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

November 8, 2024

[redacted] OWNER/ADMINISTRATOR
TRINITY OAKS INC
117 SHADY REST ROAD
ELLWOOD CITY, PA, 16117

RE: TRINITY OAKS II
117 SHADY REST ROAD
ELLWOOD CITY, PA, 16117
LICENSE/COC#: 45857

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/24/2024 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: *TRINITY OAKS II* **License #**: *45857* **License Expiration**: *11/26/2024*

Address: *117 SHADY REST ROAD, ELLWOOD CITY, PA 16117*

County: *BEAVER* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *TRINITY OAKS INC*

Address: *117 SHADY REST ROAD, ELLWOOD CITY, PA, 16117*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/19/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/24/2024*

Inspection Dates and Department Representative

07/24/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served**: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *22*

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

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

07/24/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/19/2024*

09/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/09/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/09/2024*

Inspections / Reviews *(continued)*

11/08/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/09/2024*

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

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Staff person A does not have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry. Staff person A provides unsupervised direct care to residents.

Plan of Correction ***Accept (- 09/18/2024)***

• On the employee was removed from resident care and inserted into our cleaning staff by our administrative team for lack of credentials.
• The employee and administration signed document stating the reason for being removed from resident care duties.
• Administration has reviewed and updated our hiring policies. When a prospective employee is interviewed we will require proof the GED before proceeding with the hiring process instead of hiring and allowing the prospective employee to provide the documents at a later date. This policy went into effect on 8/09/2024 and will be enforced by our administrator.

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented - 11/08/2024)

93a - Handrails

2. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

There was no handrail at the outdoor step at the laundry room or at the outdoor step by bedroom #7.

Plan of Correction ***Accept - 09/18/2024)***

• New handrails were installed on 7/26/2024 by our maintenance staff.
• Maintenance staff will check each exit monthly to make sure the handrails are in proper working condition. The first inspection of the handrails was done on 7/26/2024 no other exits needed attention at that time.
• All staff was verbally educated by our administrator on 8/12/2024 on the regulation 2600.93. We task every employee with making sure our residents are provided safe environments.
George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented - 11/08/2024)

103f - Refrigerator/Freezer Temps

3. 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

At 3:55 PM, the reach-in refrigerator in the kitchen was 52 degrees Fahrenheit, and at 3:57 PM the Frigidaire refrigerator in the pantry was 42 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 09/18/2024)***

• The fridges temperature dials were adjusted and new thermometers were installed on 7/26/2024 by our maintenance staff.
• After reviewing our fridge/freezer temperature policies we have made changes. Our new policy which went into effect on 8/12/2024 is that Kitchen staff will check the temperatures and record them on a log daily. Temperatures will be check once at begin of their shift at 7am, once at shift change at 10am and once at the end of evening at 7pm.
• All staff was verbally educated by our administrator on 8/12/2024 on our policy changes.

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented [redacted] - 11/08/2024)

125b - Combustible Restrictions

4. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

A can of Suave hairspray, which is flammable, was located on the counter in the beauty shop. The door was unlocked, and the hairspray was left unattended.

Plan of Correction ***Accept [redacted] - 09/18/2024)***

• On 7/24/2024 the hair spray was removed from its open location and locked in our cabinet this was done by our administrative assistant.
• All staff were verbally educated on 2600.125a and 2600.125b on 8/12/2024 by our administrator.
• We have also revisited our policy on combustible materials and poisonous materials and have instated a daily shift check of the building for any prohibited materials. The staff supervisor on each shift is now responsible for checking off the log that everything has been put away properly. This policy went into effect on 8/12/2024 and will be audited monthly by our Administrative to make sure logs are being done properly.

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented [redacted] - 11/08/2024)

132a - Monthly Fire Drill

5. Requirements

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

Description of Violation

The home did not conduct a fire drill in June 2024.

Plan of Correction ***Accept (- 09/18/2024)***

• Our administrator went back and corrected the logs to reflect the drill we did have in June this was done on 7/26/2024. Our administrator added a subtext to explain the error in the log.
• We also had a fire drill on 7/26/2024 done by our administrator.
• A meeting was held on 7/26/2024 with our administrative team and we decided that to prevent this from happening our policy on logging fire drills would need tweaked. Previously this was a sole Administrator task. Now however the assistant administer will now check the logs monthly as a double check system. This policy change went into effect on 7/26/2024.
George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented - 11/08/2024)

184a - Resident's Meds Labeled

6. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is prescribed – 1 tablet every 8 hours as needed for However, the label on resident #1's indicates the resident can receive it every 6 hours as needed.

Resident #2 is prescribed – 1 tablet daily. However, the label on resident #2's indicates takes twice a day.

REPEAT VIOLATION: 8/14/2023

Plan of Correction ***Accept (- 09/18/2024)***

• Our medication supervisor contacted our residents' doctors on 7/24/2024 and had the correct orders sent to us we received those orders on 07/25/24. then contacted our pharmacy who delivered the corrected labels on 7/26/2024.
• As an administration team we met on 8/09/2024 to revise our medication policies when a resident goes to the doctor and has a change. We decided that our send all medications back to the pharmacy when a change has occurred is the best route to go however we needed someone to more strictly enforce these rules. Therefore, we have inserted a medication auditor to catch these mistakes and send them back if another staff person hasn't.
• Our administrator had a meeting with all medication trained staff on 8/13/2024 to re-educate them in the proper policies and our decision to hire a person that weekly audits all medications. The auditor was hired on 08/15/2024 and will start auditing weekly on the 08/19/2024.

184a - Resident's Meds Labeled (continued)

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented (- 11/08/2024)

185a - Implement Storage Procedures

7. 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 #3 is prescribed blood glucose checks four times a day. Staff recorded resident #3's blood glucose incorrectly on the following dates and times:

Date and Time	*Glucometer Reading*	*Medication Administration Record*
[redacted]	[redacted]	[redacted]

Plan of Correction ***Accept (- 09/18/2024)***

• On 8/09/2024 the administrative team sat down to discuss where the disconnect between our glucometers and logs came from. The choice was made to do a re-eduction of medication/diabetic trained staff on 8/13/2024. Also, we decided to insert an audit process by hiring a medication auditor on 8/15/2024. This auditor works weekly going through our medications and records making sure it everything is regulatory compliant. Their first weekly check will start on the week of 08/19/2024.
• On 8/13/2024 we held a meeting with all medication trained staff led by our administrator and medication supervisor to make sure all procedures were met and discuss the importance of proper logging of blood sugars. We also introduced the staff to our idea of bringing in someone whose sole job was to-do a weekly audit of our medication room.

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented - 11/08/2024)

187a - Medication Record

8. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
11. Special precautions, if applicable.

Description of Violation

Resident #3 is prescribed in accordance with a sliding scale, not to exceed units daily. However, resident #3's medication administration record (MAR) does not indicate the resident should not receive more than units daily.

187a - Medication Record (continued)

REPEAT VIOLATION: 8/14/2023

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

• Our medication supervisor contacted our pharmacy on 7/25/2024 and had a corrected MAR sheet delivered to us on 7/26/2024.
• On 8/12/2024 our administrative team sat down to discuss why this has been a repeat issue for us. Our weekly checks did not catch this error. Therefore, it was decided that we hire a staff person to audit our medications and all logs associated with our medications weekly. Part of our auditors tasks are to check all incoming MAR sheets monthly against all medications.
• On 8/15/2024 we hired a medication auditor that works weekly going through our medication logs making sure we are compliant. This employee's first week auditing will be 08/19/2024 and doing monthly MAR checks.

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented [redacted] - 11/08/2024)

225a - Assessment 15 Days

9. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #2 was admitted to the home on [redacted]. However, her initial assessment was not completed until [redacted]
.
Resident #4 uses a bedside mobility device to reposition while in bed. However, resident #4's support plan dated [redacted] does not document the specific need for the device, the intended use and any risks associated with the use of this device, the resident's ability to use the device safely for the purpose it was intended, or the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

• On [redacted] our administrative assistant updated the support plan of resident #2. A reeducation of our administrative assistant was done verbally on [redacted] by our administrator explaining how dating should properly be done.
• On 8/12/2024 our administrative team held a meeting. We revised our assessment policies and decided that instead of our administrative assistant filing all assessment documents without a second check. That now two members of our administrative must check them before they are filed. We will denote this double check by having both administrative team members sign the documents. This policy change went into effect on 08/12/2024 and will be carried out by our administrative team.
• We were unaware of the changes in regulations for bedside mobility devices. Therefore on 8/12/2024 we updated our procedures on bedside mobility devices to include the new parameters. Our administrative assistant went through to any resident who currently uses a bedside mobility device and updated all assessments to reflect the

225a - Assessment 15 Days (continued)

change in policy this was done on 08/12/2024. Likewise, 08/12/2024 our administrator led staff meeting discussed bedside mobility devices and their current regulations.

George Knox 08/18/2024

Licensee's Proposed Overall Completion Date: *08/18/2024*

Implemented ([redacted] - 11/08/2024)