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

September 6, 2024

[redacted], PRESIDENT
FAIR OAKS OPCO LLC
2200 WEST LIBERTY AVENUE
PITTSBURGH, PA, 15226

RE: FAIR OAKS SENIOR LIVING
2200 WEST LIBERTY AVENUE
PITTSBURGH, PA, 15226
LICENSE/COC#: 45286

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/17/2024, 06/18/2024 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: *FAIR OAKS SENIOR LIVING* **License #**: *45286* **License Expiration**: *09/26/2024*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226*

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

Administrator

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

Legal Entity

Name: *FAIR OAKS OPCO LLC*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *01/16/2017* **Issued By**: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *126* **Waking Staff**: *95*

Inspection Information

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

Reason: *Complaint, Provisional, Incident, Monitoring* **Exit Conference Date**: *06/18/2024*

Inspection Dates and Department Representative

06/17/2024 - On-Site:
06/18/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *86*

Secured Dementia Care Unit

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

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *82*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *40* **Have Physical Disability**: *2*

Inspections / Reviews

06/17/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/04/2024*

07/15/2024 - POC Submission

Submitted By: **Date Submitted**: *08/05/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/26/2024*

Inspections / Reviews *(continued)*

07/29/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/05/2024*

09/06/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2024*

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

41e - Signed Statement

1. 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

The contract for resident #1, dated [redacted], indicated "The resident acknowledges that the home has provided [redacted] and their designated person a list of the resident rights as specified in this contract." However, there was no list of resident rights specified in resident #1's contract, and there was no addendum attached to the contract that indicated the list of resident rights specified in regulation 2600.42.

Plan of Correction ***Accept ([redacted] - 07/29/2024)***

Immediately on 6/17/2024 resident number 1 was given the residents rights and Admin went over residents' rights with resident number 1. Resident number 1 then signed the document, and this was presented to licensed agency representative on 6/18/2024. A copy was placed in resident number 1 file.
Starting on 6/25/2024 an audit on resident financial files was started by Compliance Director to ensure all proper documents are present in all files. Twenty files will be audited per week, monthly thereafter. Documentation will be kept.
Training for all management will be done on 6/28/2024 on 41E by admin. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented ([redacted] - 08/20/2024)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 6/14/24 there were 86 residents present in the home, however, direct care staff person A was the only aide in the home that was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 11:00 p.m. until 12:00 a.m.

On 6/15/24 there were 86 residents present in the home, however, direct care staff person A was the only aide in the home that was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 12:00 a.m. until 7:00 a.m.

On 6/16/24 there were 86 residents present in the home, however, direct care staff person B was the only aide in the home that was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 3:00 p.m. until 9:23 p.m.

On 6/16/24 there were 85 residents present in the home, however, direct care staff person B was the only aide in the home that was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 9:23 p.m. until 11:00 p.m.

On 6/16/24 there were 85 residents present in the home, however, direct care staff person A was the only aide in the

63a - First Aid/CPR Training (continued)

home that was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 11:00 p.m. until 12:00 a.m.

On 6/17/24 there were 85 residents present in the home, however, direct care staff person A was the only aide in the home that was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 12:00 a.m. until 9:00 a.m.

Plan of Correction ***Accept (- 07/29/2024)***

Immediately on 6/19/2024 a complete audit was completed by Compliance Director on CPR/First Aid and two CPR/First Aid classes were scheduled. 7/2/2024 @ 8:00 am, 7/9/2024 @ 2:00 pm. Documentation will be kept.
Director of Health Services will complete a biweekly schedule that includes at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR will be in the home at all times. This started on 7/16/2024. Compliance director will complete a weekly review or the actual staff persons who worked in the home to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR was in the home at all times. This began on 7/16/2024.
Monthly audits will be done by Compliance director to ensure any new employees or expired certifications will complete CPR/First Aid training.
Compliance Director has also entered all training into Tabula pro and will receive alerts one month prior to when employees are due for renewal. Documentation will be kept.
Training on 63a will be done with management on 6/28/2024 @ 10:00 am by admin. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 08/20/2024)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 6/17/24 at approximately 11:35 a.m. in the second-floor common shower room there was a pungent odor of urine that was emanating from a used urine-soaked adult brief that was found on the floor.

Plan of Correction ***Accept (- 07/15/2024)***

Immediately on 6/17/2024 the soiled brief was removed and disposed of.
On 7/1/2024 a training by Admin/Compliance Director will be done on regulation 85a and will be held at 7:00 am and 2:00 pm with all staff. Documentation will be kept.
Starting on 6/25/2024 Admin will do daily checks for 1 months, weekly thereafter on both common shower rooms on floor 2. Also, the task will be placed on the MAR for the med techs to check per shift that the shower room is clear of unsanitary conditions. This will require the med tech to sign off that it's been completed. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/25/2024*

Implemented (- 08/20/2024)

102k - No Common Towel

4. Requirements

2600.

102k - No Common Towel *(continued)*

102.k. Use of a common towel is prohibited.

Description of Violation

On 6/17/24 at approximately 11:35 a.m. in the second-floor common shower room there were two unlabeled wash clothes and four unlabeled towels on the portable shower chair.

Plan of Correction ***Accept (- 07/15/2024)***

Immediately on 6/17/2024 the two unlabeled wash clothes and four unlabeled towels were removed and placed in the laundry.
On 7/1/2024 a training by Admin/Compliance Director will be done on regulation 102k and will be held at 7:00 am and 2:00 pm with all staff. Documentation will be kept.
Starting on 6/25/2024 Admin will do daily checks for 1 months, weekly thereafter on both common shower rooms on floor 2. Also, the task will be placed on the MAR for the med techs to check per shift that the shower room is clear of unsanitary conditions. This will require the med tech to sign off that it's been completed. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/25/2024*

Implemented (- 08/20/2024)

103f - Refrigerator/Freezer Temps

5. 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 6/17/24 at approximately 11:21 a.m. there was no thermometer inside of the small silver refrigerator in the second-floor dining room that contained two cups of diced peaches, a bottle of Italian dressing, one quart of half-and-half, and various other refrigerated items.

On 6/17/24 at approximately 11:21 a.m. there was no thermometer inside of the small silver freezer in the second-floor dining room that held three containers of ice cream and two full Styrofoam cups of an uncovered and unlabeled frozen orange liquid.

Plan of Correction ***Accept (- 07/15/2024)***

Immediately on 6/17/2024 the admin placed thermometers in the freezer and refrigerator that are on the 2nd floor dining room. Admin discarded the uncovered and unlabeled frozen orange liquid. Documentation was given to BHSL representative on 6/18/2024.
Admin will do weekly checks starting on 6/25/2024 on all common area refrigerator's and monthly thereafter to ensure thermometers are in place and operational and that no uncovered or unlabeled products are present. Documentation will be kept.
On 7/1/2024 a training by Admin/Compliance Director will be done on regulation 103f and will be held at 7:00 am and 2:00 pm with all staff. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/25/2024*

Implemented (- 08/20/2024)

103g - Storing Food

6. Requirements

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

Description of Violation

On 6/17/24 at approximately 10:55 a.m. there was an open and unsealed thirty-two-ounce bag of brown sugar that was approximately one-quarter full found in the basement level activity lounge.

On 6/17/24 at approximately 11:21 a.m. there were two full Styrofoam cups of an unidentified frozen orange liquid there were found uncovered and unlabeled with a date of preparation or opening in the home's second-floor dining room small silver freezer.

Plan of Correction ***Accept (- 07/15/2024)***

Immediately on 6/17/2024 Admin discarded the brown sugar and unidentified frozen orange liquid.
On 7/1/2024 a training by Admin/Compliance Director will be done on regulation 103g and will be held at 7:00 am and 2:00 pm with all staff. Documentation will be kept.
Daily building walk-thru for one month, weekly thereafter will be done by admin/Compliance Director starting 6/25/2024 to ensure no unlabeled/undated or uncovered (not properly stored) food is present. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/25/2024*

Implemented (- 08/20/2024)

132a - Monthly Fire Drill

7. Requirements

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

Description of Violation

The home did not conduct an unannounced fire drill during the month of August 2023.

The home did not conduct an unannounced fire drill during the month of September 2023.

The home did not conduct an unannounced fire drill during the month of October 2023.

Plan of Correction ***Directed (- 07/29/2024)***

Unfortunately, current Admin and Compliance Director were not employed by Fair Oaks at the time of violation. Moving forward, Admin or Compliance Director will schedule and be present for all fire drills. Admin or Compliance Director will sign off on every log in in the fire book to ensure proper documentation is done and to ensure that fire drill was successful. This will start for the fire drill in July. Documentation will be kept.
Training for all management will be done on 6/28/2024 on 132a by admin. Documentation will be kept.

Proposed Overall Completion Date: 07/26/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator or designee shall audit the fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month. 7/29/24

Directed Completion Date: *07/30/2024*

Implemented (- 08/20/2024)

132e - Fire Drill Sleeping Hours

9. Requirements

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

Description of Violation

The home's last sleeping hours fire drill was held on 3/18/24 at 11:30 p.m., however, there was no previous sleeping hours fire drill indicated on the fire drill log.

Plan of Correction ***Directed (- 07/29/2024)***

Unfortunately, current Admin and Compliance Director were not employed by Fair Oaks at the time of violation. Moving forward, Admin or Compliance Director will schedule and be present for all fire drills. Admin or Compliance Director will sign off on every log in in the fire book to ensure proper documentation is done and to ensure that fire drill was successful. This will start for the fire drill in July. Documentation will be kept.
Training for all management will be done on 6/28/2024 on 132e by admin. Documentation will be kept.

Proposed Overall Completion Date: 07/26/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator or designee shall audit the fire drill record monthly to ensure a fire drill shall be held during sleeping hours once every 6 months.7/29/24

Directed Completion Date: *07/30/2024*

Implemented (- 08/20/2024)

162c - Menus Posted

10. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 6/17/24 at approximately 2:05 p.m. the menu's posted outside of the home's first-floor dining area were for dates ranging from 6/9/24 through 6/22/24 and the following week's menu was not posted.

Plan of Correction ***Accept (- 07/15/2024)***

Immediately on 6/17/2024 the next weeks menu (6/23/2024-6/29/2024) was placed outside of the home's first-floor dining area by Admin.
On 6/28/2024 the kitchen director along with all management will be trained on 162c by Admin. Documentation will be kept.
Weekly walk-thru will be done by admin moving forward to ensure that 2 weeks of menu's are always present. This was started 6/25/2024 by Admin. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/25/2024*

Implemented (- 08/20/2024)

185a - Implement Storage Procedures

11. 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

Resident #2 is prescribed Morphine Sulfate 100mg/5mL solution, take 5mg (0.25mL) sublingually every 2 hours as needed. The controlled drug record for the resident's Morphine indicated the home received a total of twenty doses or 5mL on 5/4/23 and documented the administration of fifteen doses through 5/3/24. However, on 6/18/24 the five remaining prefilled syringes of Morphine Sulfate contained approximately .5mL and the home could not account for the missing .75mL of Morphine.

The home's medication policy for the accountability of controlled substances states "The narcotic/controlled substance amount will be verified and recorded on a Controlled Substance sheet computer-generated at the pharmacy and sent with the drug. All controlled substances are counted every shift, (the previous shift med passer and the oncoming shift med passer), to agree on the number of narcotics available. The number of medications can be compared to prescribed dosages, (time & amount)." However, staff interviews with medication passers and the home's management indicated the home was not verifying the amount of Morphine Sulfate solution remaining in each of resident #2's prefilled syringes.

REPEAT VIOLATION 1/11/24 et. al., 8/17/23 et. al.

Plan of Correction ***Accept (█ - 07/29/2024)***

On 6/19/2024 the Director of Resident Care and Compliance Director audited all doses of all syringes to ensure the doses were correct. Medication techs were instructed to also check doses along with doing the narc count. Medication techs were instructed to also check count and dose when receiving narc from pharmacy.
Starting on 6/26/2024 weekly audits will be done moving forward by DRC or CD to ensure doses are correct. Documentation will be kept.
Med tech training will be scheduled on 7/10/2024 at 7:00 am and 2:00 pm. Documentation will be kept.

Proposed Overall Completion Date: 07/26/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (█ - 08/20/2024)

191 - Resident Right to Refuse

12. 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

There was no documentation that resident #1, has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

191 - Resident Right to Refuse *(continued)*

Plan of Correction ***Accept (- 07/29/2024)***

Immediately on 6/17/2024 resident number 1 was given the right to refuse or question a medication document and Admin went over this document with resident number 1. Resident number 1 then signed the document, and this was presented to licensed agency representative on 6/18/2024. A copy was placed in resident number 1 file.
Starting on 6/25/2024 an audit on resident financial files was started by Compliance Director to ensure all proper documents are present in all files. Twenty files will be audited per week, monthly thereafter. Documentation will be kept.
Training for all management will be done on 6/28/2024 on 191 by admin. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented (- 08/20/2024)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's assessment, dated , did not indicate the use of a wheelchair. However, staff interviews and resident #3's medical evaluation, dated , indicated the resident uses a wheelchair for ambulation.

Resident #4's assessment, dated , did not indicate the use of a wheelchair. However, staff interviews and resident #4's medical evaluation, dated indicated the resident ambulated by wheelchair only.

REPEAT VIOLATION 10/4/23 et. al.

Plan of Correction ***Accept (- 07/29/2024)***

Immediately on 6/17/2024 admin did addendums for resident # 3 and resident # 4 stating that both residents required a wheelchair. These addendums were given to Human Services Licensing Representative on 6/18/2024. Addendums were also placed in the resident's charts.
On 6/28/2024 admin will give training on 225c to all management. Documentation will be kept.
Starting on 6/26/2024 Compliance Director will do an audit on 10 charts' weekly for 9 weeks and 10 monthly thereafter. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 08/20/2024)

227g -Support Plan Signatures

14. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's support plan, dated was not signed by the resident and there was no indication the resident

227g -Support Plan Signatures (continued)

was unable or unwilling to sign the support plan.

Plan of Correction ***Accept ([redacted] - 07/29/2024)***

Immediately on 6/17/2024 an addendum was done by admin on resident # 3 stating resident was unable to sign.
On 6/28/2024 admin will give training on 227g to all management. Documentation will be kept.
Starting on 6/26/2024 Compliance Director will do an audit on 10 charts' weekly for 9 weeks and 10 monthly thereafter. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented ([redacted] - 08/20/2024)