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

January 31, 2025

[redacted] EXECUTIVE DIRECTOR
LIFESPACE COMMUNITIES INC
[redacted]

RE: FRIENDSHIP VILLAGE OF SOUTH HILLS
1296 BOYCE ROAD
UPPER SAINT CLAIR, PA, 15241
LICENSE/COC#: 45077

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/10/2024, 12/11/2024 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: *FRIENDSHIP VILLAGE OF SOUTH HILLS* **License #**: *45077* **License Expiration**: *11/18/2025*

Address: *1296 BOYCE ROAD, UPPER SAINT CLAIR, PA 15241*

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

Administrator

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

Legal Entity

Name: *LIFESPACE COMMUNITIES INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/09/2019* **Issued By**: *Township of Upper St Clair*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/11/2024*

Inspection Dates and Department Representative

12/10/2024 - On-Site: [redacted]

12/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *102* **Residents Served**: *78*

Special Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *32* **Residents Served**: *31*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

12/10/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/16/2025*

01/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/22/2025*

Inspections / Reviews *(continued)*

01/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/01/2025*

01/31/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2025*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence 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 assisted living residence.

Description of Violation

On 12/10/24, the Licensing Inspection Summaries from 1/11/24 and 8/12/24 were not posted in a conspicuous and public place in the residence.

Plan of Correction ***Accept (- 01/23/2025)***

All licensing summaries were moved to a binder in the mail room on 12/13/24. A sign was placed in the licensing show case in the lobby that instructs residents and visitors to the binder in the mail room for licensing summaries. Administrator to place all licensing summaries in the binder moving forward. Morning receptionist to ensure that the binder is present monthly for next 6 months. Record of checks to be kept on attached log. Administrator to sign off on audit to ensure checks are being completed.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Implemented (- 01/31/2025)

65g Initial direct care training

2. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired did not successfully complete and pass the Department-approved direct care competency test before providing direct care to residents.

.

Direct care staff person C, hired did not successfully complete and pass the Department-approved direct care competency test before providing direct care to residents.

Plan of Correction ***Accept (- 01/23/2025)***

Staff person B and C were hired during the pandemic and completed the TNA Certificate, but failed to complete the direct care certificate when the TNA expired. Staff person B completed the direct care competency test on 12/13/24. Staff person C completed the competency test on 1/11/25. An audit of all uncertified aides was completed on 1/13/25. The audit determined that 1 additional team member had a TNA certificate, but did not complete the competency testing. Team member completed the competency test on 1/15/25 (see attached certificate). All uncertified aides will complete the competency test during orientation prior to providing direct care to residents. Ongoing compliance to be monitored by Scheduler and Administrator as new team members are hired. Scheduler in-serviced on requirement for competency test prior to scheduling on the floor.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Implemented (- 01/31/2025)

81b Resident equip – good repair

3. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 12/10/24, the bed enabler in resident room #205 was not securely attached to the bed frame. The enabler was able to be pulled away from the mattress several inches posing an entanglement risk.

Plan of Correction ***Accept (- 01/23/2025)***

On 12/10/24, the bed enabler in room 205 was immediately inspected, securely reattached, and tested to eliminate the entanglement risk. On 12/11/24, all facility bed enablers were inspected (see attached audit). Effective immediately, a monthly inspection schedule has been established indefinitely, requiring staff to sign off to confirm all enablers clean, in good repair and free of hazards to ensure compliance with regulations (see attached environmental room check form). Maintenance team and all direct care staff to be inserviced on proper installation of bed enablers, regulations around bed enablers, and the policy and procedure for bed enables by 1/31/25. Administrator, Nurse Care Coordinator, and Director of Plant operations to conduct training. Documentation of education will be kept in accordance with Regulation 2600.65(i). Ongoing compliance to be monitored by Nurse Care Coordinator and Administrator after each monthly inspection.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented (- 01/31/2025)

130a Smoke detector - living unit

4. Requirements

2800.
130.a. There shall be an operable automatic smoke detector located in each living unit.

Description of Violation

On 12/10/24, there were no smoke detectors in any of the home's resident living units to include:
Units #128, #205, #218, #306 and #310.

Plan of Correction ***Accept (- 01/17/2025)***

On 1/7/25, smoke detectors were installed in all 82 living units. Smoke detectors will be tested for operability monthly by Security (see attached audit record and January audit). Record to be scanned monthly to Director of Plant Operations and Administrator. Security to be trained on requirements for smoke detectors by 1/24/25. Ongoing compliance to be monitored by Security Supervisor, Director of Plant Operations, and Administrator.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented (- 01/31/2025)

131c Kitchen fire extinguisher

5. Requirements

2800.
131.c. A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher must meet the requirements for one floor as required in subsection (a).

Description of Violation

On 12/10/24, there was no 2A-10BC fire extinguisher in the kitchen area of the home's second floor multipurpose

131c Kitchen fire extinguisher (continued)

room. The only fire extinguisher in this kitchen had a 2A-Kitchen rating.

Plan of Correction ***Accept ([redacted] - 01/23/2025)***

An additional fire extinguisher with a 2A-10BC rating was installed in the activity room kitchen on 12/13/24 (see attached picture). Security to audit all fire extinguishers monthly to ensure ongoing compliance. Documentation of monthly fire extinguishers to be kept on tag attached to the fire extinguisher. Audits began on 1/3/25 (see attached log).

Licensee's Proposed Overall Completion Date: *01/22/2025*

Implemented ([redacted] - 01/31/2025)

132d Evacuation

6. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

The residence's documentation from the fire safety expert indicates the residence's fire safe areas as follows: "Common area between building wings" and "Stairwells - both ends of building." However, the residence is evacuating residents in the simulated area to areas which are not designated in writing by the fire safety expert as fire safe areas. Additionally, the residence is only evacuating residents from the simulated affected area and the remaining residents are not evacuated at all. These residents remain in their living units.

Plan of Correction ***Accept ([redacted] - 01/23/2025)***

A meeting and supervised drill is scheduled for 1/29/25 with the Upper St Clair Fire Chief. All Staff to be retrained on proper evacuation procedures by 2/14/25. Administrator to hold special fire safety town hall to notify and educate residents on proper evacuation procedures by 2/14/25. A record of fire drills to be kept on department fire drill record form. Ongoing compliance to be monitored by Security Supervisor, Director of Plant Operations, and Administrator. Administrator shall audit the fire drill record monthly to ensure residents are able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. Audit to be done monthly at the end of each month to ensure compliance for that month.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented ([redacted] - 01/31/2025)

224a5 Written initial assessment

7. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:
vi. The individual's need for special diet or meal requirements.

Description of Violation

Resident #1's medical evaluation completed [redacted] indicates a special diet of "mechanical soft." However, the resident's initial assessment, completed [redacted], indicates that the resident's Dietary Need is "General diet, Regular Texture, Thin Liquids consistency."

224a5 Written initial assessment (continued)

Resident #2's medical evaluation completed [redacted] indicates a special diet of "consistent carb, pureed texture, thin liquids." However, the resident's initial assessment, completed [redacted], indicates that the resident's Dietary Need is "Regular diet."

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Upon admission, resident's diet was clarified by speech therapy and the resident's PCP to be a regular diet not mechanical soft. See attached order for diet change. Staff to complete an audit by 1/24/25 to ensure all residents diets match on the ASP and ADME. Nursing staff to be retained by 1/24/25 on how to properly document changes or inaccurate information on an ADME. Nurse Care Coordinator to ensure ongoing compliance by auditing new admissions ADMEs and ASPs to ensure the diet is accurate on both the ADME and ASP.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Implemented ([redacted] - 01/31/2025)

231c1 Preadmit screening

8. Requirements

2800.
231.c.1. Special care unit for residents with Alzheimer's disease or dementia.
i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #2 was admitted to the residence's special care unit on [redacted] However, the resident's written cognitive preadmission screening documented on the Department's cognitive preadmission screening form for admission to the residence's special care unit was dated [redacted]

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

All cognitive screens were audited on 1/14/25 to ensure compliance (see attached audit). Marketing team was inserviced on regulatory requirements on 1/15/25 (see attached). To ensure ongoing compliance, marketing to scan all prescreens 24 hours prior to admission to Memory Care Coordinator and Administrator. MCC and Administrator to check date on prescreen to ensure it is dated 72 hours prior to admission.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Implemented ([redacted] - 01/31/2025)