pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION**
LEGAL ENTITY

To operate **REFORMED PRESBYTERIAN HOME**
NAME OF FACILITY OR AGENCY

Located at **2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **56**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 4, 2025** until **September 4, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **429662**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 4, 2025

[redacted], Administrator
Reformed Presbyterian Women's Association
2344 Perrysville Avenue
Pittsburgh, Pennsylvania 15214

RE: Reformed Presbyterian Home
License/COC #: 429662

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 22, 2024, and November 7, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from March 4, 2025 to September 4, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
225(c)	II	29	$5	$145	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *REFORMED PRESBYTERIAN HOME* **License #:** *42966* **License Expiration:** *10/23/2024*

Address: *2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214*

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

Administrator

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

Legal Entity

Name: *REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION*

Address: *2344 PERRYSVILLE AVENUE, PITTSBURGH, PA, 15214*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/10/1983* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *35* **Waking Staff:** *26*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date:** *08/22/2024*

Inspection Dates and Department Representative

08/22/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served:** *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *26*

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

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

08/22/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/21/2024*

Inspections / Reviews *(continued)*

09/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/25/2024*

09/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/27/2024*

01/22/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The following license inspection summaries were not posted in a conspicuous and public place in the home:

- *License inspection summary, dated 6/14/24*
- *License inspection summary, dated 5/2/24*
- *License inspection summary, dated 3/27/24*
- *License inspection summary, dated 2/12/24*
- *License inspection summary, dated 11/4/23, et. al.*

Plan of Correction ***Directed (- 09/23/2024)***

1. Policy (attached) Reviewed for Survey Posting according to regulation on 8/27/24. Reviewed by Administrator, Executive Director and Assistant Administrator. Forwarded to QAPI Committee meeting on 10/22/2024. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).
2. License summaries were posted near the bulletin board on the community on 9/19/24 Residents will be made aware of the location via Resident Council.
3. Personal Care Administrator and Assistant Administrator (Personal Care Administrator Back-up) will be re-educated by the Executive Director to regulation and policy. Education Provided on 9/19/24.
4. Monthly Environmental observations will be completed beginning September to ensure compliance and reported to QAPI Committee 10/22/24. (DIRECTED: Beginning on 9/30/24: The administrator/designee shall inspect the home monthly to ensure all items specified in 2600.3c are posted in a public and conspicuous place in the home. 9/23/24). Audits to be completed by Administrator/designee.

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Implemented (- 01/22/2025)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person A, hired on did not receive orientation on the following topics:

- *Emergency medical plan*
- *Reporting of reportable incidents and conditions*

REPEAT VIOLATION: 2/12/2024; 11/14/2023, et. al.

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction ***Directed (- 09/23/2024)***

1. Employee A will have complete training by September 30th, 2024, as provided by Administrator/designee. Proof of training on file with HR. (DIRECTED: By 9/30/24: Staff person A shall receive training on all topics specified in 2600.65b. Documentation of the education shall be kept in accordance with 2600.65i. 9/23/24).
2. Audit of all current employees hired in last 3 months be completed to ensure compliance with training requirements. Audit to be completed by Administrator/designee and completed by Oct 1st 2024.
3. Monthly audits of new hires to ensure compliance with onboarding educations. Audits to begin in September and to be completed by Administrator. (DIRECTED: The monthly audits conducted by the administrator shall begin on 9/30/24 and conducted monthly thereafter for all staff persons hired in the previous month. 9/23/24). Audits to be forwarded to QAPI Committee next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).
4. Re-education regarding onboarding to be provided to Administrator, Assistant Administrator, HR Coordinator. Education to be provided by Executive director and signature on file with NHA. Education to be completed by 9/20/24 (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/23/24)
5. New Hire checklist will be reviewed and updated to utilize with new hire onboarding. Checklist to be initiated September 30th. (DIRECTED: By 9/30/24: All staff persons involved in the hiring process shall be educated on the new hire checklist by the administrator. Documentation of the staff education shall be kept in accordance with 2600.65i. 9/23/24).

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented (- 01/22/2025)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B, hired on did not receive training on the following topics during the 2023 training year:

- *Medication self-administration*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan*
- *Personal care service needs of the residents*
- *Care for residents with mental illness or intellectual disability. The home currently serves 3 residents with a*

65f - Training Topics (continued)

diagnosis of mental illness and 1 resident with a diagnosis of an intellectual disability

Direct care staff person C, hired on [redacted] did not receive training on the following topics during the 2023 training year:

- *Medication self-administration*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan*
- *Personal care service needs of the residents*
- *Care for residents with mental illness or intellectual disability. The home currently serves 3 residents with a diagnosis of mental illness and 1 resident with a diagnosis of an intellectual disability*

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

1. Direct Care Staff Person B is terminated at this time. Education cannot be completed.
2. Direct Care Staff Person C completed re-training prior to 9/19/24 on areas outlined in the citation. Proof of education to be on file with Administrator. (DIRECTED: Documentation of staff person C's training shall be kept in accordance with 2600.65i. [redacted] 9/23/24). Education provided by med Tech Training and Administrator
3. Audit of all Direct Care Staff for compliance with Annual Training Needs as completed by Administrator and to initiated in September.
4. Review and updated of Facility policy related to training and education completed on 9/4/2024
5. Monthly audit of employee files for compliance with training requirements to be completed by Administrator. (DIRECTED: Beginning on 9/30/24: The administrator/designee shall review all training documents and the home's staff training plan monthly to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. [redacted] 9/23/24). Results to be reported to QAPI Committee 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. [redacted] 9/23/24).
6. Re-education provided to Administrator, Assistant Administrator, Nurse Manager and HR Coordinator on 9/20/24 as provided by Executive Director. Signatures on file with ED.

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented ([redacted] - 01/22/2025)

82c - Locking Poisonous Materials

4. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At 10:25 AM, numerous poisonous materials with manufacturers' labels indicating, "If swallowed, get medical help or contact poison control center", were unlocked, unattended and accessible in a lower cabinet in the 2nd floor kitchenette, to include the following:

- *A 17 oz. can of Ecolab Stainless steel Cleaner & Polish*

82c - Locking Poisonous Materials (continued)

- *A 32 oz. spray bottle of Rapid Multi Surface Disinfectant*

Not all residents of the home have been assessed capable of recognizing and using poisons safely, to include resident #1.

Plan of Correction ***Directed (- 09/23/2024)***

1. Items removed from 2nd floor kitchenette at the time of discovery.
2. Re-education to requirement to be provided to all staff to be completed on 10/1/24. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/23/24). Signatures to be on file with Administrator. Education provided by Executive Director
3. Enironmental rounds to be completed by the Administrator/designee weekly to monitor for compliance. Rounds to initiate the week of September 23rd. Audit results to be communicated to the QAPI Committee on 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Implemented (- 01/22/2025)

101j7 - Lighting/Operable Lamp

5. 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

At 10:45 AM, resident #3's lamp was approximately 2' away from resident #3's bed and could not be turned on/off at bedside.

At 11:09 AM, no lamp or other source of lighting was present at resident #4's bedside.

REPEAT VIOLATION: 11/14/2023, et. al.

Plan of Correction ***Directed (- 09/23/2024)***

1. Resident #3 will have lamp within reach when in bed completed 9/10/24
2. Resident #4 will be provided a lamp at the location of bed 9/10/24.
3. Every resident room will be monitored for presence of lamp within reach, per regulation to be completed by 9/27/24 and completed by Administrator/designee.
4. Environmental Services and Direct Care staff to be education to requirement as provided by Executive Director and completed by 9/30/24. (DIRECTED: Documentation of the staff education shall be kept in accordance with

101j7 - Lighting/Operable Lamp (continued)

2600.65i. [redacted] 9/23/24). Signatures on file with Administrator.
5. Environmental rounds will be completed weekly (min 7 resident rooms) to monitor for lamp placement and regulation. (DIRECTED: The weekly audits of at least 7 resident bedrooms shall begin on 9/30/24. [redacted] 9/23/24). Audits to be completed by Administrator/designee. Results to be communicated to QAPI Committee 10/22/2024. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. [redacted] 9/23/24).

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented ([redacted] - 01/22/2025)

103f - Refrigerator/Freezer Temps

6. 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 11:30 AM, the temperature in the 3rd floor main kitchen walk-in freezer was 8 degrees Fahrenheit, and at 3:07 PM, it was 9 degrees Fahrenheit.

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

1. Freezer inspected and repaired on 9/19/24 to ensure correct temperature. Documents outlining work completed on file with Administrator. Food did not need to be discarded as all items were completely frozen.
2. Re-education to dining service managers by 9/24/24 by Executive Director. Signature on file as proof of re-education with Administrator.
3. Daily temperature checks began on 9/19/24 by Dining services and reported to QAPI Committee 10/22/2024 (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. [redacted] 9/23/24).
4. Dining services obtained temperature of all freezers and refrigerators which serve personal care on 9/19/24 and initiated daily temperature checks. (DIRECTED: Documentation of daily refrigerator and freezer temperatures shall be kept for each refrigerator and freezer. [redacted] 9/23/24).

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Implemented ([redacted] - 01/22/2025)

103g - Storing Food

7. Requirements

103g - Storing Food *(continued)*

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

Description of Violation

At 10:19 AM, there were 8 uncovered bowls of pears present on a serving tray in the 2nd floor kitchen cooler.

Plan of Correction ***Directed (- 09/23/2024)***

1. Dining Services and Direct Care workers to be re-educated by the Executive Director to requirement of food storage by 10/1/2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/23/24). Signatures on file with Administrator.
2. Weekly Audits (observing food storage and protection during meals) to be completed by Administrator/designee to monitor for compliance of food storage. (DIRECTED: The weekly administrator audits shall begin on 9/30/24 and include a weekly review of all food storage areas to ensure compliance with 2600.103g. 9/23/24). Audit results to provide to QAPI Committee 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).
3. The pears were discarded at the time of discovery on 8/22/2024. In addition, any other items discovered were removed.

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Implemented (- 01/22/2025)

105g - Lint Removal and Duct Cleaning

8. 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

At 11:06 AM, there was an accumulation of lint covering the floor, the ductwork and the wall behind the washer and dryer in the 2nd floor laundry room.

Plan of Correction ***Directed (- 09/23/2024)***

1. Lint and dirt removed upon discovery. Work order on file outlining completion of work.
2. Environmental Services will be initiated workorder to schedule cleaning of ductwork, wall and floor on a monthly basis beginning September 19, 2024 (work order attached). Works orders scheduled in computer system and on file for review.
3. Monthly environmental rounds completed by Administrator/designee to initiate in September to monitor for compliance with lint removal and duct cleaning. (DIRECTED: The monthly audits shall begin on 9/30/24. 9/23/24). Audit results to be provided to QAPI Committee 10/22/2024. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).

105g - Lint Removal and Duct Cleaning (continued)

4. All staff will be re-educated to need to keep area free of lint and dirt. Education to be completed by Executive Director by 10/1/2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/23/24).

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Implemented ([redacted] - 01/22/2025)

121a - Unobstructed Egress

9. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 11:00 AM, the emergency exit door near bedroom #226 which leads to Federal Street could not be opened by agents of the Department or by the home's Maintenance Director.

At 11:25 AM, the emergency exit door in the 3rd floor main kitchen required excessive force by agents of the Department to open.

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

1. a) Federal Street Exit/Cozy Cafe door was repaired 8/23/2024 by facility services staff. The doorframe was sanded to remove the rust. Wd40 was applied to hinges and the push bar.

b) Exit door in dining services was repaired by Facility Services by 9/1/24 and was corrected by applying WD40 to hinges, sanded the door and frame down to remove debris causing the sticking.

2. Enviornmental Services, Direct Staff and Dining Services will be re-educated to citation and requirement by Executive Director by 10/1/2024. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/23/24). Signature of education on file with Administrator.

3. All exit egress doors were audited for functioning by environmental services on 08/30/2024. Results to be reported to QAPI Committee on 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. [redacted] 9/23/24).

4. Policy and Procedure reviewed and approved by Administrator, ED and Facility Services Director on 9/4/2024

DIRECTED: Beginning on 9/30/24: Maintenance staff/designee shall inspect the home weekly to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. [redacted] 9/23/24.

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented ([redacted] - 01/22/2025)

132c - Fire Drill Records

10. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 7/30/24 at 4:09 PM does not include the exit routes used.

The fire drill record for the fire drill conducted on 3/28/24 at 3:15 PM does not include exit routes used.

REPEAT VIOLATION: 2/12/2024

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

1. Environmental Services Director and staff who conduct fire drills, will be re-educated to the regulation, documentation requirements. by 9/25/24 by Executive Director. Signature as proof of education on file with Administrator. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/23/24).
2. Fire Drill documentation will be provided to QAPI Committee monthly for review. Next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. [redacted] 9/23/24). This will initiate with August's Fire Drill Documentation

DIRECTED: Beginning on 9/30/24: The administrator shall review all fire drill records monthly to ensure accurate and complete documentation is present in accordance with 2600.132c. [redacted] 9/23/24

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented ([redacted] - 01/22/2025)

132h - Designated Meeting Place

11. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

According to the home's fire drill records, all residents were not evacuated to a designated meeting place or within a fire-safe area during numerous fire drills, to include the following:

- *During the fire drill held on 7/30/24 at 4:09 PM, 29 residents were present in the home; however, no residents were evacuated*
- *During the fire drill held on 5/30/24 at 6:23 AM, 30 residents were present in the home; however, only 11 residents were evacuated*
- *During the fire drill held on 4/24/24 at 1:24 PM, 31 residents were present in the home; however, only 18 residents were evacuated*

132h - Designated Meeting Place (continued)

- *During the fire drill held on 3/28/24 at 3:15 PM, 28 residents were present in the home; however, no residents were evacuated*

Plan of Correction ***Directed (- 09/23/2024)***

1. Re-education regarding designated meeting to be provided to environmental services, direct care and staff and administrator to be completed by 10/1/24 education to be provided by Executive Director. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/23/24). Proof of education on file with Administrator.
2. Fire Drill documentation will be provided to QAPI Committee monthly for review. Next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24). This will initiate with August's Fire Drill Documentation
3. Monthly Audit of Fire Drill Records to be completed by Administrator/Designee. Starting with September (DIRECTED: By 9/30/24: The administrator shall review all fire drill records monthly to ensure all residents evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill. 9/23/24).

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented (- 01/22/2025)

162c - Menus Posted

12. 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

At 10:33 AM, the only menu posted in a conspicuous and public place in the home ended on 8/24/24.

Plan of Correction ***Directed (- 09/23/2024)***

1. Dining service director and supervisor provided re-education to requirements for posting menus 9/19/24 by Executive Director. Signatures on file with Administrator.
2. Weekly environmental rounds (to initiated week of 9/23/24) will be completed by Administrator/Designee to ensure menus are posted as outlined in the regulation. Administrator to conduct these monthly observations beginning in September and forward results to QAPI Committee next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).
3. Menus posted on 9/19/24 in secure cabinet and residents re-educated to location during Resident Council Meeting.

162c - Menus Posted (continued)

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Implemented (- 01/22/2025)

191 - Resident Right to Refuse

13. 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

Residents #1 has not been educated on their right to question or refuse medication if they believe there may be a medication error. Resident #1 was admitted to the home on

Resident #5 has not been educated on their right to question or refuse medication if they believe there may be a medication error. Resident #5 was admitted to the home on

REPEAT VIOLATION: 11/14/2023, et. al.

Plan of Correction ***Directed (- 09/23/2024)***

1. Resident #1 to be provided resident rights document and re-educated to right to refuse medication. Document and review to be provided Social Services/Activity Director by 9/25/24 (DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall ensure the documentation that resident #1 was educated on their right to refuse or question a medication if they believe there to be an error is present in resident #1's record. 9/23/24). Signature and document on file with Administrator.
2. Resident #5 provided resident rights document and re-educated to rights to refuse medication. Document and review to be provided Social Services/Activity Director by 9/25/25 Document on file with Administrator (DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall ensure the documentation that resident #5 was educated on their right to refuse or question a medication if they believe there to be an error is present in resident #5's record. 9/23/24).
3. Every Resident currently admitted will be provided education/document on resident rights including to right to refuse medication by 10/27/24. Education to be provided by Social Services/Activity Director. Completed forms will be filed with resident file and on file with Administrator.
4. Resident contracts updated on 9/19/24 to include Right to Refuse. Administrator will audit contract files to ensure compliance. Audit results on file with Administrator and shared with QAPI Commitee at next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).
5. A new admission checklist will be created by 10/1/24 by the Administrator/designee. This check list will be used with new admission beginning in Oct. Administrator and Assistant Administrator will receive education on this checklist and procedure by Executive Director by 10/1/24.

191 - Resident Right to Refuse (continued)

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/27/2024*

Implemented (- 01/22/2025)

225a - Assessment 15 Days

14. 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 #3's medical evaluation, dated , includes diagnoses of Motion Sickness, Depression, and Allergies; however, these diagnoses are not indicated on resident #3's assessment, dated

REPEAT VIOLATION: 2/12/2024

Plan of Correction ***Directed (- 09/23/2024)***

1. Resident 3 assessment will updated by 9/24/2024 to include diagnosis of Motion Sickness and consistent with assessment. (DIRECTED: By 9/24/24: The administrator shall ensure all current diagnoses are listed on resident #3's assessment. 9/23/24). Updated DME filed and on record with Administrator. Executive Director will update document
2. All resident Assessments will be reviewed to ensure consistence with diagnosis of DME and Assessment. Record to be updated as required. Audit to be completed by Administrator/Designee. (DIRECTED: The audits of all current resident assessments shall be completed by 10/22/24. 9/23/24).
3. Administrator and Assistant Administrator and Nurse education to Assessment process and completion by Executive Director. Signature on file with Administrator. Education to be completed by 9/24/24 (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/23/24
4. Monthly audits of resident medical evaluation to be completed to ensure timely and accurately. Audits to initiated in September and audited by Administrator/Designee Audit results to be forwarded to QAPI Committee at next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. 9/23/24).

DIRECTED: Beginning on 10/1/24: The administrator shall review at least 8 different resident assessments monthly to ensure each resident has an accurate and complete assessment present, which includes all current diagnoses. 9/23/24

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented (- 01/22/2025)

225c - Additional Assessment

15. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted] includes diagnoses of Hyperlipidemia, Anemia, Gastroesophageal Reflux Disease and Edema; however, these diagnoses are not indicated on resident #1's most recent assessment, dated [redacted]

REPEAT VIOLATION: 2/12/2024; 11/14/2023, et. al.

Plan of Correction ***Directed ([redacted] - 09/23/2024)***

1. Resident 1 assessment updated to include diagnosis as outlined in the citation and consistent with assessment. Updated DME filed and on record with Administrator. Assessment to be completed by 9/24/24 and complete by Administrator/Designee.

2. All resident DME's will be reviewed to ensure consistence with diagnosis of DME and Assessment. Record to be updated as required.
3. Administrator and Assistant Administrator and Nurse education to Assessment process and completion by Executive Director by 9/24/24. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/23/24). Signature on file with Administrator.
4. Monthly audits ~~(4 records)~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 9/23/24) of resident assessment to be completed to ensure timely and accurately. (DIRECTED: Beginning on 10/1/24: The administrator shall review at least 8 different resident assessments monthly to ensure each resident has an accurate and complete assessment present, which includes all current diagnoses. [redacted] 9/23/24), Audit results to be forwarded to QAPI Committee at next meeting 10/22/24. (DIRECTED: Documentation of the quality management meeting scheduled for 10/22/24 shall be kept and include a review of all items specified in 2600.26b. [redacted] 9/23/24).

DIRECTED: By 10/22/24: The administrator/designee shall review all current resident records to ensure each resident has an accurate and complete assessment present, which includes all current diagnoses. [redacted] 9/23/24.

Proposed Overall Completion Date: 10/19/2024

Directed Completion Date: *10/22/2024*

Not Implemented ([redacted] - 01/22/2025)

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

Facility Information

Name: *REFORMED PRESBYTERIAN HOME* **License #:** *42966* **License Expiration:** *10/23/2024*

Address: *2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214*

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

Administrator

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

Legal Entity

Name: *REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION*

Address: *2344 PERRYSVILLE AVENUE, PITTSBURGH, PA, 15214*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/10/1983* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *30* **Waking Staff:** *23*

Inspection Information

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

Reason: *Monitoring, Interim* **Exit Conference Date:** *11/07/2024*

Inspection Dates and Department Representative

11/07/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served:** *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older:** *29*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *1* **Have Physical Disability:** *0*

Inspections / Reviews

11/07/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/30/2024*

Inspections / Reviews *(continued)*

12/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/21/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/06/2024*

12/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/21/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/21/2025*

01/22/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/21/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 9/25/24 at approximately 9:45 AM, the fire alarm was activated due to a faulty smoke detector on the 3rd floor of the home. The fire department responded to the home; however, this incident was not reported to the Department until 11/7/24.

REPEAT VIOLATION: 11/14/2023, et. al.

Plan of Correction ***Directed ([redacted] - 12/11/2024)***

Reportable Incident was filled out and sent via email to: [redacted] by PCHA [redacted] on 11/7/2024 at 3:30pm (see attachment)

Administrator [redacted] and Assistant Administrator (PC ADMIN- Backup [redacted] were re-educated by Executive Director [redacted] to regulation and policy. Education received on 11/26/24 at 10am. (see attachment)

*Administrator and Assistant Administrator (as backup) will complete monthly audit to ensure all reportable incidents are reported in a timely manner to DHS per regulation 2600.16, audit will start on Dec. 2024. (see attachment) ***UPDATE: Administrator and Assistant Administrator will review all internal incidents daily for 2 months then weekly thereafter to ensure reportable incidents in 2600.16a are reported to DHS with 24 hours. Administrator and Assistant Administrator are in daily morning meeting with facility wide managers and will review for reportable incidents at that time. Please see attached audit forms to be completed in December 2024, January 2025 and then weekly audit. The audit process will begin on December 9, 2024. ****

Administrator [redacted] will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.16. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. [redacted] 12/11/24).

Proposed Overall Completion Date: 12/05/2024

Directed Completion Date: *01/21/2025*

Implemented ([redacted] - 01/22/2025)

25a - Written Contract and Review

2. Requirements

2600.

25a - Written Contract and Review *(continued)*

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

Page 2 of resident #1's resident-home contract does not include the date the resident-home contract was completed or resident #1's name. These sections of resident #1's resident-home contract are blank. Resident #1 was admitted to the home on [redacted]

Page 2 of resident #2's resident-home contract does not include the date the resident-home contract was completed or resident #2's name. These sections of resident #2's resident-home contract are blank. Resident #2 was admitted to the home on [redacted]

REPEAT VIOLATION: 2/12/2024

Plan of Correction ***Directed ([redacted] - 12/11/2024)***

Resident contracts were updated by PCHA [redacted] *on 11/7/2024 at 3:45pm with missing sections. (see attachment) *** Update: Additions to contracts for Residents #1 and #2 were both initialed and dated with PCHA for completion on 12-3-24. (see attachments) ****

Administrator ([redacted] *and Assistant Administrator (PC ADMIN- Backup* [redacted] *were re-educated by Executive Director (*[redacted] *to regulation and policy. Education received on 11/26/24 at 10am. (see attachment)*

**** Update: audit pertaining to reportable incidents is omitted. ****

Administrator ([redacted] *will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.25.a. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b.* [redacted] *12/11/24).*

****Update: All resident-home contracts were reviewed to ensure each resident's contract is completed in entirety and signed by all parties. This audit was completed by PCHA (*[redacted] *completed on 12-3-2024. (see attachment). ****

DIRECTED: Beginning on 12/15/24: The administrator shall review the completed resident-home contracts within 24 hours of admission for the next 10 resident admissions to ensure each resident has a resident-home contract completed in its entirety within 24 hours of admission in accordance with 2600.25a. [redacted] *12/11/24.*

Proposed Overall Completion Date: 12/05/2024

Directed Completion Date: *01/21/2025*

Implemented ([redacted] - 01/22/2025)

65i - Training Record

3. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Numerous staff training records do not include the length of the course, to include the following:

- *"3c training", conducted on 9/19/24*
- *"Locking poisonous materials" training, conducted on 10/1/24*
- *"Lighting/operable lamp" training, conducted on 9/27/24*
- *"Lint removal and duct cleaning" training, conducted on 9/19/24 through 10/1/24*
- *"Fire drill record" training, conducted on 9/19/24 through 9/24/24*

Plan of Correction ***Accept (- 12/02/2024)***

Staff training listed in the LIS # 3 – regulation 2600.65.i. have been updated with the length of the course by PCHA, on 11/25/24 at 10am. (see attachments)

Administrator (and Assistant Administrator (PC ADMIN- Backup were re-educated by Executive Director (to regulation and policy. Education received on 11/26/24 at 10am. (see attachment)

Administrator, updated Education/ Re-education Form on 11-26-24 at 11:30am and will be used moving forward for all education purposes starting on 11-26-24. (see attachment)

Administrator (will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.25.

Licensee's Proposed Overall Completion Date: *11/28/2024*

Implemented (- 01/22/2025)

101j7 - Lighting/Operable Lamp

4. 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

At 9:50 AM, no operable lamp or other source of lighting was present at resident #3's bedside.

At 9:58 AM, no operable lamp or other source of lighting was present at resident #4's bedside.

101j7 - Lighting/Operable Lamp (continued)

REPEAT VIOLATION: 11/14/2023, et. al.

Plan of Correction ***Directed (- 12/11/2024)***

Resident #3 and #4 lights were plugged back into the wall and ensured in working order by PCHA on 11/7/24 at 11:30am. (see attachment)

DHS recommended suggestion of press on light for Resident # 4 roommate. Light was installed on 11-22-24 at 1:00pm (see attachment)

*Resident rooms will be monitored for presence and functionality of lamp with bedside reach. To be completed by PCHA (or RCD) according to weekly audit. Weekly audit was revised on 11-25-24 at 2:00pm to include review of light being operable and plugged in; to be completed by PCHA or RCD weekly to ensure compliance with regulation starting on Dec. 2024. (see attachment) *** Update: Audit has been revised to include all resident lamps being reviewed weekly. Audit will be completed by PCHA and/or RCD starting on 12-9-2024. (see attachment). ****

*Administrator (re-educated Admin staff, RCD, Activity Director and Maintenance Director on revised audit and policy for Regulation 2600.101 (see attachments). *** Update: Staff re-education was completed on 11-26-24. PCHA will maintain documentation of staff re-education in accordance with 2600.65.i. ****

Administrator (will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.101. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. 12/11/24).

Proposed Overall Completion Date: 12/05/2024

Directed Completion Date: *01/21/2025*

Not Implemented (- 01/22/2025)

121a - Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 10:05 AM, the emergency exit door in the 2nd floor "Cozy Café" activity room could not be opened by agents of the Department. Also, there was a gray garden hose stretching across the egress route outside the door.

At 10:10 AM, a gray garden hose and green plastic chair were present directly outside the emergency exit door in the 2nd floor hallway near the beauty shop, blocking this egress route.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Directed (- 12/11/2024)***

Maintenance Director/ Maintenance Staff ensured exit door in Cozy Cafe was functional and able to be opened during LIS inspection on 11/7/24 around 10:20am.

Maintenance Director produced a work order to reflect information and also inspected again on 11/26/24 at 8am. (see attachment)

Maintenance Director ensured hoses and chairs were removed from both exit doors on the 2nd floor - Cozy Cafe exit door and Hallway exit door on 11/7/24 at 10:40am. (see attachment).

*Environmental Audit for outdoor egress has been revised to reflect weekly observation of egress exit doors instead of monthly on 11-15-24 at 2pm. (see attachment). *** Update: Weekly audits of all egress routes begin on 11-18-2024. *** (DIRECTED: The weekly audits shall include an audit of all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are all unlocked and unobstructed. 12/11/24).*

*Administrator (re-educated Admin staff, RCD, Activity Director and Maintenance Director on revised audit and policy for Regulation 2600.121(see attachments). ***Update: Staff re-education for egress routes was completed on 11-26-24. PCHA will maintain documentation of staff re-education in accordance with 2600.65i. ****

Audits to be forwarded to QAPI Committee meeting on January 21, 2025, and included a review of all items specific in regulation 2600.101.j. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. 12/11/24).

Proposed Overall Completion Date: 12/05/2024

Directed Completion Date: *01/21/2025*

Not Implemented (- 01/22/2025)

132a - Monthly Fire Drill

6. 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 September, 2024.

Plan of Correction ***Directed (- 12/11/2024)***

Administrator, and Maintenace Director ( ) worked together to revise current fire drill record to reflect and include all requirements in regulation 2600.132.a. (see attachment)

Administrator, Maintenance Director and DHS Inspector discussed the regulation 132 a. during the inspection on 11-7-24 and that we need to have an unannounced fire drill on the 2nd floor and the 3rd floor - even though the fire system is connected for both floors.

132a - Monthly Fire Drill (continued)

Administrator ([redacted] re-educated Admin staff and Maintenance Director on revised fire drill record and policy for Regulation 2600.132.a. (see attachments).
**** Update: Staff re-education was completed on 11-26-24. PCHA will maintain documentation of staff re-education according to 2600.65i. ****

Monthly Environmental Audit has been revised on 11-25-24 at 2:00pm to include audit of fire drill completion. Revised Audit to start Dec. 2024 (see attachment).

Administrator ([redacted] will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.132.a. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. [redacted] 12/11/24).

**** Update: PCHA will review all fire drill documentation monthly to ensure compliance with regulation, this will start on 12-9-24. ****

Proposed Overall Completion Date: 12/06/2024

Directed Completion Date: *01/21/2025*

Not Implemented ([redacted] - 01/22/2025)

132h - Designated Meeting Place

7. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

2 different fire drill records were completed for the fire drill held on 8/30/24 at 2:16 PM. One record titled, "Fire Drill Report" indicates 26 residents were present in the home at the time of the fire drill; however, only 12 residents were evacuated. The second record, which was completed on the Department's fire drill record form, indicates 80 residents

132h - Designated Meeting Place (continued)

were present in the home at the time of the fire drill; however, only 12 residents were evacuated. [redacted]

Violation Withdrawn 1/22/25

[redacted]

2 different fire drill records were completed for the fire drill held on 10/25/24 at 11:15 PM. One record titled, "Fire Drill Report" indicates 18 residents were evacuated; however, does not indicate the number of residents present in the home at the time of the fire drill. The second record, which was completed on the Department's fire drill record form, indicates 88 residents were present in the home at the time of the fire drill; however, only 18 residents were evacuated.

Plan of Correction ***Directed ([redacted] - 12/11/2024)***

Administrator, [redacted] and Maintenace Director ([redacted] worked together to revise current fire drill record to reflect and include all requirements in regulation 2600.132.h.
Administrator emailed draft to DHS Inspector [redacted] was helpful in reviewing draft and gave feedback on 11/18 & 11/19/24 via email. (see attachment of email thread and revised fire drill record)

**** Update: PCH did implement a singular fire drill record to use with all future fire drills. Such fire drill record will be implemented starting 11-25-24. ****

*Administrator ([redacted] re-educated staff on revised fire drill record and policy for Regulation 2600.132.h. (see attachments). *** Update: Initial Staff re-education was completed on 11-26-24. All staff persons were re-educated to the home's fire drill evacuation procedure between the dates 0f 12-4-24 thru 12-6-24. 9 see attachment). PCHA conducted the re-education and will maintain documentation of re-education in accordance with 2600.65i. ****

Monthly Environmental Audit has been revised on 11-25-24 at 2:00pm to include audit of designated meeting place is achieved. Revised Audit to start Dec. 2024 (see attachment).

Administrator ([redacted] will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.132. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. [redacted] 12/11/24).

****Update: PCHA will review all fire drill documentation monthly to ensure compliance with regulation. PCHA review implementation date is 11-25-24. ****

132h - Designated Meeting Place (continued)

Proposed Overall Completion Date: 12/06/2024

Directed Completion Date: *01/21/2025*

Not Implemented (- 01/22/2025)

141b1 - Annual Medical Evaluation

8. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #5's most recent medical evaluation, dated , is not signed and dated by the medical professional who completed the medical evaluation and does not include the medical professional's license number. These sections of resident #5's medical evaluation are blank.

REPEAT VIOLATION: 6/14/2024; 5/2/2024; 2/12/2024; 11/14/2023, et. al.

Plan of Correction ***Directed (- 12/11/2024)***

Resident #5 medical evaluation was updated by PCHA on 11/26/2024 at 3:45pm with missing sections. (see attachment)

DIRECTED: By 12/16/24: The administrator shall ensure resident #5's medical evaluation is signed by the medical professional who completed the form. A copy of the completed medical evaluation shall be kept in resident #5's record. 12/11/24

Administrator (Assistant Administrator (PC ADMIN- Backup and RCD were re-educated by Executive Director (to regulation and policy. Education received on 11/26/24 at 10am. (see attachment)
**** Update: RCD will assist PCHA in completing medical evaluations to ensure compliance with regulation and audit process, this will start 12-4-24. ****

Administrator and Assistant Administrator (as backup) will complete monthly audit to ensure all medical evaluations are completed per regulation 2600.141, audit will start on Dec. 2024. (see attachment)

Administrator (will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.141. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. 12/11/24).

141b1 - Annual Medical Evaluation (continued)

****Update: PCHA reviewed all current - resident medical evaluations to ensure each resident has a completed and timely medical evaluation. PCHA conducted and completed audit on 12-3-2024. (see attached). PCHA will complete monthly audit to review medical evaluations that are due each month to ensure compliance, audit to start in December (12-3-24) and continue each month moving forward. Assistant Administrator will also complete monthly audit to ensure PCHA audit is accurate, completed timely and in compliance with regulation, to start on 12-3-24. ****

Proposed Overall Completion Date: 12/06/2024

Directed Completion Date: *01/21/2025*

Not Implemented (- 01/22/2025)

225c - Additional Assessment

9. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #5's most recent medical evaluation, dated , includes diagnoses of muscle wasting and Atrophy; however, these diagnoses are not indicated on resident #5's most recent assessment, dated .

Resident #6's most recent medical evaluation, dated , includes diagnoses of Chronic Kidney Disease, Atrial Fibrillation, Irritable Bowel Syndrome, Gastro Esophageal Reflux Disease, Hyperlipidemia, Crohn's Disease, Age-related Osteoporosis, Hemiplegia and Hemiparesis, Fibromyalgia, Gout, Anemia, Vertigo and Seizure; however, these diagnoses are not indicated on resident #6's most recent assessment, dated

225c - Additional Assessment (continued)

REPEAT VIOLATION: 2/12/2024; 11/14/2023, et. al.

Plan of Correction ***Directed (- 12/11/2024)***

Resident #5 and Resident #6 assessments were updated by PCHA, on 11/26/2024 at 3:45pm with missing diagnoses. (see attachment)

Administrator (Assistant Administrator (PC ADMIN- Backup were re-educated by Executive Director (to regulation and policy. Education received on 11/26/24 at 10am. (see attachment)

Administrator and Assistant Administrator (as backup) will complete monthly audit to ensure all medical evaluations are completed per regulation 2600.225, audit will start on Dec. 2024. (see attachment)

Administrator (will forward to OAPI Committee meeting on 1/21/2025 and verbal report all findings on LIS and include a review of all items specified in regulation 2600.225. (DIRECTED: Documentation of the quality management review shall be kept and shall include a review of all items specified in 2600.26b. 12/11/24).

****Update: PCHA reviewed all current - resident RASPS to ensure each resident has a completed and timely assessment. PCHA conducted and completed audit on 12-3-2024. (see attached). PCHA will complete monthly audit to review RASPS that are due each month to ensure compliance, audit to start in December (12-3-24) and continue each month moving forward. Assistant Administrator will also complete monthly audit to ensure PCHA audit is accurate, completed timely and in compliance with regulation, to start on 12-3-24. ****

Proposed Overall Completion Date: 12/06/2024

Directed Completion Date: *01/21/2025*

Not Implemented (- 01/22/2025)