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

November 4, 2024

GOLDEN HEIGHTS OPCO LLC

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

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/12/2024, 07/17/2024, 08/12/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *GOLDEN HEIGHTS PERSONAL CARE HOME* **Licen e #**: *45030* **Licen e 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:
Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *55* **Waking Staff**: *41*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/12/2024*

Inspection Dates and Department Representative

07/12/2024 On Site
07/17/2024 Off Site
08/12/2024 Off Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

07/12/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/06/2024*

09/11/2024 - POC Submission

Submitted By: **Date Submitted**: *10/30/2024*
Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/18/2024*

Inspections / Reviews *(continued)*

09/20/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/30/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *11/02/2024*

11/04/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *10/30/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

23a - Activities of Daily Living Assistance

1. 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

Resident ██ initial assessment and support plan, dated 7/19/23, indicates that the resident is totally immobile and "requires full hands on assistance for all transfers and mobility." Resident also "will be accompanied to bathroom to assist" and "is unable to use ██ left arm, due to left side weakness."
On ████, direct care staff A was pushing resident ██ to the bathroom in the resident's wheelchair. The wheelchair did not have leg rests in place. According to resident and staff interviews and internal documentation, direct care staff A pushed the resident's wheelchair very hard and fast to get over the threshold in the doorway entering the resident's bathroom. This caused the resident to fall out of her wheelchair and onto the floor resulting in injury to the resident. The resident was transported to the hospital and was diagnosed with a 2 centimeter facial laceration to the forehead, Right distal radius fracture and Fourth and 5th metacarpal base fracture.

Plan of Correction ***Accept ██ - 09/20/2024)***

This violation occurred because the staff person did not take their time pushing the resident in to the bathroom properly since the resident did not have her leg rests on.
After the incident and resident returned from the hospital, ask resident to use her leg rests to help keep ██ feet in up when transferring, however resident is insisting not to use the leg rests. Nursing staff has since been verbally educated on ████ to ensure to be careful when pushing resident to ensure ██ has time to lift ██ legs when entering the bathroom or moving ██ from one location to another.
Resident Care Coordinator addressed in ██ support plan on how to safely transport resident in ██ wheelchair when not using ██ leg rest to prevent this incident from happening again on ████ At that time staff was verbally educated and shown by Resident Care Coordinator on how to push resident in wheelchair. Also, this will be part of the topic on September 18, 2024, at 10:00 am and 2:30 pm on reviewing the assessment and support plans, the location of the assessment and support plans in the resident's chart, along with the importance of not pushing a resident too very hard and fast when transporting a resident in the wheelchair. This will be an ongoing education for staffing on how to properly transport residents in wheelchair to prevent this type of incident happening again.
Immediate action occurred on ████, when the administrator verbally spoke to staff on how to be careful when pushing a resident in a wheelchair without leg rests and to allow time for the resident to lift legs. Please see the supporting sign in sheet for ████ given by the Administrator. Along with Resident care Coordinator showing employees on ████ how to safely push a resident in a wheelchair. Please see sign sheet from 7.23.24
Corrective action occurred when Administrator spoke in private with employee involved on 5.15.24 to ensure the employee understood that by pushing resident quickly was the major cause of resident falling out of her wheelchair and employee needs to give resident time to pick up ██ feet and stop periodically to ensure residents feet are up. Since this was a private conversation there was no sign in sheet for this meeting. Resident Care Coordinator also updated resident assessment and support plan on transporting resident in a wheelchair. Documentation to be provide on request on this update care plan.
Preventative action will occur on September 18, 2024, at 10:00 am and 2:30pm given by the Administrator and Resident Care Coordinator. Please see the agenda format that was followed in this meeting to ensure all nursing staff in attendance understand the importance of not pushing residents too fast, along with not making the resident feel rushed when doing any type of care, allowing time for resident to keep their feet up with periods of stopping if notice resident is putting down their legs, Location of residents assessment and support plans in a resident s chart

23a - Activities of Daily Living Assistance (continued)

and to contact Resident Care Coordinator if any change is needed to this assessment and support plan. Also, who is part of Fox Rehab is having a meeting on October 2, 2024, at 2:30 pm to review transfers, transporting residents and review Hoyer lift technique. This type of in-service with Fox Rehab will be ongoing 4 times a year starting on October 2, 2024. Documentation of sign sheet and material reviewed will be available. All documentation of sign sheets with attached material to be kept in training folder in business office.

Licensee's Proposed Overall Completion Date: *10/03/2024*

Implemented - 11/04/2024)

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

Resident initial assessment and support plan, dated , indicates that the resident is totally immobile and "requires full hands on assistance for all transfers and mobility." Resident also "will be accompanied to bathroom to assist" and "is unable to use left arm, due to left side weakness."
On direct care staff A was pushing resident to the bathroom in the resident's wheelchair. The wheelchair did not have leg rests in place. According to resident and staff interviews and internal documentation, direct care staff A pushed the resident's wheelchair very hard and fast to get over the threshold in the doorway entering the resident's bathroom. This caused the resident to fall out of wheelchair and onto the floor resulting in injury to the resident. The resident was transported to the hospital and was diagnosed with a 2 centimeter facial laceration to the forehead, Right distal radius fracture and Fourth and 5th metacarpal base fracture.

Plan of Correction ***Accept 09/20/2024)***

This violation occurred because the staff person did not take their time pushing the resident in to the bathroom properly since the resident did not have leg rests on.
After the incident and resident returned from the hospital, ask resident to use leg rests to help keep feet in up when transferring, however resident is insisting not to use the leg rests. Nursing staff has since been verbally educated on to ensure to be careful when pushing resident to ensure has time to lift her legs when entering the bathroom or moving from one location to another.
Resident Care Coordinator addressed in her support plan on how to safely transport resident in wheelchair when not using leg rest to prevent this incident from happening again on At that time staff was verbally educated and shown by Resident Care Coordinator on how to push resident in wheelchair. Also, this will be part of the topic on September 18, 2024, at 10:00 am and 2:30 pm on reviewing the assessment and support plans, the ocation of the assessment and support plans in the resident's chart, along with the importance of not pushing a resident too very hard and fast when transporting a resident in the wheelchair. This will be an ongoing education for staffing on how to properly transport residents in wheelchair to prevent this type of incident happening again.
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Corrective action occurred when Administrator spoke in private with employee involved on 5.15.24 to ensure the

42b - Abuse (continued)

employee understood that by pushing resident quickly was the major cause of resident falling out of [redacted] wheelchair and employee needs to give resident time to pick up [redacted] feet and stop periodically to ensure residents feet are up. Since this was a private conversation there was no sign in sheet for this meeting. Resident Care Coordinator also updated resident assessment and support plan on transporting resident in a wheelchair. Documentation to be provide on request on this update care plan.
Preventative action will occur on September 18, 2024, at 10:00 am and 2:30pm given by the Administrator and Resident Care Coordinator. Please see the agenda format that was followed in this meeting to ensure all nursing staff in attendance understand the importance of not pushing residents too fast, along with not making the resident feel rushed when doing any type of care, allowing time for resident to keep their feet up with periods of stopping if notice resident is putting down their legs, Location of residents assessment and support plans in a resident's chart and to contact Resident Care Coordinator if any change is needed to this assessment and support plan. Also, [redacted] who is part of Fox Rehab is having a meeting on October 2, 2024, at 2:30 pm to review transfers, transporting residents and review Hoyer lift technique. This type of in-service with Fox Rehab will be ongoing 4 times a year starting on October 2, 2024. Documentation of sign sheet and material reviewed will be available. All documentation of sign sheets with attached material to be kept in training folder in business office.

Licensee's Proposed Overall Completion Date: *10/03/2024*

Implemented ([redacted] - 11/04/2024)

183b - Meds and Syringes Locked

3. 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

There was a 4 ounce tube of [redacted] labeled for resident [redacted], unsecured, unattended and accessible, on the dresser in bedroom [redacted].

Plan of Correction ***Accept [redacted] - 09/20/2024)***

This violation occurred due to the med passer not taking the ointment out of the room after using the ointment during morning care. Immediately on [redacted] the Resident Care Coordinator removed the ointment from the room and placed it the proper secured area in the med room. To enhance the currently compliant operations, on [redacted] during the 10:00 am and 2:30 pm meeting, the administrator will educate all direct care staff that prescription treatments, medications are to be kept in a secured area in the med room that is locked. Staff will understand that no prescription medications, treatments will be kept in a resident's room with a completion date of 9.19.24. Effective on 9.19.24 all direct care staff will monitor each resident's room during AM and PM care for any prescription medications, OTC medications, CAM and syringes. Direct care staff will remove anything that should not be in the room and notify the supervisor for documentation, supervisor will notify the family as needed. Effective 7.21.24 the Resident Care Coordinator and the Administrator started to perform 5 weekly room inspections to maintain ongoing compliance with ensuring prescribing medications, OTC medications, CAM and syringes will keep in a secure locked area. This includes medications kept in a resident's room. Any items found will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Not sure how to correct this one I thought I had it all covered correctly the first time.

mmediate action was providing individual education to the staff person responsible for leaving the medication in

183b - Meds and Syringes Locked (continued)

the room on the day of inspection by Resident Care Coordinator on 7.12.24.
Corrective action will be having an education meeting with the nursing staff on September 18, 2024, at 10:00 am and 2:30 pm held by the Administrator and the Resident Care Coordinator to regarding 2600.183 b regarding 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. All direct staff members will be instructed to check residents' rooms during am and pm care.
Preventative action was that room audits started by the Administrator and the Resident Care Coordinator on 7.21.24 to do random 5 residents' room a weekly for 6 months and then 5 rooms randomly audited each month for 6 months by Administrator and Resident Care Coordinator. Include audits conducted. Immediate education will be provided for staff responsible if any medications are found in a room with documentation of all audits and training to be kept in the business office. Also, a reminder letter will be included in the Resident's invoice for the month of October reminding POA/families of mediations, OTC medications, etc. cannot be placed in residents' rooms unless their proper documentation and locked area for these medications.

Licensee's Proposed Overall Completion Date: *10/03/2024*

Implemented [redacted] - 11/04/2024)