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

June 11, 2025

[redacted], OWNER
ROSALIE J DAPICE
PO BOX 6363, 528-30 PRESSLEY ST
PITTSBURGH, PA, 15212

RE: HENDERSON HOUSE
P.O.B. 6363,528-30 PRESSLEY ST
PITTSBURGH, PA, 15212
LICENSE/COC#: 43095

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/22/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HENDERSON HOUSE* **License #**: *43095* **License Expiration**: *03/10/2025*

Address: *P.O.B. 6363,528-30 PRESSLEY ST, PITTSBURGH, PA 15212*

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

Administrator

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

Legal Entity

Name: *ROSALIE J DAPICE*

Address: *PO BOX 6363, 528-30 PRESSLEY ST, PITTSBURGH, PA, 15212*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/29/1992* **Issued By**: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *21* **Waking Staff**: *16*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/22/2025*

Inspection Dates and Department Representative

04/22/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *16*

Diagnosed with Mental Illness: *21* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

04/22/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/04/2025*

Inspections / Reviews *(continued)*

05/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/31/2025*

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

05/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/30/2025*

06/11/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/31/2025*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner. At approximately 11:25 a.m., the carbon monoxide detector mounted to the wall in the home's basement across from the dry food storage area did not have dated batteries.

REPEAT VIOLATION 6/16/23

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

Immediate: Administrator changed the batteries in the smoke detector located on the wall in the home's basement across from the dry food storage are. The detector was labeled with the date the battery was changed (4/22/2025)

Continued compliance: The administrator or designee will walk the bld to audit/dates on all carbon monoxide detectors in the home. If the date is 1 year or more or the signal is failing the battery will be replaced and the detector dated. This audit will take place by 5/15/25. The administrator or designee will audit the carbon monoxide detectors 'monthly to ensure adequate signal, date of battery change. Record of the audit will be kept in the homes records. Audit will be attached to this report. First audit 5/15/25 -monthly thereafter

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented ([redacted] - 06/11/2025)

65i - Training Record

2. 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

The record of training for direct care staff person A did not include documentation of required training topics under 2600.65(f) to include:
(1) Medication self-administration training.
(3) Care for residents with dementia and cognitive impairments.
(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
(5) Personal care service needs of the resident.

The record of training for direct care staff person B did not include documentation of required training topics under 2600.65(f) to include:
(1) Medication self-administration training.
(3) Care for residents with dementia and cognitive impairments.
(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as

65i - Training Record (continued)

prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
(5) Personal care service needs of the resident.

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

Immediate: Administrator audited all staff files for the required education in 2600.65f. Staff person A and staff person B as well as one additional staff person was found not to have completed the requirements of 2600.65)1))3) (4) (5).
Training to complete the requirements is scheduled for the week of 5/15/25 5/12/25. Staff identified will attend the training. Documentation will be kept in the homes records and will be included in this report.

Continued compliance: Administrator will review staff training [lan as part of the Quality Management review. The 2025 training plan will be used as a guide to track requirements of 2600.65f 2025 training plan will be included in this report.

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

Implemented (- 06/11/2025)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

At approximately 12:03 p.m. the refrigerator portion of the second-floor General Electric refrigerator and freezer had food debris throughout the refrigerator to include a slice of what appeared to be Swiss cheese on top of the crisper drawers, and within the crisper drawer's various bits of unidentifiable food debris throughout.

At approximately 12:03 p.m. the freezer portion of the second-floor General Electric refrigerator and freezer had small bits of various unidentifiable food debris throughout as well as what appeared to be melted orange popsicle juice on the shelving of the door of the freezer.

At approximately 12:20 p.m., the ceiling fan blades in the second-floor resident room belonging to resident #1 and resident #2 was heavily matted on the left side of the fan blades with thick grey dust that was approximately one-eighth of an inch thick.

At approximately 12:20 p.m., the ceiling fan blades in the second-floor resident room belonging to resident #3 and resident #4 were heavily matted with thick grey dust that was approximately one-eighth of an inch thick.

Plan of Correction ***Accept (- 05/12/2025)***

Immediate Action: A cleaning company was hired to clean all fans in the home. The cleaning was completed on April 26 2025. Receipt will be attached to the POC
The refrigerator and freezer was deep cleaned on 4/25/25 .

Continued Compliance: The cleaning services will come once per quarter to clean all the homes ceiling fans. Documentation will be kept in the home.The next scheduled cleaning is July 2025.

85a - Sanitary Conditions (continued)

Refrigerator / freezer: Staff will check for proper storage/temperatures and cleanliness daily. A check list will be in place on the refrigerator door to document the checks. Night staff will perform a deep clean of the refigerator.freezer weekly on Thursdays. Documentation will be kept in the home. Staff education will take place 5/12/25. Check lists and education will be
attached to this report.

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented ([redacted] - 06/11/2025)

85d - Trash Receptacles

4. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 11:48 a.m., the trash can in the second-floor full bathroom next to the front stairs landing was uncovered and approximately three-quarters full of used paper towels and stored in the cabinet of the bathroom sink vanity.

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

Immediate: The trash can was removed and replaced with a can with a lid.

Continued compliance: The can will no longer be kept under the sink inside the vanity. The enclosed can will be kept in sight. Staff education will take place May 12, 2025. Adm or desidentated person on day shift will check trash cans weekly for compliance with 2600.85d. Check list will be attached to this report

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

Implemented ([redacted] - 06/11/2025)

85e - Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 10:16 a.m. in the homes trash can area there were two garbage cans unlidded, one was a green approximate 50-gallon trash can with no lid that was filled with tied garbage bags, the other was a 64-gallon lidded trash can that had its lid propped open by a piece of what appeared to be black colored Acrylonitrile Butadine Styrene (ABS) piping.

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

Immediate: the administrator purchased a new outdoor trash receptacle that has a lid. It is in place. The second

85e - Trash Outside Home (continued)

can had the ABS piping removed and is now completely closed. Photo and receipt for the purchases will be attached to this report.

Continued Compliance: Staff training on 2600.85e will take place on 5/15/25
All staff will be included. Documentation will be kept .
Administrator or designee will check the designated trash area weekly to ensure compliance. Check list attached.

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

Implemented ([redacted] - 06/11/2025)

103g - Storing Food

6. Requirements

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

Description of Violation

At approximately 12:03 p.m. in the second-floor General Electric refrigerator there was what appeared to be an eight-ounce package of Swiss cheese that was approximately one-half full and ripped open and was left uncovered.

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

Immediate Action: Th eight ounce package of Swiss cheese that was one half full and ripped open was disposed of. Staff reported this cheese was placed in the refrigerator by a resident.

Continued compliance. The administrator will schedule a meeting with the staff and residents to discuss the homes rules and the DHS 2600.103g regulation.
Home rules will be updated to include resident use of the refrigerators.
Residents are permitted to use the refrigerator on the second floor but must label their food with date, name and type of food .If the food is left for more than five days the staff may dispose of it when they check/clean the refrigerator. Staff/resident meeting notes and the updated home rules will be included in this report. Staff resident meeting is scheduled for 5/12/25 and will be attached to this report. New home rules will be in effect 30 days from the meeting date and will be posted in the home. New home rules will be attached to this report.
Daily checks of the refrigerator/freezer will be completed by staff and deep cleaning will be completed weekly on Thursday night shift. Check lists will be attached to this report. due to the required 30 days for any change in the home rules this overall completed will be approx 6/12/25

Licensee's Proposed Overall Completion Date: *06/12/2025*

Implemented ([redacted] - 06/11/2025)

103i - Outdated Food

7. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

At approximately 12:03 p.m., in the second-floor General Electric freezer there was a nine-point-five-ounce container of frozen Jicama Sticks that were not dated or labeled, were left uncovered, and were freezer burned.

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

Immediate action: The administrator disposed of the frozen Jicama Sticks.

Continued Compliance. Administrator will meet with residents and staff to explain updated house rules for the storage of resident food. The Jicama Sticks were placed in the refrigerator by a resident. House rules will be updated by May 12 to be in effect June 12, 2025. The updated rules will explain the responsibilities of residents when using the freezer or refrigerator. All food must be labeled with a name, food and date. Supplies to to this are kept beside the refrigerator for staff or resident to use. House rules will be posted and will be included in this report.

Licensee's Proposed Overall Completion Date: *06/12/2025*

Implemented (- 06/11/2025)

132c - Fire Drill Records

8. 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 5/11/24 at 2:26 p.m. the home held a fire drill; however, the fire drill record indicated it took the residents 6 seconds to evacuate the home.

On 7/31/24 at 11:09 a.m. the home held a fire drill; however, the fire drill record indicated it took the residents 48 seconds to evacuate the home. Additionally, the fire drill record indicated that the fire drill begin time was 11:09 a.m. and the time that the drill ended at 11:08 a.m.

On 11/12/24 at 11:00 a.m. the home held a fire drill; however, the fire drill record indicated it took the residents 1 hour and 28 minutes to evacuate the home. The times noted were from 11:02 a.m. to 12:30 p.m. Staff interviews indicated that this was a mistake and the time documented was incorrect.

On 12/3/24 at 4:49 p.m. the home held a fire drill; however, the fire drill record indicated it took the resident 23 seconds to evacuate the home. Additionally, the times documented in the fire drill record were from 4:49 p.m. to 4:52 p.m., which indicated a 3-minute evacuation time.

Plan of Correction ***Accept (- 05/12/2025)***

Immediate: The administrator received technical assistance from the inspectors on the day of the inspection and now understands what to record and how to complete the fire drill records correctly.

132c - Fire Drill Records (continued)

Continued Compliance: Fire Drill Records will be reviewed at the Quality Management meeting to ensure correct documentation

Education for a designee will take place week of 5/12/25. This will ensure compliance if the administrator is no available to run the fire drill.
** Administrator or designee will audit the homes fire drill records monthly to ensure documentation is complete and correct including, date, time, 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 participating, problems encountered and whether the fire alarm or smoke detector was operative. Documentation of the audit will be kept.*

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented ([redacted] - 06/11/2025)

132d - Evacuation

9. 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 12/03/24 at 4.49 p.m. the home conducted a fire drill, and all residents were evacuated in 3 minutes and 0 seconds. However, the fire safe evacuation time documented in writing by a fire safety expert on the letter dated 8/1/24 indicated a maximum safe evacuation time of 2 minutes and 0 seconds. The default time for safe evacuation was 2 minutes and 30 seconds.

Plan of Correction ***Accept ([redacted] - 05/12/2025)***

Immediate: Administrator reviewed previous years recommendations from the City of Pittsburgh Fire Inspector. In 2023, 3 minutes was safe evacuation time and in 2024 the safe evacuation time was 2.0 minutes. Both determinations were completed by the same inspector.

Continued Compliance:
1. The administrator will contact the City of Pittsburgh, Department of Public Safety for confirmation of the correct evacuation time. A supervised drill and bld inspection will be rescheduled if necessary. The department will be informed of the outcome. Until a determination is made the default will be 2 minutes and 30 seconds. Records will be kept in the home and included in this report. Of note the observed fire drill is due in August 2025 and the designated time to evacuate will be addressed at that time if effects to do so prior to Aug are not successful
** The administrator or designee will audit the fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month to ensure residents are evacuated from the entire building to a public thoroughfare, or to a afire 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 the fire safety expert.*
Audit if drills and fire safety expert determination will be attached to this POC

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

Implemented ([redacted] - 06/11/2025)

183e - Storing Medications

10. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

At approximately 3:46 p.m., there was a bottle of Timolol Maleate Ophthalmic Solution 0.55% - place one drop into the left eye two times a day that belonged to resident #5 found in the second-floor medicine cabinetry. However, the Timolol Maleate eye drops were opened and did not indicate the date of opening. The manufacturer's directions for the medication indicated "use the Timolol eye drops within the expiry date shown on the bottle and within 4 weeks of opening."

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

Immediate: The date the Timolol Maletae Opthalmic Solution 0.55% was added to the box. The expiration date was also added. The expiration date being within 4 weeks of opening.

Continued Compliance: Staff education on 2600.183e will be completed by 5/15/25. Education will be completed by the Administrator.
An audit of all short shelf life medications will take place by 5/15/25 and monthly thereafter. Audits will be completed by the administrator or designee. Audit is attached to this report and and will be kept in the homes records

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented ([redacted] - 06/11/2025)

185a - Implement Storage Procedures

11. 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 4/03/25 at 06:22 a.m., resident #6's April 2025 MAR documented a blood glucose reading of 242 mg/dL. However, resident #6's FreeStyle Lite glucometer indicated a blood glucose reading of 202 mg/dL.

On 4/10/25 at approximately 06:35 a.m., resident #6's April 2025 medication administration record (MAR) documented a blood glucose reading of 134 mg/dL. However, resident #6's FreeStyle Life glucometer indicated a blood glucose reading of 178 mg/dL.

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

Immediate: Administrator met with medication techs to re-inforce correct documentation. The glucometer reading should be transferred to the MAR immediately after the test.

185a - Implement Storage Procedures (continued)

Continued Compliance: Med Techs will be re-educated by a Certified medication trainer on the importance of correct documentation of glucose readings.
Training will be kept in the homes records and included in this report.
Weekly audits of glucometer/Mar documentation will be completed by administrator or designated medication tech. Audits will be available in the homes records. Weekly audits will continue for two months and if documentation has improved, the MAR/Glucometer audit will be done monthly. All residents requiring an accucheck glucometer reading will be included in the audit.
First weekly Audit will be May 16. Attached

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

Implemented (- 06/11/2025)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #5 assessment, dated , and the resident's medical evaluation, also dated, , both indicated that the resident was hearing impaired. However, the sensory section of the resident's assessment indicated that the "resident has no hearing issues" and that the home "will monitor for any hearing changes will recommend annual visit." Additionally, the same document indicated in the medical diagnosis section "resident is hearing impaired" and that the resident "does not wear a hearing aid device just speaks loudly."

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

Immediate: Administrator reviewed records and met with Resident #5. does have a hearing impairment but does not have a hearing aid. The RASP was updated with correct information. (Attached)

Continued Compliance. A second review of future RASPS will take place. The designated second person review will ensure documentation of needs and diagnosis are consistent and correct. The second person will sign the RASP in addition to the original writer. This second review will begin with RASPS due Ma, 20y25 and continue for 6 months. If no further discrepancies are identified the second review will be discontinued. Rasp accuracy will be addressed in the next QA report
Audit of 10 RASP sensory sections will be done by Administrator or designee.
Corrections will be made if necessary. Audit will take place by May 16, 2025 and will be attached to this report.

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

Implemented (- 06/11/2025)