



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: August 14, 2024

[REDACTED]
McCandless Square Senior Living LLC
[REDACTED]

RE: Ashton Commons Senior Living
551 Cooper Street
Wexford, Pennsylvania 15090
License #: 453540

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on February 27, 2024, February 28, 2024, and July 23, 2024, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *ASHTON COMMONS SENIOR LIVING* License #: *45354* License Expiration: *05/14/2024*
Address: *551 COOPER STREET, WEXFORD, PA 15090*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *MCCANDLESS SQUARE SENIOR LIVING LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *01/19/2022* Issued By: *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *97* Waking Staff: *73*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Provisional, Incident* Exit Conference Date: *02/28/2024*

Inspection Dates and Department Representative

02/27/2024 - On-Site: [REDACTED]
02/28/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *109* Residents Served: *68*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *16* Residents Served: *14*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *68*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *29* Have Physical Disability: *0*

Inspections / Reviews

02/27/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/15/2024*

04/30/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/06/2024

05/07/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 05/14/2024

08/12/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 2/27/2024 at 11:40 am, there was a hospice binder containing confidential information for resident #1, unlocked, unattended and accessible in the left top drawer of the desk at the first floor care base. The information included the resident's date of birth, diagnoses, medications, POLST form, ADL and IADL interventions and skilled nursing notes. There was also a prescription for resident #1's Brimonidine Tartrate-Timolol 0.2-0.5% solution 5 ml, instill one drop in both eyes twice a day for glaucoma.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

The pharmacy communication sheet that was in a closed drawer at the care based that was accessed by the surveyor was removed by the surveyor on 2/27/24. The hospice binder was secured behind a locked door at time of survey by the staffing coordinator on 2/27/24. All other care bases were assessed for any confidential information being left out and accessible on 2/27/24 by the staffing coordinator. An audit was implemented by the Wellness Director on 2/29/24 to assess that there is no confidential information being left accessible to those that do not have authority to access the information and that any such information is locked. Any issues of non-compliance during these audits was immediately addressed. The audit will continue weekly by the Wellness Director or designee through July 31, 2024. If issues of non-compliance continue, this audit will be continued until compliance is maintained. Executive Director began education to all staff on record confidentiality on 4/4/24. Staff education will be completed by 4/19/24. Documentation of the education shall be kept in accordance with 2600.65i. Executive Director, Wellness Director and designees will monitor for maintaining privacy of resident documents when rounding daily.

Licensee's Proposed Overall Completion Date: 05/08/2024

Implemented [REDACTED] - 07/24/2024)

25a - Written Contract and Review

2. Requirements

2600.

- 25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

The contract for resident #2, admitted [REDACTED]/2023, is not dated.

Plan of Correction

Accept [REDACTED] - 04/25/2024)

Resident #2's contract has been dated with date of move-in being [REDACTED]/23. All resident contracts will be audited by the Executive Director or designee to confirm that date resident assumed financial responsibility for the room is documented on the contract. Any contracts that do not indicate the financial move-in date will be updated with the date. This will be completed by 4/23/24. Executive Director or designee will review contracts for all new move-ins within 48 hours of move-in to ensure the contract includes the effective date of the contract through July 31, 2024.

25a - Written Contract and Review (continued)

Any issues identified will be immediately addressed. Executive Director provided education to the move-in coordinator on 2/29/24 of the importance of the contract including the date the resident assumed financial responsibility for the room. Documentation of the education shall be kept in accordance with 2600.65i

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] - 07/24/2024)

25b - Contract Signatures**3. Requirements**

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract for resident #9, dated [REDACTED] 022 is not signed by the resident.

Repeat Violation 7/20/2023 et al

Plan of Correction

Accept [REDACTED] - 04/25/2024)

Resident #9 moved in on [REDACTED] 22 and is unable to sign [REDACTED] name. [REDACTED] made an unlegible mark. This has been documented on the contract by the Executive Director and dated 3/6/24. . All resident current resident contracts will be audited and any missing signatures obtained by 4/23/24. All new resident contracts will be audited by the Executive Director or designee within 48 hours of move-in to confirm that the resident has signed the contract or the reason for not signing is documented on the contract. This audit will be begin on 4/15/25 and will continue through July 31, 2024. Documentation of these audits will be maintained. Executive Director provided education to the move-in coordinator on 2/29/24 that the resident must sign the contract and if the resident is unable to sign, the reason will be documented on the contract. Any new staff who act as administrator designee to assist with contract signing will be education during orientation of this requirement. Documentation of the education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] 07/24/2024)

25e - Contract Rescission**4. Requirements**

2600.

25.e. The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract and pay only for the services received. Rescission of the contract must be in writing addressed to the home.

Description of Violation

There is no notice in the following resident-home contracts indicating the resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract and pay only for the services received.

- * Resident #3, dated 6/1/2022
- * Resident #4, dated 10/14/2023
- * Resident #2, undated

25e - Contract Rescission (continued)

- * Resident #5, dated 2/27/2023
- * Resident #6, dated 7/6/2022

Plan of Correction**Accept** [REDACTED] - 04/25/2024)

Resident #3,4,2,5,6 have all been residents for longer than 72 hours. They have exceeded the 72 hour rescind requirement. An addendum to the resident-home contract was developed on 2/28/24 that informs the resident that [REDACTED] has the right to rescind the contract for up to 72 hours after the initial date and signature of the contract and pay only for the services received. All current residents at time of survey on 2/27/24 had already been a resident longer than 72 hours. All new residents since 2/27/24 have received and signed the rescind addendum. The addendum was added to our move-in document packet and move-in checklist for new residents on 2/28/24. The move-in coordinator was educated by the Executive Director of the 72 hour rescind agreement on 2/28/24. Any new designees that assist with contract signing will be educated on this addendum requirement by the Executive Director. Documentation of the education shall be kept in accordance with 2600.65i. The Executive Director will audit all move-in documents within 48 hours of move-in to ensure the rescinded agreement has been signed. These audits will continue through July 31, 2024. Documentation of these audits will maintained.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] - 07/24/2024)**82a - Poisonous Materials****5. Requirements**

2600.

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

Description of Violation

On 2/27/2023 at 12:00 PM, in the 3rd floor personal laundry cupboard, there was an unlabeled spray bottle with a green liquid and a blue liquid in a hand-labeled "laundry soap" in the cupboard of the third floor laundry room.

Plan of Correction**Accept** [REDACTED] 04/25/2024)

The unlabeled spray bottle with green/blue liquid that was hand labeled "laundry soap" was immediately disposed of on 2/27/24 by the housekeeping supervisor. All other laundry rooms were assessed for any unlabeled potentially poisonous materials by the housekeeping supervisor on 2/27/24. No other non-compliant bottles with found. Executive Director began education on 4/4/24 for all staff the poisonous materials should be stored in their original, labeled containers and that any poisonous materials that are not properly labeled should be disposed of immediately. This education will be complete by 4/23/24. Documentation of education shall be kept in accordance with 2600.65i. Housekeeping supervisor will audit laundry room three times a week to check that no poisonous materials that are not in their originally labeled container. Any issues identified will be immediately disposed of. Residents were informed of this requirement during the monthly Town Hall meeting that took place on 4/11/24 and are included in the town hall meeting minutes that are made available to residents who did not attend the town hall meeting by 4/23/24.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] - 07/24/2024)**84 - Heat Sources**

6. Requirements

2600.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from comin in contact with the heat source.

Description of Violation

On 2/28/2024 at 3:31 pm, the fireplace in the home's front living room was in use. During this time the metal frame around the fireplace measured in excess of 226 degrees.

Plan of Correction

Accept [redacted] - 04/25/2024)

The remote that controls the heat to the fire place in the lobby was removed by the maintenance director on 2/28/24. It will remain removed until a fire place screen can be secured to cover the metal frame. A fire place screen was ordered on 4/12/24 and will be installed when it arrives. There are no other fireplaces in the community.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented ([redacted] - 07/24/2024)

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 2/27/2023 at approximately 10:20 am, there were 3 uncovered trash cans in the kitchen as follows:

- * A large round can near the dishwasher which had a large hole cut out of the top.
- * 2 rectangular trash cans, one by the steam table and one by the griddle, had broken lids that were not able to be closed.

The trash cans were 1/4 to 1/2 full of trash.

On 2/27/2023 at approximately 10:58 am, there was an uncovered trash can in the server kitchen of the secured dementia care unit (SDCU). This can was full of trash.

Plan of Correction

Accept [redacted] - 04/30/2024)

New trash cans were purchased by the maintenance director on 2/27/24. Three were placed in the main kitchen and one was placed in the memory care unit. The trash cans without lids were disposed of on 2/27/24 by the maintenance director. The maintenance director assessed the community for any other areas that require trash cans with lids on 2/27/24. No other trash cans were found without lids that required them. Executive Director began educating staff on the garbage can lid requirement on 4/4/23 and will complete all education with staff by 4/23/24. Documentation of the education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented ([redacted] - 07/24/2024)

85e - Trash Outside Home

8. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

85e - Trash Outside Home (continued)

Description of Violation

The outside trash receptacles outside of the front entrance and west hallway entrance had openings on each side of the 4 panels allowing for the penetration of insects and rodents.

Plan of Correction

Accept [REDACTED] - 04/30/2024)

Executive Director purchased an outdoor trash can with a lid to replace the trash can at the front entrance and this was put in place on 3/6/24. The trash can without the lid was disposed of. Executive Director began educating staff on the garbage can lid requirement on 4/4/23 and will complete all education with staff by 4/23/24. Documentation of the education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] - 07/24/2024)

101j7 - Lighting/Operable Lamp

9. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 2/28/2024, resident #7 did not have access to a source of lighting that can be turned on/off at bedside.

Repeat Violation 7/20/2023 et al

Plan of Correction

Accept [REDACTED] - 05/07/2024)

Resident #7 was provided a light source beside bed on 2/28/24 by the maintenance director. All occupied resident rooms have been audited by the housekeeping supervisor. All occupied rooms have source of lighting beside bed. Maintenance director or designee will check all occupied rooms once per month to make sure there is an operable light source beside the bed. The audit will continue through July 31, 2024. Any issues identified will be immediately corrected. Documentation of these monthly checks will be maintained. Executive Director began education of all staff on the requirement for lighting beside and the remaining staff will be educated by 4/23/24. Documentation of education shall be kept in accordance with 2600.65i. Beginning 5/6/24, Direct care staff will monitor residents' rooms daily for functioning light beside bed and report any lack of lighting or burned out bulbs to maintenance timely.

Licensee's Proposed Overall Completion Date: 05/08/2024

Implemented [REDACTED] 07/24/2024)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

10. Requirements

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

On 2/27/2024, there were no grab bars, hand rails or assist bars at the 2 urinals in the first floor [REDACTED] common bathroom.

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)

Plan of Correction

Accepted [redacted] - 05/07/2024)

We do not believe we are in violation of this regulation. This public restroom has a toilet stall with grab bars and one of the two urinals is at ADA height. The regulatory compliance guide indicates that the home should determine the appropriate number of grab bars based on the needs of the residents served. However, grab bars were installed on 5/1/24.

Licensee's Proposed Overall Completion Date: 05/02/2024

Implemented [redacted] - 07/24/2024)

103f - Refrigerator/Freezer Temps

11. 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

There was no thermometer in the ice cream freezer in the server pantry on 2/27/2024 at 10:18 am.

Repeat Violation 7/20/2023 et al

Plan of Correction

Accepted [redacted] - 04/30/2024)

The culinary director located the thermometer for the ice cream freezer that had been removed for cleaning and placed in the freezer on 2/27/24. The culinary director re-educated the dining services staff on the requirement of have the thermometer in the refrigerators and freezers at all times on 2/28, 2/29, 3/1 and 3/2. Dining services staff is responsible for logging thermometer temperature in the refrigerators and freezers and ensuring there is a thermometer present daily. Any missing thermometers will be reported to the culinary director and corrected immediately. Culinary director or designee will audit that all kitchen refrigerators and freezers have thermometers once per week as part of routine kitchen auditing through July 31, 2024. Documentation of these audits will be maintained. Culinary director will complete this education with all culinary staff by 4/23/24. Documentation of this education will be maintained in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [redacted] - 07/24/2024)

103i - Outdated Food

12. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 2/27/2024 at approximately 10:35 am, the following open and undated items were found in the commercial freezer in the kitchen:

- * The bag inside of the box of a 72 count box of pretzel sticks, 1/2 full.
- * The bag inside of the box of chocolate danishes, 1/2 full.
- * The bag inside of the 10 lb. box of country fried chicken patties, 1/2 full.

103i - Outdated Food (continued)

Plan of Correction**Accept** [REDACTED] - 05/07/2024)

The pretzels, box of chocolates, and fried chicken patties that were not properly sealed were disposed of by the culinary director on 2/27/24. The culinary director educated the culinary staff of the requirement that food is properly sealed when open on 2/28,2/29, 3/1 and 3/2. Culinary director will ensure all culinary staff are educated on this requirement by 4/23/24. Documentation of this education will be maintained in accordance with 2600.65i. Culinary director or designee will audit that food is properly sealed daily. Any issues of non-compliance will be immediately addressed. Documentation of these audits will be maintained.

Licensee's Proposed Overall Completion Date: 05/08/2024

Implemented [REDACTED] - 07/24/2024)

105g - Lint Removal and Duct Cleaning

13. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 2/27/2024, at approximately 10:58 am, there was an accumulation of lint, approximately 1/8 inch in depth covering 3/4 of the lint trap of the dryer in the SDCU. There were no clothes in the dryer at the time.

Plan of Correction**Accept** [REDACTED] 05/07/2024)

All lint traps on all dryers were checked by the housekeeping supervisor on 2/27/24 and all lint traps were cleaned of any lint. Labels reminding staff and residents to clean the lint trap after use were placed on all dryers on 3/5/24. Housekeeping supervisor or designee will conduct lint trap audits three times per week to assess with compliance for cleaning traps. The audits will begin on 4/15/24 and will continue through October 31, 2024. Any issues identified during audits will be corrected. Documentation of these audits will be maintained.

Executive Director began educating the staff on the requirement to clean lint traps from dryers after every use on 4/4/24 will completed all education with staff by 4/23/24. Documentation of this education will be maintained in accordance with 2600.65i. Because some of the residents are independent with doing laundry, the Executive Director reminded residents of this requirement at the Town Hall resident's meeting on 4/4/24 and documented in the minutes that are posted for the residents by 4/23/24. Night time direct care staff will be responsible for monitoring lint traps daily.

Licensee's Proposed Overall Completion Date: 05/08/2024

Implemented [REDACTED] - 07/24/2024)

121a - Unobstructed Egress

14. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a - Unobstructed Egress (continued)

Description of Violation

On 2/27/2024 at 11:20 am, the second and fourth pews on the left blocked egress from the home's chapel to the outside patio.

Plan of Correction

Accept [redacted] - 04/30/2024)

The pews in the chapel that were blocking the exit doors were moved by the Executive Director on 2/27/24 so that there was unobstructed egress to the exit doors. Executive Director began educating all staff that pews cannot block the exit doors in the chapel on 4/4/24 and will complete this staff education by 4/23/23. Documentation of this education will be maintained in accordance with 2600.65i. Executive Director began monitoring that the chapel exit doors had unobstructed egress during rounds three times per week on 2/28/24. Compliance has been maintained with maintaining unobstructed egress. Documentation of these audits will be continued through July 30, 2024. Documentation of these audits will be maintained.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [redacted] - 07/24/2024)

123c - Evacuation Diagrams

15. Requirements

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The emergency evacuation diagram on the wall across from the chapel did not correctly indicate the line of travel from that location to an exit door.

Repeat Violation 7/20/2023 et al

Plan of Correction

Accept [redacted] - 04/30/2024)

Executive Director corrected the evacuation diagram on the wall across from the chapel to indicated the evacuation path on 2/29/24. The Executive Director reviewed and updated all evacuation diagrams in the building to ensure the line of travel for an evacuation were clearly indicated on the evacuation path on 3/5/24.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [redacted] - 07/24/2024)

132g - Fire Drills Days/Times

16. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The past six fire drills were routinely conducted at the end of the month between the 29th - 31st of each month as follows:

- * 8/30/2023 at 10:30 am
- * 9/30/2023 at 11:30 am

132g - Fire Drills Days/Times (continued)

- * 10/31/2023 at 4:00 pm
- * 11/29/2023 at 1:26 pm
- * 12/29/2023 at 1:36 am
- * 1/30/2023 at 5:24 pm

Repeat Violation 7/20/2023 et al

Plan of Correction

Accept [REDACTED] - 04/30/2024)

The fire drill for March was conducted on March 16, 2024, which was not the last week of the month. The Executive Director will ensure that fire drills are held on different days of the week, at different times of the day and night and different times of the month. The maintenance director was re-educated by the Executive Director of this requirement on 2/29/24. Documentation of this education shall be kept in accordance with 2600.65i. Executive Director will continue to monitor that the monthly fire drill is held on different days, different weeks and different time to ensure compliance with the regulation through October 30, 2024. Documentation of these audits will be maintained.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] - 07/24/2024)

133.1 - Exit Signs**17. Requirements**

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

On 2/27/2024, there were no exit signs over the 2 sets of French doors leading from the chapel to the outside patio.

On 2/27/2024 at 11:40 am, there was no "Not an Exit" sign on the door to the second floor balcony, that is not an egress from the building.

Plan of Correction

Accept [REDACTED] - 04/30/2024)

Exit signs were purchased by the Executive Director and placed beside the exit doors in the chapel by the maintenance director on 4/5/24. There is no requirement in 2600.133.1 that requires "this is not an exit" on the balcony doors on the upper floors according the regulation or regulatory compliance guide. We do not believe this should have been a deficiency. However, "not an exit" signs were purchased and placed beside all upper floor common balcony doors by the maintenance director on March 19, 2024.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [REDACTED] - 07/24/2024)

141b1 - Annual Medical Evaluation**18. Requirements**

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The medical evaluation for resident #6, dated [REDACTED]/2023, indicates "see attached" for the medications; however, no

141b1 - Annual Medical Evaluation (continued)

list is attached.

Plan of Correction

Accept [REDACTED] - 04/30/2024)

The medication list for Resident #6's is now attached to the DME. Wellness Director will review the most recent DME for all residents to ensure a medication list is included on or attached to the DME. This audit will be completed by 4/23/24. Any missing medication lists will be corrected. The Wellness Director will assess and verify that a completed medication list is on or attached to the DME when the DME indicates "see attached" for medications for all medical evaluations at time of move-in through July 31, 2024. Wellness Director has educated the move-in coordinator on this requirement on 2/29/24. Documentation of this education will be maintained in compliance with 2600.65i.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] - 07/24/2024)

224a - Preadmission Screen Form

19. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #4 was admitted to the home on [REDACTED]/2022; however, the resident's preadmission screening form was completed on 12/20/2022.

Repeat Violation 7/20/2023

Plan of Correction

Accept [REDACTED] - 05/07/2024)

Resident #4 was admitted on [REDACTED]/22. The preadmission screening cannot be corrected at this date. The staff responsible for completing the preadmission screening at that time are no longer employed and cannot be educated as a result. Wellness Director and Memory Care directed reviewed this requirement on 2/29/24. Wellness Director will monitor that all prescreens are completed within 30 days prior to move-in as part of the move-in checklist process for new-move-ins. Documentation of these audits will be maintained.

Licensee's Proposed Overall Completion Date: 05/08/2024

Implemented ([REDACTED]/24/2024)

225c - Additional Assessment

20. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

On 10/23/2023, a speech therapist ordered resident #4 to be provided a minced and moist (mechanical soft ground)

225c - Additional Assessment (continued)

diet and for the resident to be supervised by staff while eating in the dining room secondary to aspiration risk. It also indicates resident's food allergies. The resident's assessment, dated [REDACTED] 2023, was not updated to include the resident's needs for a special diet, supervision while eating or the resident's tomato allergy.

Repeat Violation 7/20/2023 et al

Plan of Correction

Accept [REDACTED] - 05/07/2024)

Resident #4's assessment was updated 2/28/24 to include the resident's need for a mechanical soft diet and need for supervision during meals, and food allergies Wellness director re-educated herself on this regulation on 2/29/24 . Executive Director completed an audit on all residents with special diets on 4/13/24 and any residents with special diet orders had their RASP updated on 4/15/24. Wellness Director or designee will review all new physician orders and update resident records timely as required.

Licensee's Proposed Overall Completion Date: 05/08/2024

Implemented [REDACTED] 07/24/2024)

227h - Support Plan Refuse Sign**21. Requirements**

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

The support plan, for resident #8, dated [REDACTED] 2023, is not signed by the resident, nor is there an indication of the resident's inability or refusal to sign the plan.

Plan of Correction

Accept [REDACTED] - 04/30/2024)

The support plan for resident #8 was signed by resident on 10/3/2023. Surveyor did not have the copy of the RASP with the resident's signature. This was compliant at time of survey. Wellness Director and Memory Care Director designee will audit all current support for resident's signature or reason for resident not signing is documented on the support plan. Resident signatures will be obtained on any support plans not signed by the resident or the reason for the resident not signing will be documented. This audit will be completed by 4/23/24. The current Wellness Director and Memory Care director reviewed the requirement of the resident to sign the support plan or document the reason the resident did not sign. Documentation of this review will be maintained. Wellness Director and Memory Care Director will do a weekly review of all support plans completed that week to ensure that resident has signed the support plan or that it has been documented on the support plan when the resident did not sign. These audits will continue through July 31, 2024. Documentation of these audits will be maintained.

Licensee's Proposed Overall Completion Date: 04/23/2024

Implemented [REDACTED] /24/2024)

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

Facility Information

Name: *ASHTON COMMONS SENIOR LIVING* License #: *45354* License Expiration: *05/14/2024*
Address: *551 COOPER STREET, WEXFORD, PA 15090*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED]

Name: *MCCANDLESS SQUARE SENIOR LIVING LLC*

Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *01/19/2022* Issued By: *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *106* Waking Staff: *80*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Interim* Exit Conference Date: *07/23/2024*

Inspection Dates and Department Representative

07/23/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *109* Residents Served: *78*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *16* Residents Served: *15*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *78*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *28* Have Physical Disability: *1*

Inspections / Reviews

07/23/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *Exception*

NO DEFICIENCIES FOUND