic needs surrounding toileting such as brief changes and peri care.*

Plan of Correction ***Directed - 04/15/2024)***

Appealing this tag. Residents in room was changed at 0500 and frequently has explosive diarrhea that requires complete bed change. There is no indication that resident care was neglected based on documentation.

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.23(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 4/15/24 JK

23a - Activities of Daily Living Assistance (continued)

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct private interviews of at least three residents a week for three month and three residents a month to ensure compliance with Regulation 2600.23(a). This should include creating a interview questionnaire and maintaining the documentation in the home. Documentation of interviews shall be kept. 4/15/24

The home's proposed completion date is unacceptable. The educational portion of the plan of correction shall be implemented by 4/20/24. The interviews of residents shall be initiated by 4/20/24. 4/15/24

Directed Completion Date: *04/20/2024*

Implemented (- 06/25/2024)

58a - Awake Staff 16 or More

4. Requirements

2600.

58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

According to the home's census, on and there were 60 residents, including 29 residents identified with mobility needs, being served in the home. On staff interviews and the homes documentation, indicated direct care staff person G, worked the overnight shift on from m., assigned to work the 3rd floor. The direct care staff person G was found by a hospice aide sleeping on the sofa in the 3rd floor TV room and at ., was observed sleeping by direct care staff person E after starting the daylight shift (p.m.) At approximately, ., staff attempted to wake up direct care staff person G; however, interviews indicated did not wake up until Interviews indicated direct care staff person G did not provide personal care to multiple residents during the overnight shift and were found to be soaked down to the mattress during the morning shift just after to include residents #2 and #3,

Plan of Correction ***Directed - 04/15/2024)***

Appealing this tag. Residents in room was changed at 0500 and frequently has explosive diarrhea that requires complete bed change. There is no indication that resident care was neglected based on documentation.

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons and management on the requirements of Regulation 2600.58(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 4/15/24

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct and audit once a week for a month then once a month for three months on each shift to ensure compliance with Regulation 2600.58(a). Documentation of audits shall be kept. 4/15/24

The home's proposed completion date is unacceptable. The educational portion of the plan of correction shall be

58a Awake Staff 16 or More (continued)

implemented by 4/20/24. The audits shall be initiated by 4/20/24. ██ 4/15/24

Directed Completion Date: *04/20/2024*

Implemented (██ - 06/25/2024)

82a - Poisonous Materials

5. Requirements

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

Description of Violation

On 2/15/24, there was a plastic spray bottle of yellow/green liquid that was unlabeled with no product label in the bottom right cabinet under the sink in the memory care unit.

Plan of Correction ***Directed (██ - 04/15/2024)***

Spray bottle was immediately labeled. All cleaning products were immediately verified to have proper labeling.

Community will initiate daily checklist for 3 months then checklist will be completed weekly by ED/DOW or designee starting 2/16/24.

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall Correct the violation cited (Poisonous materials shall be stored in their original, labeled containers). 4/15/24 ██

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.82(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 4/15/24██

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct an audit of the home to ensure compliance with Regulation 2600.82(a). (Poisonous materials shall be stored in their original, labeled containers) Documentation of the audit shall be kept. 4/15/24 ██

The home's proposed completion date is unacceptable. The educational portion of the plan of correction shall be implemented by 4/20/24. The audits shall be initiated by 4/20/24. JK 4/15/24

Directed Completion Date: *04/20/2024*

Implemented ██ - 06/25/2024)

85a - Sanitary Conditions

6. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 2/15/24, the following unsanitary conditions were found in the memory care kitchen, to include:
** A pile of coffee grounds, debris and other food particles/crumbs behind the garbage can.*
** Assorted debris on the floor and in the crack between the floor and previous dishwasher.*
** Coffee streaks spilling down the wall by the garbage can.*

Plan of Correction ***Directed (- 04/15/2024)***

Appeal this tag. This area was inspected at 0900 at the end of breakfast DURING clean-up. This area is cleaned after each meal and residents are not in the dining room.

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure all of the unsanitary conditions cited in the violation are corrected. 4/15/24

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons of the requirements of Regulation 2600.85(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 4/15/24 J

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct weekly audits of the home to ensure compliance with Regulation 2600.85(a). Documentation of the audit shall be kept. 4/15/24

The home's proposed completion date is unacceptable. The corrective action shall be completed by 4/16/24. The educational portion of the plan of correction shall be implemented by 4/20/24. The audits shall be initiated by 4/20/24. 4/15/24

Directed Completion Date: *04/20/2024*

Implemented - 06/25/2024)

85d - Trash Receptacles

7. 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 2/15/24, at approximately 10:00 a.m., the lid on the kitchen trash in memory care is broken and one side cannot be closed. The trash can is nearly full.

Repeat Violation: 8/2/22

Plan of Correction ***Directed - 04/15/2024)***

Trash can was immediately replaced.

Community will maintain daily checklist for 3 months then checklist will be completed weekly by ED/DOW/ ESD or designee starting 2/16/24.

85d - Trash Receptacles (continued)

Completion for compliance 5/15/24

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons of the requirements of Regulation 2600.85(d) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 4/15/24 J█

The home's proposed completion date is unacceptable. The educational portion of the plan of correction shall be implemented by 4/20/24. The audits shall be initiated by 4/20/24. JK 4/15/24

Directed Completion Date: *04/20/2024*

Implemented █ - 06/25/2024)

95 - Furniture and Equipment

8. Requirements

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

Description of Violation

On 2/15/24 the memory care kitchen lower cabinet door, to the right of where the dishwasher was removed. Was hanging by the bottom hinge.

Plan of Correction ***Directed █ - 04/15/2024)***

Hinge was immediately fixed. Inspectors were told that furniture and equipment was being removed due to community remodel starting on 3/18/24.

Community will initiate daily checklist for 3 months then checklist will be completed weekly by ED/DOW or designee starting 2/16/24.

Completion date 5/15/24

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons of the requirements of Regulation 2600.85(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.95. 4/15/24 JK

The home's proposed completion date is unacceptable. All aspects of the accepted plan of correction shall be implemented by 4/20/24. JK 4/15/24

Directed Completion Date: *04/20/2024*

Implemented (█ - 06/25/2024)

103c - Food Protected

9. Requirements

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

Description of Violation

On 2/15/24, at approximately 9:50 a.m., there was an unlabeled, undated plate of eggs, bacon, and a muffin covered with a plastic lid sitting on the kitchen counter in the memory care unit. Breakfast is served from 7:30 a.m. to 9:00 a.m. Staff indicated the plate of food was put aside for resident #4, who slept in.

Plan of Correction ***Directed - 04/15/2024)***

Food was immediately discarded
Staff was immediately educated with policy review
All staff will be educated on food storage and proper labeling

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct weekly audits of the home to ensure compliance with Regulation 2600.103(c). Documentation of the audit shall be kept. 4/15/24

The home's proposed completion date is unacceptable. The audits shall be initiated by 4/20/24. 4/15/24

Directed Completion Date: *04/20/2024*

Implemented - 06/25/2024)

103e - Left Overs

10. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 2/15/24, at approximately 9:50 a.m., there was a covered, unlabeled, undated plate of eggs, bacon, and a muffin sitting out on the kitchen counter in the memory care unit. Breakfast is served from 7:30 a.m. to 9:00 a.m. Staff indicated the plate of food was put aside for resident #5, who slept in.

Plan of Correction ***Directed - 04/15/2024)***

Food was immediately discarded
Staff was immediately educated with policy review
All staff will be educated on food storage and proper labeling

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall conduct weekly audits of the home to ensure compliance with Regulation 2600.103(e). Documentation of the audit shall be kept. 4/15/24 JK

103e Left Overs (continued)

The home's proposed completion date is unacceptable. The audits shall be initiated by 4/20/24 ██ 4/15/24

Directed Completion Date: *04/20/2024*

Implemented (██ - 06/25/2024)

225a - Assessment 15 Days

11. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

The assessment, dated ██ for resident #1 does not indicate an assessment for ██. The section is blank.

Plan of Correction ***Directed (██ - 04/15/2024)***

This was completed appropriately. The RASP absolutely was completed and aggression was listed in the EMR. It was explained and SHOWN to inspector the EMR and when printed the RASP needs adjusted as certain checkmarks do not print. It was discussed and proven during inspection and at exit.

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit all current resident assessments to ensure each resident has an accurate assessment completed and in the resident's record. 4/15/24 ██

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit all newly completed resident assessments to ensure each resident has an accurate assessment completed and in the resident's record. 4/15/24 ██

The home's proposed completion date is unacceptable. The audits shall be initiated by 4/20/24 ██ 4/15/24

Directed Completion Date: *04/20/2024*

Implemented (██ - 06/25/2024)

227c - Support Plan Revision

12. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1 was assessed as having moderate supervision needs, understanding instruction, short and long term memory, orientation to time, place, and person, judgement and is hard of hearing refusing to wear her hearing aids. Additionally, the residents support plan indicates the resident's judgment is impaired related to outcome of recent slums assessment that revealed some cognitive deficit and has not exhibited any behaviors that are harmful to self or others. However, the support plan was not updated to address resident #1's supervision needs with the noted wandering tendencies and poor judgement, as follows:

227c - Support Plan Revision (continued)

On , interviews indicated at an undetermined date and time in ,2024, resident #5 reported resident #1) wandered into resident #5's bedroom across the hall got into the resident's bed had consensual sexual intercourse, and then got up and left the room. However, when interviewed resident #1 denied having sex with resident #5 and stated they were not friends.

Resident #5 was assessed as having moderate supervision needs and minimal problem with judgment due to and medical evaluation dated , indicates the resident has fair cognitive functioning. However, the support plan, dated , does not address the supervision needs of the resident or the ongoing sexually inappropriate behaviors (verbal and physical) exhibited by the resident towards female staff. Interviews indicated the female staff are required to have two staff present while in resident #5's room, due to the inappropriate behaviors.

On , resident #5 reported resident #1, assessed with , wandered into resident #5's bedroom, got into resident #5's bed, had sexual intercourse and leaving the room shortly after. Resident #5 indicated "I wouldn't know who resident #1 was even if was standing right in front of me." Resident #5 was not able to identify who resident #1 was.

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Plan of Correction ***Directed - 04/15/2024)***

We are appealing this. There were no prior concerns of wandering with resident #1 and it was made clear that resident #1 felt she had a friendship with #5

Proposed Overall Completion Date: 05/15/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall update resident #1's and resident #5's support plans. 4/15/24

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit all current resident support plans to ensure each resident has an accurate support plan completed and in the resident's record. 4/15/24

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit all newly completed resident support plans to ensure each resident has an accurate support plan completed and in the resident's record. 4/15/24

The home's proposed completion date is unacceptable. The corrective action shall be completed by 4/16/24. The audits shall be initiated by 4/20/24. 4/15/24

Directed Completion Date: *04/20/2024*

Implemented - 06/25/2024)