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

May 14, 2024

[REDACTED], PRESIDENT
GOLDEN HEIGHTS OPCO LLC
3522 ROUTE 130
IRWIN, PA, 15642

RE: GOLDEN HEIGHTS PERSONAL CARE HOME
3522 ROUTE 130
IRWIN, PA, 15642
LICENSE/COC#: 45030

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/07/2024, 03/08/2024 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: *GOLDEN HEIGHTS PERSONAL CARE HOME* **License #**: *45030* **License Expiration**: *03/01/2025*

Address: *3522 ROUTE 130, IRWIN, PA 15642*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *GOLDEN HEIGHTS OPCO LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/23/1999* **Issued By**: *L&I*

Type: *I-2* **Date**: *05/11/2010* **Issued By**: *Penn Twp.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *03/08/2024*

Inspection Dates and Department Representative

03/07/2024 - On-Site:

03/08/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *63*

Secured Dementia Care Unit

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

Hospice

Current Residents: *63*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *33* **Have Physical Disability**: *2*

Inspections / Reviews

03/07/2024 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/08/2024*

Inspections / Reviews *(continued)*

04/10/2024 POC Submission

Submitted By: [redacted] **Date Submitted**: *05/14/2024*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *05/19/2024*

05/14/2024 Document Submission

Submitted By: [redacted] **Date Submitted**: *05/14/2024*

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

60a Staff/Support Plan

1. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted] there were 63 residents in the home, including 33 residents who have mobility needs and 17 residents who require a 2-person assist for transfer. On [redacted] during the [redacted] [redacted] shift, only 3 staff were present in the home. According to staff interviews, staff do not evacuate all residents outside the building or to a fire safe area because they would not be able to meet the designated safe evacuation time of 7 minutes. This level of staffing is insufficient to meet the needs of the residents and to evacuate them in an emergency.

Plan of Correction ***Accept [redacted] - 04/10/2024)***

The 3-7-24 date is incorrect the automatic fire alarms went off on 2.28.24. This violation occurred due to employees being informed by Apartment 4 person that there was no fire and she called 911 to inform the dispatcher that there was not fire. At that time employees stopped evacuating. Unfortunately, since this was not a fire alarm that was set off by our maintenance man the time was not recorded by any staffing onsite that morning.
What has been done to fix the problem:
Administrator provided verbal coaching to staff who worked overnight that only the fire company can give directive to stop evacuating to a fire safe area or outside, and the fire company will give the all clear for everyone to return back to their rooms. This was done on 2.28.24, meeting was held with employees who worked on the 3-11 shift and a gentleman who worked on midnight shift to educate them on where the door tags are located and how to evacuate residents.
Since the time was not recorded that night, the local fire expert who sets the approved evacuation times was contacted. He revised our required evacuation time to 9 minutes and 30 seconds, up from the prior requirement of 7 minutes. Please see documentation establishing new time allowance.
How do we prevent this from happening again:
Staffing patterns have been adjusted to ensure that there will always be adequate staffing to meet the needs of residents (added emphasis given to needs in the event of evacuation to a fire safe area and/or outside within the allowed timeframe given by the fire expert).
The facility also will hold a re-orientation with its Lodge Care Team Associates (staff who are boarded onsite in apartments connected to the facility) to review and reiterate their job descriptions that whenever they are onsite that they be available to assist in the event of emergency. They are also our first line of defense to cover any staff call-offs, along with a sign-up sheet to be posted by the schedule to ensure proper coverage for midnight shift. This was noted on the schedule starting on 3.22.24 and will be ongoing to ensure proper staffing is working and reviewed by the Administrator and RCC.
Documentation kept in training binder in the business office.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented ([redacted] - 05/14/2024)

103e Left Overs

2. Requirements

2600.

103e - Left Overs *(continued)*

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 3-7-24, a bag of cut chicken in the triple freezer was unlabeled and undated.

Plan of Correction ***Accept (█ - 04/10/2024)***

Why did this happen:
The dietary cook forgot to place the correct information on the bag of chicken when it was placed in the refrigerator.
What was done to fix the problem:
The dietary cook immediately disposed of the cut-up chicken since there was no date on the bag of chicken. This was completed on 3.7.24.
How to prevent this from happening again:
Administrator spoke with the Dietary supervisor and all cooks were verbally coached on 3.8.24 regarding 2600.130 e. The Dietary Supervisor will ensure all items are properly labeled and dated when placed in the refrigerator 5 days per week. Both cooks will also ensure the proper label and date is placed on items prior to going into the refrigerator daily.
This violation will be discussed weekly in the manager meetings with the Administrator checking the refrigerator after the meeting to ensure compliance with 2600.130 e. This is an ongoing process

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented (█ - 05/14/2024)

132h - Designated Meeting Place

4. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

On or about 2-21-24 at 2:30 AM, a fire alarm was activated due to an incident in a ground floor apartment. According to multiple staff and resident interviews, staff failed to evacuate all residents from their bedrooms to the outside of the building or to a fire safe area designated by a fire safety expert on 1/5/24.

Plan of Correction ***Accept (█ - 04/10/2024)***

The date of this violation is incorrectly listed as 2.21.24 - this incident actually occurred on 2.28.24. This violation occurred as a result of staff halting the evacuation before all residents were out after a fire alarm was triggered in a private apartment unit (not a personal care resident room). The reason staff halted the evacuation was due to the person residing in Apartment 4 (where the alarm was triggered) entering the personal care home during the alarm to advise staff that █ had accidentally triggered the alarm while cooking in █ apartment and stated that █ called 911 to also inform them there was no fire (only smoke from cooking). With this information, staff stopped evacuating residents to fire safe areas/outside, believing they were acting in residents' best interest by not further disturbing them over a false alarm.
Immediately on 2.29.24 the staff involved were verbally instructed that only the fire personnel can make the determination to stop an evacuation process once the alarm has been triggered. Two fire train the trainer

132h Designated Meeting Place (continued)

personnel had a meeting with staffing on 2/28/24 to re train again how to evacuate residents to a fire safe area/outside and the use of door tags.
How to prevent 2600.132 h of occurring again:
Senior management team conducted a walkthrough of the building on 4.3.24 with a copy of the evacuation plan that is also posted inside the building. More efficient and time saving evacuation protocols were adopted utilizing the existing fire safe areas and fire exits. Specifically, staff will use the exit doors to evacuate residents to outside the building wherever the fire is located, and all other residents will be evacuated from their rooms into the fire safe areas opposite of where the fire is located in the building. Previously, all residents were funneled to the interior fire safe area, which slowed response time and did not utilize the numerous (much closer) outdoor fire exits.
Meeting will be held on 4.12.24 and 4.19.24 given by the train the trainer on fire safety personnel to re educate nursing staff on how to evacuate the residents to a fire safe area (including the new patterns to take residents outside as well). Also, every month after each fire drill a brief meeting will be held to discuss the drill and ways to improve safety for all involved. Next fire drill is to be held before 4.18.24 on midnight shift. This will be an ongoing process.
Documentation will be kept in the training file that is kept in the business office.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented (- 05/14/2024)

183b - Meds and Syringes Locked

5. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On a bottle of , that belonged to Resident #1, was unlocked and accessible on the nightstand in the resident's bedroom.

REPEATED VIOLATION: 1/11/2023, et al

Plan of Correction ***Accept (- 04/10/2024)***

This is a repeat violation. Prior was for treatments found in the room in which a treatment cart was utilized for each side and continues to be used today, however OTC of a was found in one resident's room and was removed immediately from the room during the inspection.
This violation occurred due to a family member bringing this medication directly to resident without the RCC or Administrator's knowledge.
To Prevent this from occurring again:
In the April community newsletter mailed to the responsible parties, we reminded/informed families that all OTC medications must be brought to the office so the RCC and Administrator can ensure there is an order on file. Documentation can be provided.
Weekly TX/OTC audit will be done by RCC and Administrator via a walk though of every resident's room to prevent TX/OTC being left in a room. Weekly audits started on 4.3.24 and next one scheduled for 4.10.24. Documentation can be provided.
This will be an ongoing process and will be discussed at the 4.12.24 and 4.19.24 staff meetings. Documentation can

183b Meds and Syringes Locked (continued)

be provided on the meeting sign in sheets which will be kept in the training binder in the office file.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented (- 05/14/2024)

183d - Prescription Current

6. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #2 was prescribed 1 spray to each nostril daily as needed. This medication was discontinued on however, on , it was still in the medication cart.

Plan of Correction ***Accept (- 04/10/2024)***

This violation occurred due to the missed medication being an "as needed" medication. The med passer was unaware that this med was not a current medication.
Immediately the RCC removed this medication from the cart when it was discovered to be a discontinued medication.
To Prevent this from happening again:
RCC and Administrator have implemented a discontinued medication audit. This will be used since the office receives all orders for discontinuation of medications. Once the order is received, RCC or Administrator will chart that the med was discontinued, remove the medication from med cart, and complete the audit to ensure the medication has been disposed per facility policy. This audit started on 4.5.24 and is ongoing with documentation kept in the business office in a binder for audits. Also will be discussed in the meeting on 4.12 and 4.19.24 along with quarterly meetings with nursing staff.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented - 05/14/2024)

184a - Resident's Meds Labeled

7. 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 #2 is prescribed 1 capsule daily as needed for ; however, the label indicates Resident #2 is prescribed 1 capsule daily.

No pharmacy label is present on Resident #2's , which was stored in the home's medication cart.

184a - Resident's Meds Labeled (continued)

Plan of Correction ***Accept - 04/10/2024)***

This happened due to orders being changed and the changes not reflected on the medication that was in the cart.
What was done to fix the problem:
RCC contacted the Administrator regarding the and placed a sticker on the medication that states "New orders see MARS" with initial and date the sticker was affixed. For the , the resident's name and sticker was placed on the medication and it was removed from the cart since it was noted to now be a discontinued medication.
This violation occurred since in place protocols were not followed when the medication changed from a straight order to as needed medication.
To prevent this from happening again, in the April community newsletter all responsible parties have been notified/reminded that they are to bring any/all OTC medications to the office to ensure proper labeling of OTC. A new audit sheet has been started on 4.2.24 to audit two carts per week, completed by RCC and/or Administrator with the next audit scheduled for 4.9.24. This documentation will be kept in a binder in the business office and will be ongoing audits. This will also be discussed in the nursing meetings on 4.12.24 and 4.19.24 and every quarter with nursing staff. All meeting sign in sheets are kept in the business office training file.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented - 05/14/2024)

184b - Labeling OTC/CAM

8. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

A bottle of , belonging to Resident #2, was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept (- 04/10/2024)***

This happened due to OTC was not properly labeled when the medication was given to the med passer.
What was done to fix the problem:
RCC contacted the Administrator, and placed a sticker on the Aspirin that states: "New orders see MARS" with initial and date the sticker was affixed and included the resident's name.
This violation occurred since in place protocols were not followed when accepting the OTC medication.
To prevent this from happening again, in the April community newsletter all responsible parties were notified to bring any/all OTC medications to the office to ensure proper labeling of OTC. A new audit sheet has been started on 4.2.24 to audit two carts per week, completed by RCC and Administrator with the next audit scheduled for 4.9.24. This documentation will be kept in a binder in the business office and will be ongoing audits. This will also be discussed in the nursing meeting on 4.12.24 and 4.19.24 and every quarter with nursing staff. All meeting sign in sheets are kept in the business office training file.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented - 05/14/2024)

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

On [redacted], Resident #1's blood glucose was [redacted]; however, Resident #1's blood glucose was recorded as [redacted] on the resident's March 2024 medication administration record (MAR).

On [redacted], Resident #1's blood glucose was [redacted]; however, Resident #1's blood glucose was not recorded on the March 2024 MAR.

Plan of Correction ***Accept ([redacted] - 04/10/2024)***

This error occurred due to the med passer transposing the CBG meter reading when recording it in the MAR: documenting the level as [redacted]" as opposed to [redacted]" as well as not documenting the 8:33 pm reading into the MAR.
To prevent this from occurring again:
RCC has made a weekly CBG meter check to ensure that what is written in the MAR is entered correctly. Med passers have been instructed to have another staff person sign off on a sheet to verify that correct number is entered into the MAR from the blood glucose reading. The weekly CBG meter checks started on 3.11.24 and double checks started on 4.1.24 to have two people sign off. The audit sheets are kept in the business office in a binder and the double blood sugar checks are kept in the front of the controlled book. This is ongoing and will be re-enforced on the 4.12.24 and 4.19.24 meetings and every quarterly meeting thereafter. These audits can be made available if needed for POC.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented ([redacted] - 05/14/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

On [redacted], Resident #2 was prescribed [redacted] – 1 tablet twice daily for [redacted] days. This medication was not administered from [redacted]

On 2/25/24, Resident #2 was prescribed [redacted] – [redacted], then [redacted] This medication was not administered from [redacted].

Plan of Correction ***Accept ([redacted] 04/10/2024)***

This occurred due to the third party pharmacy not carrying over the medication correctly from the order of February to the March 1 MAR.
As soon as the RCC was notified that those mediations were not carried over correctly she contacted the pharmacy to advise them of the problem and the pharmacy restarted the correct medications again.
How to prevent this type of error of occurring again:
The intent of the RCC and Administrator auditing 2 med carts per week is so that this type of error will be caught

187d Follow Prescriber's Orders (continued)

more effectively (audits started on 4.2.24 with next one 4.9.24). Reeducating the med passers on 4.12.24 and 4.19.24 and quarterly meetings to ensure med passers make RCC and Administrator aware of problems with the MARS and medication without delay. RCC and Administrator are always available 7 days per week to help with any questions or concerns on the medications. Med passers also have been shown how to print a resident's MAR and copy the label of the medication onto the MAR so the medication can be given in accordance with prescriber's orders. All documentations will be kept in the business office binder or training file. Documentation can be available if needed for POC.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented (- 05/14/2024)