Department of Human Services
Bureau of Human Service Licensing

March 11, 2021

[redacted] CEO
HALCYON SENIOR LIVING LLC
105 REBECCA DRIVE
VENETIA, PA 15367

RE: HALCYON SENIOR LIVING
528 DEWEY AVENUE
BRIDGEVILLE, PA, 15017
LICENSE/COC#: 45109

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/12/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Larry Mazza

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *HALCYON SENIOR LIVING* **Licen e #**: *45109* **Licen e Expiration Date**: *08/31/2021*
Addre : *528 DEWEY AVENUE, BRIDGEVILLE, PA 15017*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *4126770800* **Email**: [redacted]

Legal Entity

Name: *HALCYON SENIOR LIVING LLC*
Address: *105 REBECCA DRIVE, VENETIA, PA, 15367*
Phone: *7404918721* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/13/1998* **Issued By**: *L&I*
Type: *I-2* **Date**: *05/14/2020* **Issued By**: *Borough of Bridgeville*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *27* **Waking Staff**: *20*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *02/12/2021*

Inspection Dates and Department Representative

02/12/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *88* **Residents Served**: *18*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd Floor* **Capacity**: *44* **Residents Served**: *0*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *18*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *9* **Have Physical Disability**: *0*

Inspections / Reviews

02/12/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *02/27/2021*

3/8/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/12/2021*

3/10/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/12/2021*

3/11/2021 - Document Submission

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

25a - Written Contract and Review

1. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

The resident-home contract for resident #1 is incomplete and does not include the name of the resident or the date the contract was completed. Resident #1 was admitted to the home on [redacted]

Plan of Correction **Accept**

On 2/15/2021, the contract was completed and resident name and date was added. All contracts were audited on 2/15/2021 to ensure all resident contracts are complete with resident name and date, and administrative staff will ensure contracts are complete moving forward.
See attached: audit sheet, education provided to staff, and updated completed contract for Resident #1.

The home has implemented an admission checklist that will be completed prior to resident / designee sign in or within 24 hours of the admission. This will be placed in the resident agreement file in the business office after audit has been done to ensure all needed signatures are completed. Audit of the contracts will also be part of the home's QA process throughout the year.
Attached: Admission Checklist, Copy of QA Policy

Completion Date: *03/09/2021*

Document Submission **Implemented**

See attached "Review of 2600.25(a)" document.

25b - Contract Signatures

1. 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 does not include the signatures of the administrator or the resident.

25b - Contract Signatures *(continued)*

Plan of Correction **Accept**

On 2/15/2021, the contract was completed and resident name, date, as well as administrator signature. All contracts were audited on 2/15/2021 to ensure all resident contracts are complete with resident name and date, and administrative staff will ensure contracts are complete moving forward.
See attached: audit sheet, education provided to staff, and updated completed contract for Resident #1.

The home has implemented an admission checklist that will be completed prior to resident / designee sign in or within 24 hours of the admission. This will be placed in the resident agreement file in the business office after audit has been done to ensure all needed signatures are completed and resident's name, date, and Administrator signature is complete. Audit of the contracts will also be part of the home's QA process throughout the year.
Attached: Admission Checklist, Copy of QA Policy

Completion Date: *03/09/2021*

Document Submission **Implemented**

See attached "Review of 2600.25(a)" document.

60a - Staff/Support Plan

1. **Requirements**

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home currently serves 18 residents, including 9 residents with mobility needs. Of the 9 residents with mobility needs, 4 residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair, and resident #3 requires the physical assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift. According to multiple staff persons, it takes approximately 5-7 minutes to safely transfer resident #3 using the Hoyer lift. The home's most recent fire safety inspection conducted by a fire safety expert, dated 5/21/20, indicates the maximum safe-evacuation time to the numerous fire-safe areas is 6 minutes. The home routinely schedules 2 direct care staff persons during the 3:00pm-11:00pm and 11:00pm-7:00am shifts, as well as 2 direct care staff persons during the 7:00am-3:00pm shifts on the weekends, which is not adequate to safely evacuate all residents in the event of an emergency.

60a - Staff/Support Plan *(continued)*

Plan of Correction **Accept**

The home's current census is 18 residents. Resident #3 had a change in condition and was sent to E.R. Resident #3 now requires a higher level of care and will be discharged from the hospital to a SNF. In addition since the survey on 2/12/21, two residents whom were on hospice ceased to breathe. Both were two person assists with transfers. We have had a reduction of three residents whom were two person assists. The home has added additional staff on the 11pm 7am shift (see attached nursing schedule). Ancillary activities and dietary staff are crossed trained and work 7am 3pm and 3pm 11pm shifts on weekdays and weekends (see attached schedules and direct care training course competencies). In addition, Wellness Director and Administrator are always on call for staffing shortage needs. Acuity of residents will be routinely monitor and on going. Staffing will be adjusted to meet all needs of the residents. (In Service Training of regulation 2600.60(a) was done on 3/5/2021 with all management staff).
See attached: Direct Care Staff schedule, DHS Competencies Trainings, In Service Training of Regulation 2600.60(a).

Staffing Outline:
1. The home will review in morning stand up meetings with all department heads any resident change in condition and resident needs that may effect staffing.
2. Wellness Director will assess all residents monthly as part of the month end clinical indicator report. This report identifies resident change in condition which is addressed in changes to the resident's RASP or plan of care needs which will drive staffing levels.
3. During the annual RASP review and completion, changes in resident condition in relation to resident needs and staffing will be addressed.
4. Staffing needs as related to census and resident needs will be reviewed and addressed as part of the home's QA program throughout the year.
Attached: QA Policy, Morning Stand Up Agenda Form, Direct Care Staffing Policy

Completion Date *03/09/2021*

Document Submission **Implemented**

See attached "Review of 2600.60(a)" document.

100b - Removal Snow/Obstructions

1. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

At 10:10am, there was an approximate 1" accumulation of snow on the landing and sidewalks outside of the fire exit doors from the back hall stairwell.

100b - Removal Snow/Obstructions *(continued)*

Plan of Correction **Accept**

On 2/12/2021, snow was removed from outside walkways and landing of the fire exit doors at the back hall stairwell. Maintenance and housekeeping staff was in-serviced to ensure that snow is cleared from all fire exit doors during and after each snow fall. Also snow removal company has added that exit to their service.
See attached: Pictures, education provided to staff

Completion Date: *02/12/2021*

Document Submission **Implemented**

See attached "Review of 2600.100(b)" document.

101j7 - Lighting/Operable Lamp

1. 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

Resident #2 does not have an operable lamp or other source of lighting that can be turned on/off at bedside.

Plan of Correction **Accept**

On 2/12/2021, lamp was moved to bedside within reach of resident. Staff was in-serviced on regulation 101j7. Staff to ensure lamp functional and change out light bulb when and if needed. Staff to communicate to maintenance any non-functioning light via maintenance request log.
See attached: Pictures, in-service education provided to staff, audit sheet

Completion Date: *02/12/2021*

Document Submission **Implemented**

See attached "Review of 2600.101j7" document.

121a - Unobstructed Egress

1. Requirements

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

Description of Violation

At 10:10am, significant bodily force was required by an agent of the Department to open the fire exit doors at the back hall stairwell.

121a - Unobstructed Egress *(continued)*

Plan of Correction **Accept**

On 2/12/21, Maintenance Director lubricated and adjusted hardware on mentioned egress doors. Door will be inspected as part of the monthly fire drill training to ensure all doors operate properly. Doors will be inspected monthly as part of preventative maintenance program.
See attached: Pictures, audit of egress doors, in-service education provided to staff.

Completion Date: *02/12/2021*

Document Submission **Implemented**

See attached "Review of 2600.121(a)" document.

224a - Preadmission Screen Form

1. **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's preadmission screening form, dated 12/13/20, does not include a determination that the home can meet the resident's needs or that the resident can safely use and avoid poisonous materials. These sections of the form are blank.

Plan of Correction **Accept**

On 2/12/2021, preadmission screening form was updated to include that the home can meet the resident's needs and that the resident can safely use and avoid poisonous materials. Wellness Director and clinical staff educated on regulation 2600.224.a. Wellness Director will review all preadmission screen form for accuracy and completeness ongoing.
See attached: Preadmission corrected and dated, audit, and in-service education provided to staff.

All resident records were audited for all prescreen admissions on 2/15/21.

Completion Date: *03/09/2021*

Document Submission **Implemented**

See attached "Review of 2600.224(a)" document.