

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

September 4, 2024

[REDACTED], DIRECTOR CLINICAL SERVICES
MON-YOUGH COMMUNITY SERVICES INC
[REDACTED]
[REDACTED]

RE: UPMC WESTERN BEHAVIORAL
HEALTH AT MON YOUGH
624 LYSLE BLVD.
MCKEESPORT, PA, 15132
LICENSE/COC#: 43003

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/06/2024 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: UPMC WESTERN BEHAVIORAL HEALTH AT MON YOUGH License #: 43003 License Expiration: 09/18/2024

Address: 624 LYSLE BLVD., MCKEESPORT, PA 15132

County: ALLEGHENY Region: WESTERN

Administrator

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

Legal Entity

Name: MON-YOUGH COMMUNITY SERVICES INC

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 03/28/2001 Issued By: L&I

Type: I-2 Date: 06/25/1999 Issued By: City of McKeesport

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 24 Waking Staff: 18

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:

Reason: Renewal Exit Conference Date: 08/06/2024

Inspection Dates and Department Representative

08/06/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 27 Residents Served: 24

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 24 Are 60 Years of Age or Older: 13

Diagnosed with Mental Illness: 24 Diagnosed with Intellectual Disability: 8

Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

08/06/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/23/2024

Inspections / Reviews (*continued*)

08/21/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/27/2024

09/03/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/04/2024

09/04/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [REDACTED] did not receive orientation on the topics specified in 2600.65a until [REDACTED] and [REDACTED]

Plan of Correction

Accept ([REDACTED] - 09/03/2024)

An audit was conducted on 8/6/24. Supervisors reviewed regulation 65.a. on 8/7/24, training sheet enclosed. Supervisors reviewed and made changes to the new hire check list that is completed for each staff member that is hired. The items listed in 65.a. have been added into a section that is to be completed within the first day of hire. The homes monitoring steps to ensure all new hires receive all required training items on the first day of hire is to use the training sheet/check list. Supervisors print a new check list for each new hire before or on their date of hire and utilize this checklist to ensure all trainings are completed in a timely manner. Check list was changed to reflect which trainings are required within the first day of hire. See check list. Checklist was implemented on 8/7/24. Supervisors will keep a check list for each new hire and follow the check list. The homes next QM meeting will be conducted on 9/4/24.

Licensee's Proposed Overall Completion Date: 09/04/2024

Implemented ([REDACTED] - 09/04/2024)

85d - Trash Receptacles

2. 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

At approximately 10:00am, no lid was present on the trash can in the private bathroom of bedroom #12. At the time of inspection, the uncovered trash can was approximately 1/4 full of trash.

Plan of Correction

Accept ([REDACTED] - 09/03/2024)

An audit was conducted 8/6/24. A trash can without a lid was found in the bathroom of room 12 on the second floor. It was replaced immediately (picture attached). 15 more trash cans were purchased (receipt enclosed) and all other rooms were checked and a new can was given when needed. Staff were reeducated on regulation 85.d. on 8/7/24, training sheet enclosed. Weekly primary room checks, to be conducted by direct care staff, weekly, includes

85d - Trash Receptacles (continued)

checking all resident bedrooms for a trash can with a lid implemented on 8/7/24. Form enclosed. Monthly supervisor site check, to be conducted by either the supervisor or assistant supervisor implemented on 8/7/24, specifies to check all resident bathrooms/bedrooms for trash cans with a lid. Homes next QM meeting to be conducted on 9/4/24.

Licensee's Proposed Overall Completion Date: 09/04/2024

Implemented (█) - 09/04/2024)

102f - Towel/Washcloth/Soap**3. Requirements**

2600.

102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

At approximately 12:00pm, there were no towels present in resident #1's private bathroom.

Plan of Correction

Accept (█) - 09/03/2024)

An audit was conducted 8/6/24. The bathroom of room █ on the second floor was found to not contain towels. They were immediately found in the residents bedroom and placed in the private bathroom within the room (picture attached). Staff were reeducated on regulation 102.f. on 8/7/24, training sheet enclosed. Weekly primary room checks for all residents, to be conducted by direct care staff, weekly, includes checking for towels in the bathroom. New form implemented on 8/7/24. Form enclosed. Monthly supervisor site check implemented on 8/7/24, to be conducted by either the supervisor or assistant supervisor, specifies to check all resident bathrooms for towels. The homes next QM meeting will be conducted on 9/4/24.

Licensee's Proposed Overall Completion Date: 09/04/2024

Implemented (█) - 09/04/2024)

144c2 - Smoking Area Distance**4. Requirements**

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

At approximately 10:00am, 5 chairs, each containing 2 cushions, were present in the 2nd floor designated outdoor smoking area; however, none of the cushions included tags indicating they meet California fire standards.

Plan of Correction

Accept (█) - 09/03/2024)

An audit was conducted on 8/6/24. Cushions on a smoking patio were found to be non fire retardant, they were thrown out immediately, picture enclosed. Staff were reeducated on regulation 144.c on 8/7/24. which includes the smoking policy. Training sheet enclosed. The shiftly cleaning list, which is conducted by direct care staff, now includes to check smoking patios for any flammable materials and if found to remove immediately (form enclosed), implemented on 8/7/24. Monthly supervisor check list, to be conducted by either the assistant supervisor or

144c2 - Smoking Area Distance (continued)

supervisor implemented on 8/7/24, specifies to check the smoking patios for flammable materials and to remove immediately if found (form enclosed). UPMC MH Residential Smoking Policy was updated on 8/7/24 to include only fire resistant furniture can be used in the smoking areas (form enclosed). The homes next QM meeting will be conducted on 9/4/24.

Licensee's Proposed Overall Completion Date: 09/04/2024

Implemented (█) - 09/04/2024

187a - Medication Record**5. Requirements**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

8. Frequency of administration.

Description of Violation

Resident #1 is prescribed Acetaminophen Extra Strength 500mg tablets-Take 2 tablets by mouth every 6 hours as needed; however, resident #1's August 2024 medication administration record (MAR) indicates Acetaminophen Extra Strength 500mg tablets-Take 2 tablets by mouth every 8 hours as needed.

Plan of Correction

Accept (█) - 09/03/2024

An audit was conducted on 8/6/24. Resident 1's PRN page was immediately corrected as well as the electronic MAR (forms enclosed). Staff were reeducated on regulation 187.a. on 8/7/24 (form enclosed). Medication documentation checklist was updated to include checking that the pharmacy label matches the MAR (form enclosed). Medication documentation checklist is a form that includes the steps followed when implementing or discontinuing a medication to ensure it is documented appropriately on all forms It is used each time a new medication is added to a resident's medication regime or when one is discontinued. Direct care staff and supervisors both use this form. MH Residential Nurse is to conduct monthly checks on the medication cart to ensure compliance. Each check will include looking for expired medication, matching the pharmacy labels against the MAR, and any other concerns IE: ensuring all medication is present and labels can be read etc. Monthly cart check form is enclosed and was implemented on 8/7/24. Homes next QM meeting is to be conducted on 9/4/24.

Licensee's Proposed Overall Completion Date: 09/04/2024

Implemented (█) - 09/04/2024