pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MERCY LIFE CENTER CORPORATION**
LEGAL ENTITY

To operate **GARDEN VIEW MANOR**
NAME OF FACILITY OR AGENCY

Located at **441 SWISSVALE AVENUE, PITTSBURGH, PA 15221**
(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 **May 27, 2025** until **May 27, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **440690**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: May 27, 2025

Mercy Life Center Corporation

RE: Garden View Manor
441 Swissvale Avenue
Pittsburgh, PA 15221
License: 44069

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on February 11, 2025, February 12, 2025, April 14, 2025 and April 17, 2025 and the corrections you have made after our inspections, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *GARDEN VIEW MANOR* **License #**: *44069* **License Expiration**: *06/13/2025*

Address: *441 SWISSVALE AVENUE, PITTSBURGH, PA 15221*

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

Administrator

Name:

Legal Entity

Name: *MERCY LIFE CENTER CORPORATION*

Addres

Phone:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *04/08/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Complaint, Provisional* **Exit Conference Date**: *02/12/2025*

Inspection Dates and Department Representative

02/11/2025 - On-Site:

02/12/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *52*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *52* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *52* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

02/11/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2025*

03/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/09/2025*

03/10/2025 - POC Submission

Submitted By [redacted] **Date Submitted**: *03/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/21/2025*

05/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/20/2025*

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

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 dates ranging from 2/4/25 through 2/12/25, resident #1 was not administered the prescribed Furosemide 80mg tablet by mouth once daily because the medication was not available on the cart or in the home to give to the resident. However, the medication error was not reported to the Department's personal care home regional office or the Department's personal care home complaint hotline within 24 hours in a manner designated by the Department and was not reported to the Department.

REPEAT VIOLATION 8/2/24 et. al.

Plan of Correction ***Accept [redacted] 03/10/2025)***

Furosemide 80 mg was not available for resident #1 due to a refill being needed. The home was unable to get the refill in the appropriate time frame due to the guardian's expectation that [redacted] would facilitate and attend all medical appointments. During the inspection, the home presented documentation showing that good faith efforts had been made to assist Resident #1 in obtaining the medication, but due to the guardian's actions the medication was not available from 2/4 to 2/16. The home was able to obtain the Furosemide on 2/17 and Resident #1 has received Furosemide 80 mg as ordered since.

A medication error incident report was submitted to DHS on 2/13 documenting the error by omission. On 2/13 an APS report was filed reporting the role guardian due to her role in preventing the home from obtaining the medication. This APS report was submitted as a separate incident report to DHS on 2/13.

The home will complete a training of incident reporting to include medication error specific reporting. This will cover the five types of medication errors and reporting process. The home's administrator, Team Leads, and RNs will monitor all medication errors and ensure that reporting is completed within 24 hours of discovery. The home will post signage in the medication rooms which prompt staff to complete all required reporting of medication errors, including those by omission this will be posted.

- *On 2/21/25 the residential manager and PCHA reviewed incident reporting requirements and materials, and revised ensure the reporting process was adherent to reporting regulation 2600.16.c.*
- *By 3/1/25 the home's residential manager will place copies of the training materials in all staff offices and medication rooms.*
- *By 3/1/25 the home's team leads will post signage in all medication rooms reminding staff of reporting criteria for medication error.*
- *By 3/30/25 Incident report training will be completed by the home's compliance officer/supervisor/PCHA for all staff. Completion of the incident report training will be documented on training logs and maintained in the staff chart.*
- *By 3/20/25, The home's PCHA will develop a tracking tool to monitor incident report completion within 24 hours for the nineteen reportable events to ensure compliance with Regulations 2600.65(i) and 2600.16(c). The tracker will be implemented by 3/20/25. The tracker will be reviewed and signed by the PCHA weekly, and the reviewed trackers will be placed in the audit zone.*

16c - Written Incident Report (continued)

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ██ 05/08/2025)

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On 2/11/25 at approximately 12:55 p.m. the privacy coding pages for licensing inspections started on 5/22/24, 8/2/24, and 10/22/24, and processed on 12/13/24 were found attached to the respective reports which were unlocked, unattended, and accessible and publicly and conspicuously posted in the display case in the home's main lobby area. The names of residents were lined out using permanent marker but could still be read from the privacy coding sheets to include residents #1 through #8

Plan of Correction ***Accept ██ 03/10/2025)***

The previous LIS was posted in the display case with privacy coding, the coding was partially obscured. The home removed the LIS removing the privacy coding during the inspection. The LIS posted in the display case continues to remain without the privacy coding.

Effective 2/20/25 the home will no longer print or post the LIS privacy coding sheet in any public spaces. All staff were provided with an education on resident right to privacy and confidentiality and the importance of ensuring all postings are free of resident confidential information. The PCHA verified that LIS is still free of privacy coding on 2/24/25.

- *Beginning 3/1/25 the Team Leads will ensure that future LIS are posted free of any privacy coding and that the home's common/unsecure areas are free of confidential information by doing visual inspections. The completion of these inspections will be documented on "signage checklist" the home's PCHA will review that the checklist is being completed on a monthly bases.*
- *On 3/7/25, the homes' PCHA checked and verified that the privacy coding sheet was not present in the display case.*
- *By 3/20/25 the PCHA and Team Leads will ensure that resident confidentiality is reviewed with all staff. This will ensure that staff are aware of what information cannot be displayed or stored in unsecure areas. Documentation of this will be placed on training logs and will be stored in the staff chart.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ██ 05/08/2025)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract for resident #1, dated [redacted]/25, was not signed by the resident's [redacted]

REPEAT VIOLATION 5/22/24 et. al.

Plan of Correction ***Accept [redacted] 03/04/2025)***

The home had made efforts to get the guardian's signature, by having several meetings and making numerous phone calls but had not been successful. An email of the Admission Agreement (resident contract) was sent to Resident #1's [redacted] on 2/6/25, this letter was in the chart at the time of the inspection, where it remains. Resident 1's [redacted] presented at the home on 2/19/25 and reviewed and signed the Admission Agreement.

To prevent this from happening in the future the home reviewed all the Admission Agreements (resident contracts) for the current year of 2025, to ensure they are complete and had all required signatures.

- *Beginning 2/24/25 for all new admissions, the PCHA or Team Lead will have the Admission Agreement prepared before admission and will be presented for signature. If the resident/responsible party declines to sign at this time, this will be documented, and the resident will be reapproached within 24 hours.*
- *By 2/28/25 the home will review Admission Agreements to ensure they are complete and filed in resident charts with signatures.*
- *By 2/28/25 all updated admission agreements have been provided to the resident/payee/guardian.*

Licensee's Proposed Overall Completion Date: *03/08/2025*

Implemented [redacted] 05/08/2025)

26a - Quality Management Plan

4. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

There was no periodic review of the home's quality management plan in 2024.

Plan of Correction ***Accept [redacted] 03/10/2025)***

During 2023 to 2024, the home did not review the quality management plan. Beginning in December 2024 the home began to have weekly meetings in consultation with another PCHA, the Residential Manager, and Pittsburgh Mercy's Risk and Compliance to review the active POC and provisional license and develop plans to improve on the home's operations and record keeping. The meetings focus on implementing improvement steps targeting areas of complaints, existing violations, staff records and resident records. These quality management meetings are

26a - Quality Management Plan (continued)

documented on a spreadsheet but had not been placed on the home's quality management plan.

Moving forward, the home will resume completing quality management reviews quarterly to ensure compliance and quality management improvements and will complete an annual review to establish best practices and training for the next year.

- *Starting on 3/15/25, the home will have quarterly quality management review meetings beginning (March, June, September, December) and will resume annual final reviews in June. Progress towards quality improvement will be documented on the homes Quality Management Plan.*
- *On 3/7/25, the home scheduled meetings for Quality Management reviews on 3/26/25, 6/18/25 (annual), 9/24/25, and 12/17/25. These meetings will be attended by the PCHAs from the organization's PCHs and the residential manager. Participation in the quality management review will be documented on the home's Quality Management Plan, and are confirmed by the signature of attendees. This documentation stored. in the home's audit zone.*
- *Beginning 6/1/25 the home will schedule an annual review to support the development of the staff training plan for the next training year (training year runs 7/1 to 6/30).*

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented (- 05/08/2025)

26b - Quality Management Plan Content

5. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's quality management plan did not indicate there would be a review of:
(1) The reportable incident and condition reporting procedures
(2) Complaint procedures
(3) Staff person training
(4) Licensing violations and plans of correction, if applicable
(5) Resident or family councils, or both, if applicable (the home has resident council)

Plan of Correction ***Accept - 03/10/2025)***

The home did not have a quality management plan available during the inspection.

- *On 2/20/25 The home's administrator and residential manager reviewed the quality management plan to ensure that it contained all required domains (reportable incident/condition reporting, complaints, staff training, licensing violations/POC, and resident counsel).*
- *On 3/7/25, the home's Compliance Officer completed updates to the home's Quality Management Plan to reflect a review of all topics from Regulation 2600(b). The PCHA will use this form during all Quality Management Review Meetings.*
- *Starting on 3/7/25, the approved form will track progress during quarterly reviews (March, June, September, December) and annually in June. The quality management plan will be maintained by the PCHAs, and Team Leads, this documentation will be maintained in the home's audit zone.*

26b - Quality Management Plan Content (continued)

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented ██ - 05/08/2025)

63a - First Aid/CPR Training

6. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

During the dates and times indicated, there were no staff persons present in the home that were trained in first aide and certified in obstructed airway techniques and Cardiopulmonary resuscitation (CPR):

- *1/31/25 from 12:00 a.m. until 7:00 a.m. there were 52 residents present in the home.*
- *1/31/25 from 11:00 p.m. until 11:59 p.m. there were 52 residents present in the home.*
- *2/1/25 from 12:00 a.m. until 7:00 a.m. there were 52 residents present in the home.*

On 1/31/25 from 8:00 p.m. until 11:00 p.m., there were 52 residents in the personal care home and direct care staff person A was the only staff person present in the home trained in first aide and certified in obstructed airway techniques and CPR.

On 2/8/25 from 12:00 a.m. until 7:00 a.m., there were 52 residents in the personal care home and direct care staff person B was the only staff person present in the home trained in first aide and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept ██ 03/10/2025)***

Due to deficits in training plans and tracking, multiple staff at the home had lapses in their CPR/First Aid Certification. The home reviewed the schedule and worked to ensure that two or more staff with current CPR/1st Aid training are always present. The home contacted the organization's training and development department and arranged additional training resources.

- *On 02/14/25 the home's schedule was reviewed to ensure that a minimum of 2 CPR/First Aid compliant staff were scheduled.*
- *On 2/13/25 an audit was completed of staff CPR/First Aid training by the home's residential manager.*
- *Beginning on 2/13/25 the home established a master list for tracking all current CPR/First Aid cards to ensure ongoing compliance.Beginning*
- *Beginning 3/1/25 the home will maintain staff CPR/First Aid cards in two locations 1.) in the staff chart 2.) in the designated CPR/First Aid folder in the audit zone.*
- *On 3/5/25, the home's supervisor reviewed all past and current schedules to ensure at minimum two staff with CPR/1st Aid certifications on each shift. The home's supervisor has obtained additional certified staff to ensure that each shift can meet Regulation 2600.63(a).*
- *On 3/7/25, the residential senior manager verified that all staff now have a current CPR/1st Aid certificate/card on file or are scheduled to complete CPR training on or before 3/12/25.*
- *Beginning 3/15/25 CPR/First Aid compliance will be reviewed as part of Quarterly Quality Management to ensure ongoing compliance.Beginning on 3/20/25, the home PCHA and Supervisor will review CPR/1st Aid*

63a - First Aid/CPR Training (continued)

compliance quarterly using the tracking tool developed. This tool will be maintained in the home's audit zone.

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ███ 05/08/2025)

65b - Rights/Abuse 40 Hours

7. 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

Ancillary staff person C was hired ███/22 and as of 2/11/25 had worked an excess of 40 hours but did not receive an orientation that included the following:
(2) Emergency medical plan.

Direct care staff person D was hired ███/24 and as of 2/11/25 had worked an excess of 40 hours but did not receive an orientation that included the following:
(2) Emergency medical plan.

Direct care staff person E was hired ███/24 and as of 2/11/25 had worked an excess of 40 hours but did not receive an orientation that included the following:
(2) Emergency medical plan.

Direct care staff person F was hired ███23 and as of 2/11/25 had worked an excess of 40 hours but did not receive an orientation that included the following until 3/8/24:
(4) Reporting reportable incidents and conditions

Plan of Correction ***Accept ███ 03/10/2025)***

On the date of inspection, the home was unable to provide documentation of training for the Emergency Medical Plan occurring in the first 40 hours. Moving forward to ensure compliance with regulation 2600.65b the home's initial training log has been updated to clarify and clearly indicate which trainings meet regulatory training requirements, The new initial training log will provide structure to guide staff to assist in ensuring required topics are covered within the initial 40 hours.

- *On 2/20/25 the home's residential manager and compliance manager reviewed and updated the site's Emergency Medical Plan and made needed updates to ensure full compliance with regulation 65b a copy of this plan is maintained in the home's audit zone.*
- *By 3/15/25 the PCHA and Designated Person will ensure that staff persons C, D, E and F receive training in the Emergency Medical Plan. Documentation of this will be provided and placed in the staff's chart and training log.*
- *By 3/15/25 the home will have revised the Initial Training Log to reflect the Emergency Medical Plan training.*
- *Beginning on 3/15/25 the home's PCHA or designee will review all Initial Training Logs after the completion*

65b - Rights/Abuse 40 Hours (continued)

of the first 40 hours.

- *By 3/15/25 all staff training charts will be audited, and any missing training will be assigned to the staff with a deadline for them to be completed during their next assigned shift. Completed training courses will be placed in staff charts and training logs.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] 05/08/2025)

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
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 E, hired [redacted]/24, did not successfully complete the Department-approved direct care training course or pass the competency test and as of 2/11/25 had provided unsupervised direct care services to residents of the personal care home.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff E was a recent transfer from a different residential unit and had not completed the department approved Direct Staff Care training when it was initially assigned.

- *On 2/8/25 the home's designated person had followed up on staff E Direct Care Staff Training Course. Staff E completed the approved Direct Care Staff training on 2/15/25.*
- *Starting on 2/20/25, the home's administrator will give written instruction to all new hires to complete the department-approved Direct Care staff training as the first task upon starting work at the home.*
  On 3/7/25, a PCH Supervisor audited all staff charts to identify outstanding initial training required to comply with Regulation 2600.65(d). All staff were notified of outstanding training(s) that must be completed on their next shift(s). This audit will be reviewed and signed off by the PCHA by 3/20/25 and will be maintained in the audit zone.
  Beginning on 3/7/25, the home's PCHA will review all initial training logs for completion during the second week of employment for all new hires.
- *By 3/15/25 the home's initial training log will be updated to ensure compliance with regulation 2600.65d. The home's updated initial training log will indicate which organizational trainings meet the DHS training expectations. The department approved Direct Care Staff training will be clearly marked as the first required training.*

65d - Initial Direct Care Training (continued)

- *By 3/15/25 all staff training charts will be audited and any staff found deficient in Direct Care Staff training will be assigned this for completion during their next assigned shift. Completed training courses will be placed in staff charts and training logs.*

Proposed Overall Completion Date: 03/15/2025

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented (██ - 05/08/2025)

65f - Training Topics

9. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
3. Care for residents with dementia and cognitive impairments.
5. Personal care service needs of the resident.
6. Safe management techniques.
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 F, hired ████23, did not receive annual training in required topics for the 7/1/23 to 6/30/24 training year to include:

(1) Medication self-administration training.

(3) Care for residents with dementia and cognitive impairments.

(5) Personal care service needs of the resident.

(6) Safe management techniques.

(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

Plan of Correction ***Accept (██ 03/10/2025)***

The staff annual training log and certificates for staff F were not available at the time of inspection.

- *By 3/20/25 staff F will complete assigned trainings in Emergency Medical Plan, Medication Self Administration, Reportable Incidents, Care for Residents with Dementia and Cognitive Impairments, Personal Care Home Service Needs, Safe Management Techniques, Care for residents with Mental Illness/Intellectual Disabilities. Copies of these training certificates and the training logs will be maintained in the staff chart.*
- *By 3/15/25 all staff training charts will be audited and any staff found deficient in required departmental training will be assigned this for completion during their next assigned shift(s).*
- *By 3/15/25 the home will review the annual 2024 to 2025 training plan and log to clearly indicate what training courses meet the educational requirements to meet regulation 2600.65g.*
- *Beginning 3/15/25 the home will begin to review staff training progress at quality management reviews (March, June, September, December).*
- *By 6/30/25 home will review and establish the upcoming 2025 to 2026 training plan and log, and clearly indicate all department required trainings.*

65f - Training Topics (continued)

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] 05/08/2025)

65g - Annual Training Content

10. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Ancillary staff person C, hired [redacted]/22, did not receive required annual training for the 7/1/2023 through 6/30/24 training year to include:
(1) Fire safety by a fire safety expert(FSE) or staff trained by FSE
(5) Falls and accident prevention

Direct care staff person F hired [redacted]23, did not receive annual training for the 7/1/23 to 6/30/24 training year to include:
(5) Falls and accident prevention.

Plan of Correction ***Accept [redacted] 03/10/2025)***

The staff training log for staff C and F did not reflect all required departmental training.

- *By 2/15/25, staff C will be assigned Fire Safety and Falls Prevention training to be completed by 2/22/25.*
- *By 2/15/25 staff F was assigned training for Falls Prevention to be completed by 2/22/25.*
- *By 3/15/25 all staff training charts will be audited and any staff found deficient in required. departmental training will be assigned this for completion during their next assigned shift(s).*
- *By 3/15/25 the PCHA and designee will review the annual 2024 to 2025 training plan and log to clearly indicate what training courses meet the educational requirements to meet regulation 2600.65g.*
- *Beginning 3/15/25 the home will begin to review staff training progress at quarterly quality management reviews (March, June, September, December).*
- *By 6/30/25 home will review and establish the upcoming 2025 to 2026 training plan and log, and clearly indicate all department required trainings a copy of this will be maintained in the audit zone.*

65g - Annual Training Content (continued)

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented █ 05/08/2025)

65i - Training Record

11. 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

There was no record of training for ancillary staff person C that included initial orientation in general fire safety and emergency preparedness or orientation that included resident rights, the emergency medical plan, mandatory abuse reporting, and reporting of reportable incidents and conditions.

There was no record of training for direct care staff person D that included initial orientation in general fire safety and emergency preparedness or orientation that included resident rights, the emergency medical plan, mandatory abuse reporting, and reporting of reportable incidents and conditions.

There was no record of training for direct care staff person E that included initial orientation in general fire safety and emergency preparedness or orientation that included resident rights, the emergency medical plan, mandatory abuse reporting, and reporting of reportable incidents and conditions.

Plan of Correction ***Accept█ 03/10/2025)***

At the time of the inspection consistent documentation and logging of training was not available for staff C, D, and E for the 2023 to 2024 training year. In January 2025, the home implemented an improved training plan and tracking training completions system.

To ensure compliance with the retention of all staff training records, the home is taking the following steps.

- *Starting in January 2025, staff at the home were directed by the PCHA to place all completed training in the training binder to ensure easy verification.*
- *Beginning 3/15/25 the PCHA will review staff training progress at quarterly quality management reviews (March, June, September, December).*
- *By 3/15/25 the PCHA and designee will review the annual 2024 to 2025 training plan and log to clearly indicate what training courses meet the educational requirements to meet regulations.*
- *By 3/15/25 the PCHA, compliance manager, and residential manager will audit all staff charts and contact staff in writing to request copies of all completed but undocumented trainings.*
- *By 4/1/25 the PCHA and residential manager will verify all existing staff training documentation will be compiled and filed correctly, with training logs in the staff chart.*
- *By 3/20/25 the PCHA and Team Leads will produce a binder containing the content of all assigned training.*
- *By 6/30/25 the PCHA and designee will review and establish the upcoming 2025 to 2026 training plan and log, and clearly indicate all department required trainings. Copies of all assigned training content summaries will be placed in a binder kept with the staff training logs.*
- *By 5/15/25 the PCHA and designee will review all staff training logs and certificates to ensure compliance*

65i - Training Record (continued)

with regulation 2600.65i and ensure that all training logs and certificates provide (staff name, date, training source/trainer, title). If staff is found to be deficient in training this will be assigned in writing to be completed by 6/30/25.

- *By 7/15/25 the PCHA will provide staff with an updated training plan for the 2025 to 2026 training year.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented (█ - 05/08/2025)

82a - Poisonous Materials

12. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 2/11/25 at approximately 12:17 p.m. the housekeeper cart on the first-floor had a thirty-two fluid ounce spray bottle of an unlabeled cleaning solution that ancillary staff person G indicated was urine remover and had approximately one-point-five ounces of liquid remaining in the spray bottle. The safety data sheet for Chlorox Urine Remover indicated if the solution was in the eyes, to call a poison control center or physician for treatment advice, and if ingested or inhaled, to call a physician or poison control center immediately.

Plan of Correction ***Accept █ 03/10/2025)***

The product found during inspection, Clorox Urine Remover, is provided by the home's supplier in one-gallon jugs. Staff had transferred this item into a smaller bottle for ease of use, but did not label it appropriately.

- *During the 2/12/25 inspection, the home obtained a copy of the label and material safety data sheet with instructions. The inspector provided technical assistance and indicated that for this product the correct MSDS label, providing instructions to contact poison control for eye exposure, inhalation or consumption was needed.*
- *Despite the instruction, on 2/12/25, the unlabeled product bottle was removed from the cleaning cart until a replacement product in its original packaging could be obtained.*
- *On 2/12/25 the residential manager provided the housekeeping supervisor with instructions on how to label products placed in non-manufacturer bottles, if necessary.*
- *Beginning on 3/1/25 the housekeeping supervisor will spot check housekeeping carts for general safety and product labeling on a weekly basis and document the findings. In the event that any unlabeled products are found they will be disposed of.*
- *On 3/1/25, the home's housekeeper supervisor verified that the home would not purchase items that needed to be dispensed into smaller bottles. All cleaning products will remain in the original manufacturer's packaging.*
- *By 3/7/25 the housekeeping supervisor will provide training to all housekeepers about how to access MSDS and how to label products safely if no other option is available.*
- *By 3/20/25, all housekeeping staff and home staff will be educated on Regulation 2600.82(a) to ensure the understanding that no products in non-manufacturer packaging are used and disposed of immediately. Staff will be educated on the risks of unlabeled products. Training documentation, including topics covered, the date, length, and attendees, will be maintained in the staff charts.*

82a - Poisonous Materials (continued)

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ██ - 05/08/2025)

85a - Sanitary Conditions

13. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/11/25 at approximately 11:58 a.m. the ceiling fan vent cover in the second-floor bathroom across from stair tower A was matted with an approximately one-eighth-inch thick layer of grey dust and lint.

Plan of Correction ***Accept ██ - 03/10/2025)***

A ceiling fan vent cover was found to have a thick layer of dust at the time of inspection. On 2/11/25, the housekeeping staff cleaned the vent, checked the other vents in the home, and ensured they were all clean and free of debris.

- *By 3/1/25 the home will implement a schedule of vent cleaning to ensure that all vents are cleaned at minimum, once per month.*
- *By 3/1/25 the home's compliance manager will work with the housekeeping supervisor to revise the home's safety checklist to ensure that it includes visual inspection of all floors, walls, ceilings, windows, doors, and surfaces to ensure that they are in good repair and free of hazards.On 3/1/25, the home's housekeeper supervisor will implement and monitor a vent cleaning schedule to ensure all vents are cleaned at least once a month. The housekeeper will review this with the PCHA monthly, and the monitoring log will be kept in the audit zone.*
- *On 3/1/25, the home's housekeeper supervisor will implement and monitor a vent cleaning schedule to ensure all vents are cleaned at least once a month. The housekeeper will review this with the PCHA monthly, and the monitoring log will be kept in the audit zone.*
- *By 3/20/25, the home's PCHA and housekeeping supervisor will educate the housekeepers on Regulation 2600.85(a) regarding the method for assessing and addressing sanitary condition issues. Training documentation, including topics covered, the date, length, and attendees, will be maintained in the staff charts.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ██ 05/08/2025)

88a - Surfaces

14. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/11/25 at approximately 12:28 p.m. the home's first-floor laundry room flooring was in a state of disrepair, there

88a - Surfaces (continued)

was one entire missing ten-inch-by-ten-inch floor tile in front of furthest Huebsch dryer to the left of the door and then four additional tiles in front of the Huebsch dryer immediately to the left of the door that were missing approximately one-half of a tile and formed the shape of the letter "T" and exposed the wooden sub-floor underneath. Additionally, there was a section of flooring tile in front of the hand sink that was missing and measured approximately six-inches long by one-inch wide that exposed the wooden sub-floor beneath.

Plan of Correction ***Accept ██ - 03/10/2025)***

There were areas of damaged flooring found during the inspection of the home. The home's maintenance department repaired the damaged floor on 2/12/25 during the inspection.

Effective immediately, any damaged or hazardous conditions will be reported for repair upon discovery.

- *By 3/1/25 the home's compliance officer will work with the housekeeping supervisor to revise the home's safety checklist to ensure that it includes visual inspection of all floors, walls, ceilings, windows, doors, and surfaces to ensure that they are in good repair and free of hazards.*
- *Beginning 3/1/25 the housekeeping supervisor, maintenance supervisor and their Senior Manager will complete a visual inspection of all areas of the home twice a month.*
- *Beginning on 3/1/25 the housekeeping supervisor will monitor the safety checklist for accuracy and compliance weekly.*
- *By 3/8/25 the home's housekeeper supervisor will provide training to all housekeepers on regulation 2600.88.a and the use of the safety checklist to ensure safety and compliance.*
- *By 3/8/25 the home's housekeeping staff will also be provided with an education on how to report damaged or unsafe items for repair/replacement.*
- *By 3/20/25, the home's PCHA and housekeeping supervisor will provide education to both the home's staff and housekeeping staff on how to monitor the surfaces of the home, including doors, windows, and ceilings, to ensure that they are in good condition and free of hazards per Regulation 2600.88(a). Documentation of the training, including the date, time, instructor, and topics covered, will be maintained in the staff charts.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ██ - 05/08/2025)

89b - Hot Water Temperature

15. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 2/11/25 at approximately 11:43 a.m., the water temperature at the sink in the private bathroom of resident room #217 belonging to resident #8 measured 126.7 degrees Fahrenheit.

89b - Hot Water Temperature (continued)

REPEAT VIOLATION 10/22/24, 5/22/24 et. al.

Plan of Correction ***Accept ███ 03/10/2025)***

The water's temperature was recorded at over 120F at 11:43am. This is a time of increased water usage, and two boilers control the water temperatures throughout building, The home's plumber monitored the temperature in room 217 later 2/11/25 and found the temperature remained below 120 F for the duration of his monitoring. To ensure compliance with regulation 2600.89.b the plumber reduced the temperature on the boiler to 117F on 2/11/25.

- *On 2/21/25 the home's compliance manager and housekeeping supervisor verified the temperature of the boiler that controls tubs and sinks to be held at 117F and verified that the temperature in room 217 remained below 120F degrees.*
- *On 2/21/25 the home's administrator provided the housekeeping supervisor with training on how to manually verify and calibrate thermometers using ice water to ensure accuracy in monitoring.*
- *Beginning 3/1/25 the home's housekeeping supervisors and assigned housekeepers will monitor water temperatures daily to ensure that they remain below 120F.*
- *By 3/1/25 the home's compliance officer will work with the housekeeping supervisor to revise the home's safety check-list to ensure compliance with regulation 2600.89b and the housekeeping supervisor will ensure compliance with water temperature at least one time per week, this will be documented with the housekeeping supervisors initial and the date/time of review.*
- *By 3/15 the home's plumber will schedule a return visit to monitor and adjust the home's boilers if needed.*
- *Long-term monitoring Plan: When the home maintains temperatures below 120F consistently for at least 30 days, the monitoring schedule will be adjusted to three times weekly for long-term monitoring. If water temperatures exceed 120F degrees the home's housekeeping supervisor is to be notified, and monitoring will be increased to daily checks, and the plumber will be contacted if required.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ██ - 05/08/2025)

92 - Windows

16. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 2/11/25 at approximately 11:24 a.m., the window screen in the bedroom of resident room #215 belonging to resident #9 was detached from the base of the frame in an area that measured approximately sixteen-inches across.

Plan of Correction ***Accept ███ 03/04/2025)***

A screen was found to be damaged from daily use during the inspection on 2/11/25. The home repaired the screen and reinstalled it in room #215 on 2/12/25.

92 - Windows (continued)

- *By 3/1/25 the home's compliance officer will work with the housekeeping supervisor to revise the home's safety checklist to ensure that it includes a weekly visual inspection of all windows, screens, and doors to ensure that they are in good repair and fully screened.*
- *By 3/8/25 the home's housekeeper supervisor will provide training to all housekeepers on regulation 2600.92 and the use of the safety checklist to ensure safety and compliance.*
- *By 3/8/25 the home's housekeeping staff will also be provided with an education on how to report damaged or unsafe items for repair/replacement.*
- *Beginning on 3/1/25 the housekeeping supervisor will monitor the safety checklist for accuracy and compliance weekly.*

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented (█ 05/08/2025)

95 - Furniture and Equipment

17. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 2/11/25 at approximately 11:55 a.m., in room #225, the home's fitness room, the slats of the window blinds were in a state of disrepair, multiple blinds were cracked and broken in multiple areas, and sections of the blinds were missing altogether.

REPEAT VIOLATION 10/22/24

Plan of Correction ***Accept █ 03/04/2025)***

During the inspection on 2/11/25, the fitness room window blinds were damaged, in poor repair, and not replaced. On 2/12/25 The home replaced the blinds on the second day of the inspection.

- *By 3/1/25 the home's compliance officer will work with the housekeeping supervisor to revise the home's safety checklist to ensure that it includes visual inspection of all furniture and equipment to ensure that they are in good repair and free of hazards.*
- *By 3/8/25 the home's housekeeper supervisor will provide training to all housekeepers on regulation 2600.95 and the use of the safety checklist to ensure safety and compliance.*
- *By 3/8/25 the home's housekeeping staff will also be provided with an education on how to report damaged or unsafe items for repair/replacement.*
- *Beginning on 3/1/25 the housekeeping supervisor will monitor the safety checklist for accuracy and compliance weekly.*

95 - Furniture and Equipment (continued)

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented (- 05/08/2025)

96a - First Aid Kit

18. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 2/11/25, the first aid kit in the home's kitchen did not include a breathing shield.

Plan of Correction ***Accept (- 03/10/2025)***

During the inspection on 2/11/25 the home's kitchen first aid kit was found to be missing a breathing shield. The home replaced the missing breathing shield during the inspection on 2/11/25.

- *By 3/15/25 designated staff (RCAs) will label each first aid kit with a list of required items, and they will initial the checklist to verify all required items are present, and all products are in date and usable.*
- *By 3/15/25 staff will tape and date/initial first aid kits to show the date of last review. First Aid kits will be visually inspected by an RCA monthly, and any missing items will be replaced. Verification of the first aid kits will be reported to the PCHAs monthly.*
- *By 3/1/25 the PCA and RN will initiate a process to replace all first aid kits and ancillary items needed annually to ensure that the kits always remain in good condition. The home's residential manager is exploring additional first aid kit/storage options to ensure easy storage of all required items and PPE.*

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented (- 05/08/2025)

101j5 - Bedside Table/Shelf

19. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

On 2/11/25 at approximately 12:04 p.m., there was no bedside table or shelf in resident room #204 for resident #10.

Plan of Correction ***Accept (- 03/04/2025)***

On 2/11/25 the resident in room 204 had moved bed away from nightstand. The location where he likes to place bed does not allow for a bedside table. To support the resident in choice to have bed in this location the home will place a bedside table near the bed.

- *By 3/1/25 the home's maintenance department will have a bedside table placed next to the bed.*

101j5 - Bedside Table/Shelf (continued)

- *By 3/1/25 the home's housekeeping staff will be provided with training on checking for the presence of a bedside table in resident rooms as part of safety checks and room cleaning to ensure compliance with regulation 2600.101.j.*

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] 05/08/2025)

101j7 - Lighting/Operable Lamp

20. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 2/11/25 at approximately 12:04 p.m., there was no operable source of light at bedside in resident room #204 for resident #10.

Plan of Correction ***Accept [redacted] 03/04/2025)***

On 2/11/25 the resident in room 204 had moved [redacted] bed away from [redacted] lamp. The location where [redacted] likes to place [redacted] bed does not allow for a lamp. To support the resident in [redacted] choice to have [redacted] bed in this location the home will install a battery powered light in this area so that resident #120 will have easy access to a light from [redacted] bed.

- *By 3/1/25 the home's maintenance department will mount a battery powered light to the wall near the resident's bed.*
- *By 3/1/25 the RCA will provide resident #10 with counseling on the importance of how to notify staff of any battery issues.*
- *By 3/1/25 the home's housekeeping staff will be provided with education on checking that the light is present in [redacted] room as part of safety checks and room cleaning to ensure compliance with regulation 2600.101.j.*
- *By 3/1/25 the home will implement a process of dating and initialing the installation of batteries in bedside lamps. Batteries will be replaced every six months, or as needed.*

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] 05/08/2025)

105g - Lint Removal and Duct Cleaning

21. 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.

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

On 2/11/25 at approximately 1:31 p.m., the ground floor laundry room had three Speed Queen stackable washer and dryer units within and the unit furthest to the left had a layer of purple and grey lint approximately one-sixteenth-of-an-inch thick coating the lint trap.

Plan of Correction ***Accept ██ - 03/04/2025)***

During the inspection on 2/11/25 lint was found in the dryer in the ground floor laundry room. All dryer lint traps were checked and emptied on 2/11/25. The home's residential manager met with the housekeeping supervisor and reviewed regulation 2600.105.g. The housekeeping supervisor educated housekeepers on the importance of cleaning the lint trap after each load of laundry.

- *On 2/20/25 the home's residential manager and housekeeping supervisor verified that all dryers in the home were free of lint in all lint traps.*
- *On 2/20/25 the home's housekeeping supervisor posted signage on all dryers prompting all users to clean the lint trap before and after each use.*
- *Beginning 3/1/25 housekeeping staff will initial a checklist to verify they emptied the trap after each load.*
- *Beginning on 3/1/25 the house keeping supervisor will complete spot checks of the lint traps and check lists five times per week to ensure ongoing compliance with regulation 2600.105g. When the home has maintained and documented lint-free dryers consistently for at least 30 days, the housekeeping supervisor's monitoring schedule will be adjusted to three spot checks weekly for long-term monitoring.*
- *By 3/1/25 the home's compliance officer will work with the housekeeping supervisor to revise the home's safety checklist to ensure that it includes documentation verifying the lint free status of the dryers. This form will be used for long-term monitoring.*

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented ██ - 05/08/2025)

107d - Procedure Emergency Management Agency Submission

22. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were not reviewed in 2024.

107d - Procedure Emergency Management Agency Submission *(continued)*

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The home had not submitted its written emergency procedures to be reviewed, updated and submitted annually to the local emergency management agency. On 2/20/25 home's compliance manager contacted the Borough of Wilkinsburg and requested a copy of the most current EOP for the Borough of Wilkinsburg. The home verified that the most current copy of the PEMA emergency plan is available onsite. On 2/21/25 the home's residential manager and compliance manager reviewed the home's existing "Garden View Manor CMHPCH Emergency Procedures and Disaster Plan" to ensure that it is fully compliant with 2600 regulations.

- *On 2/21/25 the home's residential manager and compliance manager updated the home's emergency procedures binder to reflect the updated "Garden View Manor CMHPCH Emergency Procedures and Disaster Plan."*
- *On 2/24/25 the home contacted the Borough of Wilkinsburg regarding a review of the home's emergency procedures and to obtain the most current EOP from the local municipality.*
- *Upon receipt of written verification of the review of the home's written emergency procedures. The home will post verification of the written emergency procedures review in the display case in the home's main lobby, a copy of this documentation will be retained by the PCHA.The home's [redacted] will provide education to all staff about the use of the home's updated written emergency procedures.*
- *By 3/20/25 the home will develop a written process to review and submit the "Garden View Manor CMHPCH Emergency Procedures and Disaster Plan" as the home's written emergency procedures for annual review.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] - 05/08/2025)

130h - Inoperable Smoke Detector

23. Requirements

2600.
130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction ***Accept [redacted] 03/10/2025)***

At the time of the inspection the home had an existing procedure for what to do when the smoke detector or fire alarms are inoperable. The home has an existing procedure directing staff to round and inspect the home's interior and exterior every 15 minutes until the smoke detector or fire alarm are restored and fully operational. This process was posted in the home's ground floor lobby near the fire panel, but it was not presented at the time of inspection.

- *On 2/21/25 the home's residential manager verified the procedure, and ensured it remained posted near the fire panel and updated the emergency binder to reflect regulation 2600.130.h with a copy of the 15-minute interior and exterior check procedure.*

130h - Inoperable Smoke Detector (continued)

- *By 3/20/25 the home's fire trainers will provide education to all staff about how to monitor/document every 15 minutes during periods of inoperable fire alarms and proof of training will be maintained Copies of this documentation will be maintained in the audit zone.*
- *Moving forward, the home will ensure that all new staff are provided with a review of the procedure and regulation 2600.130.h to ensure safety and compliance.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented (- 05/08/2025)

132b - Safety Inspection/Fire Drill

24. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's current fire safety inspection and supervised fire drill conducted by a fire safety expert was held on 12/13/24. However, the previous fire safety inspection and supervised fire drill conducted by a fire safety expert was held on 10/19/23.

Plan of Correction ***Accept - 03/10/2025)***

The home did not have the fire inspection and fire drill conducted by a fire expert completed within 365 days between 2023 and 2024. The annual fire inspection and drill was conducted 12/13/24.

- *By 3/20/25 the home will have an updated procedure for contacting the fire expert to schedule the annual fire inspection and drill 10 months out to ensure enough time to schedule and complete these tasks. This procedure will be used to ensure ongoing compliance.*
- *By 10/13/25 the home will contact the fire expert to schedule the next annual fire inspection and drill.*
- *By 12/13/25, the fire inspection and drill will be completed, and the PCHA will retain copies of these tasks.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented 05/08/2025)

132c - Fire Drill Records

25. 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

On 12/13/24 the home conducted a fire drill supervised by a fire safety expert, however, the fire drill was not recorded and logged in the fire drill record and there was no indication of the date, time of day, evacuation time, exit route,

132c - Fire Drill Records (continued)

number of residents participating, number of residents evacuated, number of staff present, if the alarm sounded, if the alarm was operable, or if any problems were encountered.

Plan of Correction ***Accept ███ 03/10/2025)***

The home completed the observed drill with an external fire safety expert on 12/13/24 but the home's actual fire drill record was not completed by the home or fire safety expert, although the fire letter and supporting documentation reflect the drill occurring.

- *On 2/25/25 the home's PCHA contacted the fire expert to inquire about the process and clarify how the home can work best with him to ensure this is not omitted moving forward.*
- *Beginning on 2/25/25 to ensure that the fire record is completed accurately the house keeping supervisor or designated person will complete all fire drill records using the appropriate form which reflects all the correct data for regulation 2600.132.c. This will include making the entry for the annual observed fire drill.*
- *Beginning on 3/20/25, the home's PCHA will review the monthly fire drill log and ensure it is completed and accurate to reflect Regulation 2600.132(c); this information will be placed on a fire drill review log which will be maintained in the home's audit zone.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented ███ - 05/08/2025)

132d - Evacuation

26. Requirements

2600.
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 home.

Description of Violation

On 5/30/24 at approximately 12:34 a.m., the home conducted a fire drill with 49 residents in the home, however, only 47 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

On 5/31/24 at approximately 5:10 p.m., the home conducted a fire drill with 50 residents in the home, however, only 49 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

On 5/31/24 at approximately 11:20 p.m., the home conducted a fire drill with 50 residents in the home, however, only 49 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

On 6/3/24 at approximately 11:36 p.m., the home conducted a fire drill with 50 residents in the home, however, only 47 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

On 7/5/24 at approximately 9:09 a.m., the home conducted a fire drill with 50 residents in the home, however, only 49 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

On 11/20/24 at 9:25 a.m. the home conducted a fire drill in three minutes with 50 residents in the home. However, the fire safe evacuation time of five minutes was no longer valid as of 11/3/24 and the default time was two minutes and thirty seconds.

132d - Evacuation (continued)

On 12/13/24 the home conducted a fire drill supervised by a fire safety expert. However, residents of the personal care home were not evacuated to a public thoroughfare or fire safe area designated in writing by that fire safety expert and were instead directed to the home's dining room which was not a fire safe area.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

On multiple occasions during the inspection cycle, there were fire drills where some residents did not evacuate, and accurate documentation of the home's response was not maintained. The home permitted the fire safety letter extending the home's time to 5 minutes lapse for a period which exceeded a month.

- *Beginning on 2/25/25 to ensure that the fire record is completed accurate the house keeping supervisor or designated person will complete all fire drill records using the appropriate form which reflects all the correct data for regulation 2600.132.c. This will include making the entry for the annual observed fire drill.*
- *Beginning on 2/25/25 the home's PCHA has been identified as the responsible party for scheduling the annual observed fire drill, securing the fire letter, and coordinating with the home's housekeeping supervisor who assists in operating the drill.*
- *Beginning on 3/1/25 the home will implement a scheduling process to trigger the scheduling of the annual fire drill and fire letter 10 months from the last observed drill to ensure that it can be scheduled and completed prior to the expiration of the last letter.*
- *Beginning 2/25/25 the home's housekeeping supervisor, PCHA and designated staff (as determined by the home) will meet after each fire drill to discuss which residents did not evacuate and known factors contributing to the failure to evacuate. Based on the situation the home will follow two courses of corrective action. The outcome of this discussion will be documented on the annual fire drill record.*
- *Starting on 2/25/25, if a resident cannot evacuate due to physical conditioning issues, the resident's PCP will be contacted and a referral for PT will be requested within 72 hours. The home's expectation is that the resident complies with recommended PT treatment plans to ensure the ongoing ability to evacuate the building. If the resident refuses to complete PT or demonstrates a sustained inability to evacuate, the home will pursue discharge to the appropriate level of care/placement.*
- *Beginning on 2/25/25 if a resident refuses to evacuate the home due to behavioral issues or mental health needs the following process will be followed.*
  - *On the first occurrence, within 72 hours of the refusal to evacuate the homes [redacted] designated person will meet with the resident to discuss barrier to evacuation and reinforce that mandatory monthly fire drill participation is a house rule (#10 on the Admission Agreement), they will also be offered a "Warning letter" documenting the meetings occurrence.*
  - *On the second occurrence within 72 hours of the refusal to evacuate the homes [redacted] or designated person will meet with the resident to discuss the pattern of refusal, address any identified barriers, and issue a "Pre-eviction letter" stating continued failure to evacuate will result in a 30-day discharge notice.*
  - *On the third occurrence, within 72 hours of the refusal to evacuate the homes PCHA, Team Lead, or designated person will meet with the resident and issue a "Discharge Notice" advising the resident that they have 30 days to vacate the premise. In the event that the resident refuses to evacuate after receiving the discharge notice, they may face additional penalties including immediate discharge.*
  - *All residents who receive discharge notices may appeal the discharge, however if there are additional events of non-evacuation the appeal will be rejected. All meetings and discussions with residents, SC, and guardians will be documented in the resident's record.*
- *Effective 3/4/25, the home's PCHA/Supervisor/Team Lead will increase staffing across all shifts if there is a*

132d - Evacuation (continued)

resident who is unable to evacuate the building during a fire alarm to comply with Regulation 2600.132(d).

- *By 10/1/25 the home's PCHA will contact the external fire safety expert and schedule the next observed drill to occur before 12/13/25.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] 05/08/2025)

143a - Emergency Medical Plan

27. Requirements

2600.
143.a. The home shall have a written emergency medical plan that includes the following:

Description of Violation

The home did not have an emergency medical plan.

Plan of Correction ***Accept [redacted] 03/10/2025)***

Recently, all residential programs operated by the organization changed the disaster plan format. The format utilized did not meet departmental regulations to be considered an emergency medical plan. On 2/21/25 the home's residential manager and compliance manager updated the home's emergency medical plan to ensure that it contained all the requirements of 2600.143. On 2/21/25 the home's residential manager and compliance manager updated the home's emergency procedures binder to reflect the updated "Garden View Manor CMHPCH Emergency Procedures and Disaster Plan"

- *By 3/20/25 designated staff will update the Emergency Medical Plan to include the current and accurate resident face sheets.*
- *By 3/20/25 the home's PCHA, Designated Person, Team Lead will provide education to all staff about the use of the home's updated written emergency medical procedures as outlined by "Garden View Manor CMHPCH Emergency Procedures and Disaster Plan."*
- *The Plan will be reviewed on a semi-annual basis.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] 05/08/2025)

183d - Prescription Current

28. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 2/12/25 at approximately 11:15 a.m., there were multiple doses of morning and evening 5mg tablets of Haloperidol on the pharmacy roll-pack for resident #5. However, resident #5's Haloperidol 5mg tablet was discontinued on 2/10/25.

183d - Prescription Current *(continued)*

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Medication remained on the pack-med roll after its discontinuation. On 2/11/25 the home's RN reviewed the pac-med roll to ensure that all discontinued medications were removed from the roll to ensure that this medication was not administered in error. On 2/11/25 The MAR will indicate the medication was discontinued, and the physician's order will be retained.

- *On 2/26/25 the home's PCHA ensured that all medication rooms had clear posting of the 5-Rs to encourage compliance with safe medication practices.*
- *On 2/26/25 the home's supervisor worked with the home's newly hired RN to review and train on the process of MAR reconciliation to ensure accuracy.*
- *On 3/11/25, the PCHA will meet with the Senior Manager of Nursing and the home's RNs to review Regulations 2600.181 to 2600.191 and Regulations 2600.141 to 2600.143 to ensure that the Senior Manager and the home's RNs are aware of regulations regarding the medication administration process, including having current orders for all medications.*
- *By 3/20/25, the home's RNs will complete weekly MAR audits to ensure that all medication entries on the MAR are complete and accurate to ensure compliance with Regulation 2600.183(d).*
- *By 3/30/25 [redacted] will develop, facilitate, and monitor the education mandatory for all staff who administer medications. This education will include instructions on how to remove all medications from the medication cart which are discontinued by the practitioner and how to destroy them, according to facility policy.*
- *By 3/30/25 all staff who pass medications will complete the mandatory education presented by the Senior Manager of Nursing.*
- *Starting 4/15/25, the Senior Manager of Nursing will review completed cart and MAR audits quarterly for accuracy. The audits will ensure the home's RNs are completing the cart and MAR audits correctly and in compliance with Regulation 2600.183.d and all other medication-related Regulations 2600.181 to 2600.191.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] - 05/08/2025)

184a - Resident's Meds Labeled

29. 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

The pharmacy label for resident #4's Lantus Solostar 100U/mL indicated "Inject 10 units into the skin nightly." However, the pharmacy label was altered, the number 10 was scratched out and replaced with the number 13 above it, which was also scratched out and replaced with the number 11 to the right of the word "nightly." Resident #4 is prescribed

184a - Resident's Meds Labeled (continued)

Lantus Solostar 100U/ml inject 8 units into the skin nightly.

Plan of Correction ***Accept 03/10/2025)***

The home did not correctly manage the labeling of Resident #4 Lantus Solostar 100U/mL and altered the label. On 2/11/25 a label was placed on the Lantus Solostar 100U/mL for resident #4 stating "Dose change refer to MAR. On 2/17/25 the home obtained pre-printed stickers indicated "dose change refers to MAR"

- *On 2/26/25 the home's designee worked with the home's newly hired RN to review and train on the process of MAR reconciliation to ensure accuracy.*
- *By 3/15/25 identified RNs will complete audits of the home's medication carts and MARs to ensure compliance with all regulations. Moving forward cart audits will be completed monthly.*
- *By 3/20/25 the home's Senior Manager Nursing, will develop, facilitate, and monitor the education that will be mandatory for all staff who currently administer medications instructing that no pharmacy label is altered, and the correct way to use the "refer to MAR" stickers documentation of this will be maintained on training logs in the staff chart.*
- *By 3/20/25, the home's RNs will complete weekly MAR audits to ensure that all medication entries on the MAR are complete and accurate to ensure compliance with Regulation 2600.184(a).*
- *Starting 4/15/25, the Senior Manager of Nursing will review the completed cart and MAR audits quarterly for accuracy, ensuring the home's RNs are completing the cart and MAR audits correctly to ensure the standards of Regulation 2600.184(a) and all other medication-related Regulations 2600.181 to 2600.191 are met.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented 05/08/2025)

187a - Medication Record

30. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #9 is prescribed Salonpas 3.1%-6.0%-10% patch, apply 1 patch to affected area up to 3 times a day as

187a - Medication Record (continued)

needed. Remove after 8 hours. Resident #9 has been administered the medication, however, the resident's February 2025 medication administration record(MAR) did not include the medication to document the administration and removal of the Salonpas 3.1%-6.0%-10% patch.

Resident #5 is prescribed DOK 100mg capsule, take one capsule by mouth 2 times a day. Resident #5 has been administered the medication, however, the resident's February 2025 MAR did not include the medication to document the administration of the DOK 100mg capsule.

REPEAT VIOLATION 10/22/24, 5/22/24 et. al.

Plan of Correction ***Accept [redacted] 03/10/2025)***

The home prints the MARs and failed to provide a current MAR for Resident #9 Salonpas patch and Resident #5 DOK. On 2/11/25 the home's RN created a new PRN MAR page for resident #9 Salonpas patch. On 2/11/25 the home's RN created a MAR entry on the existing MAR page for resident #5 DOK 100mg.

On 2/26/25 the home's designee worked with the home's newly hired RN to review and train on the process of MAR reconciliation to ensure accuracy.

- *On 3/11/25, the PCHA will meet with the Senior Manager of Nursing and the home's RNs to review Regulations 2600.181 to 2600.191 and Regulations 2600.141 to 2600.143 to ensure that the Senior Manager and the home's RNs are aware of regulations regarding the medication administration process, including having current orders for all medications.*
- *By 3/20/25 identified RNs will complete audits of the home's medication carts and MARs to ensure compliance with all regulations. Moving forward cart audits will be completed monthly and documentation will be maintained isn the audit zone.*
- *By 3/20/25 the home's Senior Manager Nursing, will develop, facilitate, and monitor the education that will be mandatory for all staff who currently administer medications instructing the order is current, and transcribe the prescription label to a MAR to include all items included in 2600.187.a. Documentation of this education will be maintained on training logs in the staff chart.*
- *By 3/30/25 all staff who pass medications will complete the mandatory education presented by the Senior Manager of Nursing.*
  By 3/20/25, the home's RNs will complete weekly MAR audits to ensure that all medication entries on the MAR are complete and accurate to ensure compliance with Regulation 2600.187(a).
- *Starting 4/15/25, the Senior Manager of Nursing will review the completed cart and MAR audits quarterly for accuracy, ensuring the home's RNs are completing the cart and MAR audits correctly to ensure the standards of Regulation 2600.187(a) and all other medication-related Regulations 2600.181 to 2600.191 are met.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] 05/08/2025)

187b - Date/Time of Medication Admin.

31. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #9 is prescribed Hydroxyzine Pamoate Cap 25mg, take one capsule by mouth four times a day as needed. However, on 2/8/25 at approximately 6:52 p.m., direct care staff person H documented the February 2025 medication administration record before administering the medication and the medication was not in the home or available to administer to resident #9.

Plan of Correction ***Accept (03/10/2025)***

At the time of inspection resident #1 Hydroxyzine Pamoate was not available for administration on 2/8, but staff signed that it was administered prior to realizing that the medication was not available.

- *Resident #9 Hydroxyzine Pamoate Cap 25 mg was onsite at the time of the inspection, having been delivered on 2/10/25, and has been administered as ordered since.*
- *On 3/11/25, the PCHA will meet with the Senior Manager of Nursing and the home's RNs to review Regulations 2600.181 to 2600.191 and Regulations 2600.141 to 2600.143 to ensure that the Senior Manager and the home's RNs are aware of regulations regarding the medication administration process, including having current orders for all medications.*
- *By 3/20/25 the process of reordering PRN medications will be reviewed with all staff who order medication, to ensure that all medications are reordered when there are 7 days' worth (e.g., for resident #9 medication this would be 28 doses out).*
- *By 3/30/25 the home's RNs will complete weekly MAR audits to ensure that all medication entries on the MAR are complete and accurate to ensure compliance with Regulation 2600.187(b).*
- *By 3/20/25 the home's Senior Manager Nursing, will develop, facilitate, and monitor the education that will be mandatory for all staff who currently administer medications instructing them in the correct management of PRN and regular medication reordering, and the documentation of all medication passes after the administration.*
- *By 3/30/25 all staff who pass medications will complete the mandatory education presented by the Senior Manager of Nursing.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented - 05/08/2025)

187d - Follow Prescriber's Orders

32. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #9 is prescribed Hydroxyzine Pamoate Cap 25mg, take one capsule by mouth four times a day as needed. However, on 2/11/25 resident #9 indicated he had requested the Hydroxyzine capsule on 2/8/25 and 2/9/25 but it was not available in the home to be administered to the resident.

Resident #4 is prescribed Trihexyphenidyl 2mg tablet, take one tablet by mouth every morning and take one tablet around 4 p.m. However, on dates ranging from 1/27/25 through 2/11/25, resident #4 was administered the second

187d - Follow Prescriber's Orders (continued)

Trihexyphenidyl 2mg tablet at 8:00 p.m.

Resident #1 is prescribed Furosemide 80mg tablet, take one tablet by mouth daily. However, on dates ranging from 2/4/25 through 2/12/25 the Furosemide 80mg tablet was not available in the home and not administered to resident #1.

Plan of Correction ***Accept █ - 03/10/2025)***

At the time of inspection there were several irregularities found, each of those items is corrected. Resident #9 Hydroxyzine Pamoate Cap 25 mg was onsite at the time of the inspection, having been delivered on 2/10/25, and has been administered as ordered/requested since. On 2/12/25 the home's RN contacted the prescriber and sought clarification on the order for resident #4 Trihexyphenidyl. On 2/12/25 the home's RN ensured the MAR and medication had the same prescriber instructions. On 2/17/25 the home obtained the Furosemide 80 mg and Resident #1 has continued to receive it as ordered. Additional delays in obtaining this medication occurred due to the guardian's requirement that the guardian manage all medical appointments. Due to lack of responsiveness an APS report was filed and reported to DHS.

- *By 3/15/25 identified RNs will complete audits of the home's medication carts and MARs to ensure compliance with all regulations and that all MARs match the prescriber's orders. Moving forward cart audits will be completed monthly.*
- *By 3/20/25 the Senior Manager Nursing, will develop, facilitate, and monitor the education mandatory for all staff who administer medications. This education will include verifying the order is current and the label and MAR match. The importance of following all prescribed instructions will be emphasized. This education will also include a review of procedures for obtaining clarification from the pharmacy and prescribers if there is a variance between the MAR and medication label.*
- *By 3/20/25 all staff who pass medications will complete mandatory education presented by the Senior Manager of Nursing documentation will be placed on thier training log in the staff chart.*
- *On 3/11/25, the PCHA will meet with the Senior Manager of Nursing and the home's RNs to review Regulations 2600.181 to 2600.191 and Regulations 2600.141 to 2600.143 to ensure that the Senior Manager and the home's RNs are aware of regulations regarding the medication administration process, including having current orders for all medications.*
- *By 3/20/25, the home's RNs will complete weekly MAR audits to ensure that all medication entries on the MAR are complete and accurate to ensure compliance with Regulation 2600.187(d) copies will be maintained in teh audit zone.*
- *For resident #1, the home's supervisor completed an incident report on 2/13/25. The resident was notified of the error on 2/13/25 by the home's supervisor; the resident's designated person was notified on 2/13/25 by the home's supervisor; the resident's prescriber was notified on 2/13/25. The prescriber directed no additional steps at this time.*
- *For resident #4, the home's supervisor completed an incident report on 3/4/25. The resident was notified of the error on 3/4/25 by the home's supervisor; the resident's designated person was notified on 3/4/25 by the home's supervisor; the resident's prescriber was notified on 3/4/25. The prescriber directed no additional steps at this time.*
- *For resident #9, the home's supervisor completed an incident report on 3/4/25. The resident was notified of the error on 3/4/25 by the home's supervisor; the resident's designated person was notified on 3/4/25 by the home's supervisor; the resident's prescriber was notified on 3/4/25. The prescriber directed no additional steps at this time.*

187d - Follow Prescriber's Orders (continued)

- *By 3/20/2025, all medication passers will be provided with an education on medication error incident reporting to include the documentation of notifications to the resident, designated person, and prescriber and the documentation of the home's follow-up on all prescriber instructions this will be documented on a training log in staff chart.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented (- 05/08/2025)

224a - Preadmission Screen Form

33. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #8, admitted 24, did not have a preadmission screening.

Resident #10, admitted /24, did not have a preadmission screening.

Plan of Correction ***Accept - 03/10/2025)***

Document management was not maintained. All staff will be trained to copy Pre-Admission Screening onto colored paper to identify the importance of record retention.

- *Starting on 3/1/25, the home's PCHA and designated staff began auditing all resident charts to ensure Pre-admission screenings are present.*
- *On 3/5/25, the PCHA completed Resident #8 and #10's Preadmission Screening to replace the missing documentation. The updated Preadmission Screening has been placed in the chart of Resident #8 and Resident #10*
- *By 3/1/25 the PCHA will ensure all new admissions will have their preadmission screening copied onto marigold paper before filing it in the resident chart.*
- *By 3/20/2025, all admission agreements will be copied onto marigold paper to indicate this document should not be purged.*
- *By 3/20/25, the home's administrator will review all resident chart audit forms and complete readmission screenings for any missing documents. Confirmation that this has been completed will be placed on the audit form, and the updated document will be filed in the resident chart.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented - 05/08/2025)

225c - Additional Assessment

34. Requirements

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

225c - Additional Assessment *(continued)*

1. Annually.

Description of Violation

The assessment, dated [redacted]/24, for resident #5 was incomplete and left blank in multiple areas including managing health care, securing health care, securing and using transportation, making and keeping appointments, judgment and the ability to use and avoid poisonous materials.

REPEAT VIOLATION 5/22/24 et. al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

At the time of inspection Resident #5 chart contained an incomplete RASP, which did not fully comply with departmental expectations.

- *On 3/6/25, the home's PCHA completed Resident #5's RASP and reviewed it with her to ensure compliance with Regulation 225(c). The updated RASP assessment was signed by the PCHA and resident and filed in the resident's chart.*
- *By 3/15/25 the home's residential manager and PCHA will create a tracking tool to ensure that all resident assessments are completed within regulation.*
- *By 3/20/2025 the home's PCHA will provide training and guidance to identified staff to ensure that they are aware of the process and evaluation criteria to ensure that resident assessments are done thoroughly, accurately and within the designated time period.*
- *By 3/20/23, all resident assessments will be reviewed by designated staff and reviewed by the PCHA. The reviewed audit forms will be maintained in the home's audit zone and reviewed at the Quarterly Quality Management Meetings.*
- *By 3/20/25 designated staff will audit all resident assessments to ensure they are complete and accurate. The PCHA will verify that the assessments were complete and accurate. The resident assessment will be stored in the resident chart, the audit form will be stored in the audit zone.*
- *By 3/20/25 the home's PCHA/Supervisor/Designed Staff will have updated resident assessments to ensure they are accurate and complete.*

Licensee's Proposed Overall Completion Date: *03/20/2025*

Implemented [redacted] - 05/08/2025)

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

Facility Information

Name: *GARDEN VIEW MANOR* **License #**: *44069* **License Expiration**: *06/13/2025*

Address: *441 SWISSVALE AVENUE, PITTSBURGH, PA 15221*

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

Administrator

Name

Legal Entity

Name: *MERCY LIFE CENTER CORPORATION*

Addres

Phone

Certificate(s) of Occupancy

Type: *I-2* **Date**: *04/08/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *55* **Waking Staff**: *41*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *04/17/2025*

Inspection Dates and Department Representative

04/14/2025 - On-Site:

04/17/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *55* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *55* **Diagnosed with Intellectual Disability**: *3*

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

Inspections / Reviews

04/14/2025 - Partial

Lead Inspector **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/03/2025*

05/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/09/2025*

05/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/06/2025*

Reviewer: . [redacted] **Follow-Up Type:** *Exception*

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/14/25 at 9:54 a.m., there was an approximate one-eighth-inch layer of dust on the ceiling light fixture and chain attached to the fixture in resident room #207 belonging to resident #2.

On 4/14/25 at 10:53 a.m., there was an approximate one-eighth-inch layer of black dust covering the bathroom ceiling exhaust fan in the private bathroom of resident room G7 belonging to resident #3.

Plan of Correction ***Accept [redacted] 05/05/2025)***

The ceiling light fixture and chain attached to the fixture in resident room #207 belonging to resident #2 was cleaned on 4/14/25.
The bathroom ceiling exhaust fan in the private bathroom of resident room G7 belonging to resident #3 was cleaned on 4/14/25.

• On 4/23/25, the forms for the housekeeping supervisor to check that all areas are cleaned to meet standards and regulations, specifically to reflect thorough cleaning of all ceiling fans, light fixtures, chandeliers and chains and vents were revised. The housekeeping supervisor will complete the reviews for maintaining sanitary conditions and document the findings on these forms monthly beginning 5/1/25. These forms will be maintained in the "Housekeeping" binder in the ground floor supervisor's office.
• On 4/29/25, the housekeeping supervisor educated the housekeeping staff on Regulation 2600.85(a) regarding this regulation, the method for assessing and addressing sanitary condition issues, the specific violations, and a review of the updated cleaning forms. The DHS "Adult Residential Licensing Record of Training" form was used to record this training. Training documentation, including topics covered, the date, length, and attendees, will be maintained in the staff charts.
• Starting 5/15/25, Garden View Manor has contracted with a cleaning service to do deep cleaning one time every month. The housekeeping senior manager will inspect every room after the cleaning service is completed to ensure all areas are cleaned monthly. The cleaning service will begin monthly cleaning. The checklist form used by the housekeeping senior manager will be maintained in the "Housekeeping" binder in the ground floor supervisor's office.

Licensee's Proposed Overall Completion Date: 05/16/25

Licensee's Proposed Overall Completion Date: *05/16/2025*

Implemented ([redacted] 05/08/2025)

96a - First Aid Kit

2. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

96a - First Aid Kit *(continued)*

Description of Violation

On 4/14/25 at approximately 4:46 p.m., the brand new first aid kit provided by direct care staff person A did not include a breathing shield.

Plan of Correction ***Accept ██ 05/05/2025)***

- *On 4/14/25, during the audit, a breathing shield was placed inside of the first aid kit.*
- *By 5/3/25, and additional supplies for missing or expired items will placed into all first aid kits, including breathing shields and all of the new first aid kits and all first aid kits will be audited again.*

- *Instructions for first aid kit checks:*
  - *o First aid kit checks and checklists are completed one time a month by direct care staff and checked by the Team Leads or Supervisors. These forms will be maintained in the "Housekeeping" binder in the ground floor supervisor's office.*
  - *o The designated staff (direct care staff) will label each first aid kit with a list of required items, and they will initial the checklist to verify all required items are present, and all products are in date (not expired) and usable.*
  - *o The designated staff (direct care staff) will tape and date/initial first aid kits to show the date of last review.*
  - *o Any missing items will be replaced by the Team Leads or Supervisors.*
    - *The PCHA and Team Leads will replace all first aid kits and ancillary items needed monthly to ensure that the kits always remain in good condition.*
- *Verification of the first aid kits being checked and complete will be reported to the PCHAs monthly.*

Licensee's Proposed Overall Completion Date: 05/03/2025

Licensee's Proposed Overall Completion Date: *05/03/2025*

Implemented ██ 05/08/2025)

132d - Evacuation

3. Requirements

2600.
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 home.

Description of Violation

On 3/26/25 at 6:32 a.m. the home conducted a fire drill with 50 residents in the home, however, only 44 residents were evacuated to a public thoroughfare designated in writing by a fire safety expert. Additionally, residents were evacuated from the home in 5 minutes and 6 seconds, but the safe evacuation time designated in writing by a fire safety expert on 12/13/24 was 5 minutes and 0 seconds.

Plan of Correction ***Accept ██ 05/05/2025)***

- *On 3/26/25 The fire safety expert for Garden View Manor was consulted about an action plan if the fire drill exceeds the 5 minutes he designated as a safe evacuation time. The fire safety expert instructed the PCHA to conduct fire drills on the same day until all residents are able to evacuate the building in the safe evacuation time designated.*
- *On 2/25/25 the Discharge Criteria was revised and procedures were added to address residents not*

132d - Evacuation (continued)

evacuating the building.

- *Procedures:*
  - *If a resident cannot evacuate due to physical conditioning issues, the resident's PCP will be contacted and a referral for PT will be requested within 72 hours. The home's expectation is that the resident complies with recommended PT treatment plans to ensure the ongoing ability to evacuate the building. If the resident refuses to complete PT or demonstrates a sustained inability to evacuate, the home will pursue discharge to the appropriate level of care/placement.*
  - *If a resident refuses to evacuate the home due to behavioral issues or mental health needs the following process will be followed.*
    - *On the first occurrence, within 72 hours of the refusal to evacuate the homes [redacted] or designated person will meet with the resident to discuss barrier to evacuation and reinforce that mandatory monthly fire drill participation is a house rule (#10 on the Admission Agreement), they will also be offered a "Warning letter" documenting the meetings occurrence.*
    - *On the second occurrence within 72 hours of the refusal to evacuate the homes [redacted] or designated person will meet with the resident to discuss the pattern of refusal, address any identified barriers, and issue a "Pre-eviction letter" stating continued failure to evacuate will result in a 30-day discharge notice.*
    - *On the third occurrence, within 72 hours of the refusal to evacuate the homes [redacted] or designated person will meet with the resident and issue a "Discharge Notice" advising the resident that they have 30 days to vacate the premise. In the event that the resident refuses to evacuate after receiving the discharge notice, they may face additional penalties including immediate discharge.*
  - *All residents who receive discharge notices may appeal the discharge, however if there are additional events of non-evacuation the appeal will be rejected. All meetings and discussions with residents, SC, and guardians and will be documented in the resident's record.*
  - *Effective 3/4/25, the home's PCHA/Supervisor/Team Lead will increase staffing across all shifts if there is a resident who is unable to evacuate the building during a fire alarm to comply with Regulation 2600.132(d).*
- *On 3/27/25, the four residents who did not evacuate during the fire drill on 3/26/25 were issued warning letters as per the above procedure. The letters were given to the residents and a copy is maintained in the resident's individual chart.*

Licensee's Proposed Overall Completion Date: 03/26/25

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented [redacted] - 05/08/2025)

144c1 - Smoking Area Guidelines

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:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 4/14/25 at approximately 10:42 a.m., resident #4 was sitting on the front porch in front of an open window smoking a cigarette near the entrance to the kitchen. The smoke was blowing into the home through the open window, there was no fireproof receptacle or ashtray in this area, and it was not the designated smoking area.

Plan of Correction ***Accept (05/05/2025)***

• On 4/29/25, Metal No Smoking signs were installed on the front of the building on both levels.
• On 4/29/25, the tables and chairs were removed from the front of the building to discourage smoking in non-designated areas.
• On 4/29/25, the Tobacco Policy was revised to include steps to address smoking in non-designated areas.
• Beginning 4/29/25, all residents found to be smoking in non-designated smoking areas will be prompted to smoke in the designated smoking area.
• Beginning 4/29/25, when residents are smoking outside of the designated smoking area, a smoking violation warning will be issued. We will follow all steps of our Tobacco Policy and issue further warnings, have treatment team meetings as needed or issue a discharge notice when the policy is not followed.

• The steps from the Tobacco Policy are below:
1. Upon the first use inside of the building or outside of the designated smoking area, the primary counselor will:
a) Review the tobacco policy with the person served and will ask her/him to participate in a wellness activity as an alternative to tobacco use, e.g.: playing basketball, walking, yoga, etc.
b) Staff and person served will assess likelihood of continued tobacco use inside of the building and develop an individualized plan to include tobacco cessation.
1) The person's served primary care doctor can offer enhanced tobacco cessation services to persons served. These services may include nicotine replacement therapies, group and individual treatment therapies, wellness alternatives and incentive programs.
c) Staff will inform the person served that upon the next time s/he smokes inside of the building or outside of the designated smoking area, a treatment team meeting will occur to address the issue and develop plans for the person served to stop smoking inside of the building.
d) A meeting will be held with the treatment team (person served, MH Residential staff, the person's served Service

Coordinator/RSC/CTT/ECSC, CIT/County OBH Staff, etc. and other treatment team members). At this meeting the following will occur:
1) Review of the tobacco policy with the person served.
2) Education of tobacco use and effects on health of a person with the person served.
3) Develop an individualized plan to address the issue for the person served.
4) Additional tobacco cessation services will be offered to the person served.
5) Review of the person's served emergency relocation plan.

144c1 - Smoking Area Guidelines (continued)

e) This is the first warning, and the person served will be notified of this in writing. The Treatment Team will be notified. A copy of this letter will be maintained in the resident's chart.

2. If a second use inside of the building or outside of the designated smoking area occurs, a meeting will be held with the treatment team (person served, MH Residential staff, the person's served Service Coordinator, Community Treatment Team (CTT) or Enhanced Clinical Service Coordinator (ECSC), CIT/County OBH Staff, etc. and other treatment team members.) At this meeting the following will occur.

a) Review or revise the individualized plan to address the issue for the person served.

b) Additional tobacco cessation services will be offered to the person served.

c) Develop a specific plan for housing in the event the person is ultimately discharged from the program. Review this with the person served.

d) This is the second warning (pre-discharge) and the person served will be notified of this in writing. The treatment team will be notified. A copy of this letter will be maintained in the resident's chart.

3. If a third use inside of the building or outside of the designated smoking area occurs, a meeting will be held with the treatment team (person served, MH Residential staff, the person's served Service Coordinator/RSC/CTT/ECSC, CIT/County OBH Staff, etc. and other treatment team members) to determine a plan. The person served will be asked to agree to the plan in writing with the understanding that there may be additional recommendations which may include discharge.

a) This is the final warning, and a 30-day discharge will be issued in writing to the person served. The Treatment Team will be notified. A copy of this letter will be maintained in the resident's chart.

b) The person served may appeal this discharge (on the appeal form in writing) by stating that [redacted] agrees to not smoke inside of the building or outside of the designated smoking area again and what skills [redacted] will use to prevent smoking inside of the building or outside of the designated smoking area.

1) Due to safety concerns with tobacco use inside of the building mor outside of the designated smoking area, the appeal process to the 30-day discharge for tobacco use is as follows:

o The person served will complete the "Notice of Appeal" form and submit it to the MH Residential Senior Manager within 24 hours of being issued the 30-day Discharge Letter.

o The MH Residential Senior Manager will respond to the person served with a decision within 72 hours of receipt of the Notice of Appeal.

c) If the appeal is denied, the person served must leave the program by the end of the 30 days indicated on the letter.

d) If the appeal is approved, the person served may remain in the program if they have no occurrences of smoking inside of the building within the 30 days.

e) If additional policy violation(s) occur within the 30 days after the 30-day discharge has been issued, the Treatment Team will be notified and the person served will be relocated to her/his emergency relocation site immediately.

f) If the 30 days has passed with no occurrences of smoking inside of the building or outside of the designated smoking area, and the person served again smokes inside of the building or outside of the designated smoking area, the process will start over with the first warning.

4. At any time, if any use results in serious concerns to the safety of the person served or others, a 30-day or immediate discharge may occur. The Treatment Team will be notified.

a) Ex: the resident is smoking inside of the building and discards the lit tobacco onto a mattress or into a trash can or a fire starts due to tobacco use on program premises, etc.

b) A meeting with all Treatment Team members will occur as soon as possible, but no later than 72 hours after the incident. The Treatment Team will discuss plans for the person served, which may include immediate discharge.

144c1 - Smoking Area Guidelines (continued)

Licensee's Proposed Overall Completion Date: 04/29/25

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented█ - 05/08/2025)

185a - Implement Storage Procedures

5. 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

On 4/17/25 at approximately 10:59 a.m., the mini-fridge in the first-floor medication room indicated a temperature of 48 degrees Fahrenheit. At approximately 11:34 a.m. the temperature was re-checked and measured 50 degrees Fahrenheit. At approximately 2:01 p.m. the temperature was checked again and indicated a reading of 34 degrees Fahrenheit. However, resident #6's prescribed Mounjaro 10mg/0.5mL single-dose pen was stored in the mini-fridge, and the manufacturer's directions for Mounjaro 10mg/0.5mL indicate "Store your Pen in the refrigerator between 36° to 46° F (2°C to 8°C)."

Plan of Correction ***Accept █ - 05/05/2025)***

- *On 4/28/25, a new refrigerator was ordered and placed in the medication room.*
- *On 4/28/25 Temperature tracking forms were placed on the front of each medication room refrigerators and staff who administer medications document the temperatures daily.*
- *Instructions and plan for monitoring refrigerator temperatures:*
  - *o Temperature is recorded one time daily. Thermometer needs to be hanging or standing inside of the refrigerator.*
  - *o If thermometer does not read 36°F-46°F in the med room refrigerator, corrective action is needed. Document action below (on the form). (Insulin needs to be kept at temps between 36?F - 46?F)*
  - *o If corrective action was taken*, record temperature again after at least 8 hours and if thermometer does not*

185a - Implement Storage Procedures (continued)

read 36°F-46°F indicate another corrective action and report this to the supervisor.

** If corrective action was taken, record temperature again after at least 8 hours. If thermometer does not read 36°F-46°F report this to the supervisor who will develop another corrective action to resolve the issue.*

• Completed monthly forms will be stored in the "Nursing" binder in the ground floor supervisor's office.

Licensee's Proposed Overall Completion Date: 04/25/25

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented [redacted] 05/08/2025)

224a - Preadmission Screen Form

6. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted [redacted]25, however, the resident's preadmission screening form was dated 2/5/25.

Resident #7 was admitted [redacted]5, however, the resident's preadmission screening form was dated 1/7/25.

Plan of Correction ***Accept [redacted] 05/05/2025)***

• Beginning 4/17/25, new admissions will be admitted to the program within 30 days of the completed Department's preadmission screening form. The PCHA and Utilization Care Manager will track and confirm these timelines are met. The PCHA will use a tracking form to ensure the dates are within the timeframe. This form is located on OneDrive.

• Beginning 4/17/25, if a resident is admitted after the 30 days of the completed Department's preadmission screening form, the PCHA will complete a new Department preadmission screening form on the day of the resident's admission.

Licensee's Proposed Overall Completion Date: 04/17/25

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented [redacted] 05/08/2025)