pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: October 28, 2019

Ms. Nichole Mitcham
Administrator
CA Senior McCandless II Operator, LLC
130 E Randolph S., Suite 2100
Chicago, Illinois 60601

RE: Anthology of McCandless
8651 Carey Lane
Pittsburgh, Pennsylvania 15237
License #: 449980

Dear Ms. Mitcham:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living) review on October 8, 2019, of the above facility, we have determined that your submitted plan of correction is:

Fully implemented and in compliance. Continued compliance must be maintained.

If you need assistance, please contact me at 412-565-5614.

Sincerely,

Janine Wenzig
Human Services Licensing Supervisor

Enclosure
<Licensing Inspection Summary>

Violation Report

Facility Information

Name: *Anthology of McCandless* **License Number:** *44998*
Address: *8651 Carey Lane , Pittsburgh, PA 15237*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: *Nichole Mitcham* **Phone:** *412-392-7000* **Email:** *nmitcham@anthologyseniorliving.com*

Legal Entity

Name: *CA Senior McCandless II Operator, LLC*
Address: *130 E Randolph S. Suite 2100, Chicago, IL, 60601*

Certificate(s) of Occupancy

Type: *I-1* **Date:** **Issued By:**

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *33* **Waking Staff:** *25*

Inspection

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

Inspection Dates and Department Representative

10/08/2019 - On-Site: Josh Hoover, Courtney Barry, Scott Klein, Janine Wenzig

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *94* **Residents Served:** *24*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *4th floor* **Capacity:** *37* **Residents Served:** *3*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *9*
Are 60 Years of Age or Older: *24*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

17 - Record Confidentiality

Regulations

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

At approximately 9:50a.m., the unlocked and unattended cupboard in the 2nd floor chart room contained resident records with names, diagnoses, dates of birth, and care needs for numerous residents, to include residents #1 and #2. Also, there were multiple resident assessment and support plans (RASPs) on the counter in the chart room, to include the RASPs for residents #3 and #4.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

There are locks in place for all cabinets that contain resident records. Staff have participated in additional in-serving to review the requirement that all records should be stored in a secure place at all times. Additionally a sign was posted next to the door of the chart room reminding staff to lock all cabinets and secure all information prior to exiting.

By 11/30/19 - A designated staff person, daily and on each shift, will monitor the home to ensure confidential resident records are kept locked. - JRW 10/23/19

By 11/30/19 - The administrator or designee will monitor the home at least weekly, to ensure confidential resident records are kept locked. - JRW 10/23/19

Legal Entity Representative

Nichole Mitcham, PCHA — Signature

Nichole Mitcham, Executive Director — Printed Name and Title

10-22-19 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 10/23/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 10/23/19 (Date)

[X] Implemented

[ ] Not Implemented

65b - Rights/Abuse 40 Hours

Regulations

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:

Description of Violation

The following staff persons did not receive training on the emergency medical plan or the reporting of reportable incidents and conditions:

- Staff person A, hired 8/28/2019
- Staff person B, hired 8/28/2019
- Staff person C, hired 8/28/2019
- Staff person D, hired 9/30/2019

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Emergency medical plan and the reporting of reportable incidents and conditions' was missing from the new hire training agenda. Both topics have been added to the new hire agenda and will be covered in the first 40 hours of training for all direct care staff. All direct care staff who were missing this training have received it and documentation for the training has been added to file.

Legal Entity Representative

Nicole Mitcham, PCHA — Signature

Nicole Mitcham, Executive Director — Printed Name and Title

10/21/19 — Date

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The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 10/23/19 (Date)

[X] Implemented

[ ] Not Implemented

132b - Safety Inspection/Fire Drill

Regulations

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

There is no documentation of the home's fire safety inspection, and a fire drill has not been conducted by a fire safety expert.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Fire Marshal was on site 9/11 to do a site visit with the Executive Director and Director of Plant Ops but no formal documentation was submitted. The home started admitting residents on September 4, 2019 and was still in the annual calendar window.

A Fire Marshal was back on site 10/21 for a supervised fire drill. The drill was documented on the department's form, attached.

Legal Entity Representative

Signature: [signature], PCHA

Printed Name and Title: Nichole Mitcham, Executive Director

Date: 10/21/19

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The above plan of correction is approved as of 10/23/19 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 10/23/19 (Date)

X Implemented

☐ Not Implemented

132c - Fire Drill Records

Regulations

2600.

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

Description of Violation

The fire drill log for the drill held on 9/27/2019 does not include the number of staff persons participating in the drill.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

All staff who participated in the fire drill on 9/27/19 signed the in-service training log but the total number of staff were not added to the fire drill record.

Future fire drill records will be reviewed by the Executive Director to assure all information is added correctly to the fire drill record each month.

Legal Entity Representative

Nicole Mitcham, PCHA — Signature

Nicole Mitcham, Executive Director — Printed Name and Title

10/21/19 — Date

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X Implemented

☐ Not Implemented

132d - Evacuation

Regulations

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

The home does not have a safe evacuation time designated in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the fire drill on 9/27/2019, which took 6 minutes and 21 seconds.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Fire Marshal was on site to meet with the Executive Director and Director of Plant Ops on 9/11/19. A walk through was completed and an evacuation time was verbally reviewed but the formal evacuation time was not received in writing, despite the community's requests.

The Fire Marshal was back at the home on 10/21/19 and completed the designated time form on site, attached. The home has a designated evactuation time of 8 minutes.

Legal Entity Representative

Nichole Mitcham, PCHA — Signature

Nichole Mitcham Executive Director — Printed Name and Title

10/21/19 — Date

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Plan of correction implementation status as of 10/23/19 (Date)

X Implemented

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☐ Not Implemented

183d - Prescription Current

Regulations

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

There was a card of Sudogest 60mg tablets for resident #5 on the medication cart; however, resident #5 does not have a current order for this medication.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Sudogest for Resident #5 was on his med list from previous community and sent to current community upon transfer. New DME at current community does not have Sudogest listed, and the medication has not been given.

Sudogest was destroyed on 10/8/19.

Director of Health & Wellness will conduct an audit of all resident medications by 10/25/19 to assure that all medications on the cart have a current order.

Legal Entity Representative

Nichole Mitcham, PCHA — Signature

Nichole Mitcham, Executive Director — Printed Name and Title

10/8/19 — Date

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The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 10/25/19 (Date)

[X] Implemented

[ ] Not Implemented

184a - Labeling OTC/CAM

Regulations

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #6 is ordered Insulin Aspart 100units/ml; however, the insulin pen in the medication cart did not have a pharmacy label.

Resident #6 is ordered Insulin Glargine 100units/ml; however, the insulin pen in the medication cart did not have a pharmacy label.

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Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #6 brought the insulin from home.

All medications brought into the community should have a pharmacy label. Director of Health & Wellness will audit all medications on the cart to assure community is in full compliance. Director of Health & Wellness will audit carts on a monthly basis to assure compliance is maintained.

Legal Entity Representative

Nichole Mitcham, PCHA — Signature

Nichole Mitcham, Executive Director — Printed Name and Title

10/21/19 — Date

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[X] Implemented

[ ] Not Implemented

185a - Implement Storage Procedures

Regulations

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

The Aspart insulin pen for resident #6 was not dated with the date the pen was opened.

The Glargine insulin pen for resident #6 was not dated with the date the pen was opened.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #6 brought his insulin from home.

Any time a resident moves in or starts insulin the nurse or Director of Health & Wellness will add a date for when the pen is openned.

The Director of Health & Wellness has completed an in-service with nursing staff and will review with any future nursing staff hired.

Legal Entity Representative

Nichole Mitcham, PCHA — Signature

Nichole Mitcham, Executive Director — Printed Name and Title

10-21-19 — Date

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[X] Implemented

[ ] Not Implemented

190c - Record of Training

Regulations

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The documentation of medication administration training for staff person B does not indicate the date of the training or whether or not the course was successfully completed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Staff person B completed her medication training with a hired instructor on site at the home. The instructor has confirmed the date of the training and that the staff person did pass all portions of the training. The instructor has updated the form to reflect that information, attached.

By 11/15/19 - The administrator or designee will review the medication training documents of all staff to ensure they are completed in full. - JRW 10/23/19

Type t

Legal Entity Representative

Nichole Mitcham, PCHA — Signature

Nichole Mitcham, Executive Director — Printed Name and Title

10-21-19 — Date

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[X] Implemented

[ ] Not Implemented

224a - Preadmission Screen Form

Regulations

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

The preadmission screening for resident #7, admitted 9/4/2019, is undated; therefore, it could not be determined if it was completed within 30 days prior to admission.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The date for the pre-screening was not recorded.

The Director of Health & Wellness will review all completed pre-screenings to assure info was completely properly for all current residents. For any future admissions the Execuive Director will review all pre-screenings to assure the forms are completed in their entirerty before they are added to the resident chart.

Legal Entity Representative

Nichole Mitcham, PCHA
Signature

Nichole Mitcham, Executive Director
Printed Name and Title

10-21-19
Date

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X Implemented

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☐ Not Implemented

231c - Preadmission Screening

Regulations

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

A cognitive preadmission screening was not completed for resident #8, who was admitted to the SDCU on 10/2/2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The preadmission screening for resident #8 has been completed and is on file.

The Director or Memory Care or Director of Health & Wellness will complete the preadmission screening for all residents on SDCU 72 hours prior to admission. If the preadmission is not completed in that time period the move in would be delayed until the preadmission screen is completed in its' entirety.

The Executive Director will review all prescreenings prior to admission to assure compliance.

Legal Entity Representative

Nichole Mitchem, PCHA — Signature

Nichole Mitchem, Executive Director — Printed Name and Title

10-21-19 — Date

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Plan of correction implementation status as of 10/23/19 (Date)

[X] Implemented

[ ] Not Implemented

234a - Admission Support Plan

Regulations

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

A support plan was not completed for resident #8, who was admitted to the SDCU on 10/2/2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The support plan for resident #8 has been completed and is on file.

Moving forward the Director of Health & Wellness will confirm that all residents on the SDCU will have a completed support plan on file with 72 hours prior to admission. The Executive Director will also review that this regulation is being met for every admission to the SDCU.

Legal Entity Representative

Nichole Mitchum, PCHA — Signature

Nichole Mitchum, Executive Director — Printed Name and Title

10/21/19 — Date

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[X] Implemented

[ ] Not Implemented