

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

November 6, 2024

[REDACTED]
FDG CB OPCO LLC
[REDACTED]

RE: ATRIA AT CRANBERRY WOODS
3020 FAIRPORT LANE
CRANBERRY TOWNSHIP, PA, 16066
LICENSE/COC#: 45268

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/10/2024, 06/06/2024 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: ATRIA AT CRANBERRY WOODS **Licen e #:** 45268 **Licen e Expiration:** 04/13/2025
Address: 3020 FAIRPORT LANE, CRANBERRY TOWNSHIP, PA 16066
County: BUTLER **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: FDG CB OPCO LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 01/29/2021 **Issued By:** Cranberry Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 116 **Waking Staff:** 87

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 06/06/2024

Inspection Dates and Department Representative

05/10/2024 - On-Site: [REDACTED]
 06/06/2024 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: 115 **Re ident Served:** 84

Secured Dementia Care Unit

In Home: Yes **Area:** SDCU **Capacity:** 41 **Re ident Served:** 28

Hospice

Current Re ident : 4

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 84
Diagnosed with Mental Illness: 2 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 32 **Have Physical Disability:** 0

Inspections / Reviews

05/10/2024 Partial

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

Inspections / Reviews *(continued)*

07/18/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 08/07/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 07/25/2024

07/26/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 08/07/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 08/16/2024

11/06/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: 08/07/2024
 Reviewer: [REDACTED] Follow-Up Type: Not Required

16c - Written Incident Report

1. 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

Resident [redacted] ceased to breathe on resident [redacted] date of death. However, the home did not report this incident to the Department.

Plan of Correction

Accept [redacted] - 07/18/2024)

* Residents [redacted] death was reported late on [redacted] and final report was completed on [redacted] to include death certificate.

* DHS Inspector educated Executive Director/Assistant Executive Director on reporting unexpected deaths, even if death was not at community on 6/6/24.

* Executive Director/Designee will educate all Directors on 2600.16c including proper incident reporting by 7/29/24.

* Beginning week of 7/5/24 and for the next 90 days Executive Director/Designee and or Resident Services Director/Designee will perform weekly audits of all incidents to ensure proper and timely reporting.

Licensee's Proposed Overall Completion Date: 07/29/2024

Implemented [redacted] 11/06/2024)

42b - Abuse

2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] resident [redacted] was admitted to the home with multiple diagnoses, including [redacted], and [redacted]. Prior to admission, resident [redacted] resided in the independent living section of the facility, suffered a serious fall on [redacted] and was hospitalized [redacted] was in rehabilitation and on a mechanical soft diet until admitted to the home, as the home does not offer modified diets.

Resident [redacted] assessment and support plan, dated [redacted], indicates a diagnosis of dysphagia and staff will report complaints of difficulty swallowing or choking episodes. Resident [redacted] requires assistance with mechanics of eating during meals and may need assistance with using eating utensils and staff will provide assistance 3 times/day, requires assistance with securing health care and staff will assist as needed, and requires physical assistance with transfers and staff will assist to ensure safety.

On [redacted], resident [redacted] was diagnosed with [redacted] by [redacted] physician, who ordered a consult with a Gastroenterologist. However, the home did not assist with securing the consultation.

During [redacted] stay at the home, resident [redacted] condition declined. From [redacted] resident [redacted] was visited by multiple medical professionals who documented the following concerns: Difficulty eating with decreased appetite, was very weak and debilitated, resident reports decreased appetite and multiple instances of gagging and dry heaving when bringing food to [redacted] mouth and during meals, upon swallow evaluation, patient presents with mild to mod

42b - Abuse (continued)

██████████ with difficulty with solid foods, resident reports ██████████ had to cancel a medical procedure due to weakness and weight loss, resident presenting with ongoing ██████████ and concerns for weight loss, concerns for ██████████ and ██████████, gagging and dry heaving following bites of fruit and soup, and resident has protein calorie malnutrition. On ██████████ resident ██████████ physician ordered a hospice consultation; however, the home did not assist with securing the consultation.

From ██████████ resident ██████████ suffered three ██████████. On ██████████, at approximately 12:00 PM, while eating chili for lunch in the independent dining room, resident ██████████ vomited and returned to ██████████ bedroom. Between 3:00 PM – 4:00 PM, staff person A entered the resident’s bedroom and observed the resident was not feeling well. The resident indicated ██████████ vomited at lunch, ██████████ voice was very hoarse, and ██████████ was complaining of being very cold. Resident ██████████ did not want to go to the hospital, and staff person A could not take the resident’s temperature or vitals because the home does not allow staff to do so. Between 7:00 PM – 8:00 PM, staff person A entered resident ██████████ bedroom and found the resident was still ill, stated ██████████ was cold, and required two blankets; however, ██████████ did not want to go to the hospital. At approximately 8:30 PM, resident ██████████ requested an ambulance be called. At 8:51 PM, resident ██████████ was transported to the hospital via ambulance, where ██████████ was diagnosed with ██████████ and ██████████.

Resident ██████████ ceased to breath on resident ██████████ date of death. Resident ██████████ hospital records indicate the cause of death as ██████████ and ██████████.

Plan of Correction

Accept ██████████ 07/26/2024)

- * Resident ██████████ was alert and oriented x3 and was deemed able to manage ██████████ own diet prior to returning to community on ██████████
- * Resident ██████████ and family (including POA) declined when Resident Service Director attempted to arrange for the Gastroenterologist consult that was ordered on 3/6/24 by Resident ██████████ physician.
- * Resident ██████████ family (including POA) declined to have a hospice consult done on 3/27/24 as resident ██████████ could not continue physical therapy if hospice was initiated.
- * On or before 7/29/24, Executive Director/Designee will retrain all care staff on 2600.42b to include calling paramedics if they feel a resident needs to go to hospital and proper procedure for refusal of EMT services.
- * Executive Director/Designee will educate all staff regarding communicating any decline or change of condition observed in a resident to their Directors by August 9th, 2024.
- * Beginning 7/5/24 and continuing for the next 90 days Executive Director/Designee and/or Resident Service Director/Designee will perform weekly audits on all incidents to ensure compliance with 2600.42b
- * Beginning week of 7/29/24 and for the next 90 days, Executive Director/Designee and Therapy Director/Designee will perform weekly audits to review any change of condition/decline in function in residents.

Licensee's Proposed Overall Completion Date: 08/09/2024

Implemented ██████████ 11/06/2024)

252 - Record Content

3. Requirements

2600.

252. Content of Resident Records - Each resident’s record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

252 - Record Content (continued)

5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [redacted] ceased to breathe on resident [redacted] date of death. However, resident [redacted] record does not include [redacted] death certificate.

Plan of Correction

Accept ([redacted] - 07/18/2024)

* Death certificate for Resident [redacted] was requested on [redacted] and re-requested on [redacted].

* Death certificate for resident [redacted] was obtained and reported to DHS on [redacted] and copy was placed in Resident [redacted] file.

* Beginning week of 7/5/24 and for next 90 days Executive Director/Designee will meet with Resident Service Director/Designee to audit all current resident files to ensure proper content.

* Regional Care Director will provide education to community Business Director, Executive Director, Assistant Executive Director and Resident Services Director on 2600.252 including resident record content by 7/29/24.

* Beginning 7/5/24 and for the next 90 days Executive Director/Designee and/or Community Business Director will conduct weekly audits of all new admissions records to ensure all required content is present in the record.

Licensee's Proposed Overall Completion Date: 07/29/2024

Implemented [redacted] - 11/06/2024)