pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: November 8, 2019

Ms. Kelly Covone-Henning
Administrator
Canterbury Place
310 Fisk Street
Pittsburgh, Pennsylvania 15201

RE: Canterbury Place
License #: 429490

Dear Ms. Covone-Henning:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 10, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Janine Wenzig
Human Services Licensing Supervisor

Enclosure
<Licensing Inspection Summary>

Violation Report

Facility Information

Name: *CANTERBURY PLACE* License Number: *42949*
Address: *310 FISK STREET,, GROUND FLR AND FLRS 2,3,5,&6,, PITTSBURGH, PA 15201*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Kelly Covone-Henning* Phone: *4126229000* Email: *COVONEHENNINGK@UPMC.EDU*

Legal Entity

Name: *CANTERBURY PLACE*
Address: *310 FISK STREET, PITTSBURGH, PA, 15201*

Certificate(s) of Occupancy

Type: *I-2* Date: *10/14/2016* Issued By: *City of Pgh*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *44* Waking Staff: *33*

Inspection

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

Inspection Dates and Department Representative

10/10/2019 - On-Site: Courtney Barry, Desmond Grace, Amy Duncan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *78* Residents Served: *36*

Secured Dementia Care Unit

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

Hospice

Current Residents: *na*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *1*
Have Mobility Need: *8*
Are 60 Years of Age or Older: *36*
Diagnosed with Intellectual Disability: *2*
Have Physical Disability: *2*

121a - Unobstructed Egress

Regulations

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

Description of Violation

There is an electronic lock that is unlocked with a code entered into a keypad, on the 6th floor exit door near the fireside lounge leading to the dining room. The lock prevents the immediate egress of residents from the building. The home is not licensed as a secured dementia care unit.

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 electronic lock that is located outside the 6th floor dining room has been updated with access code fastened to the wall beside the keypad. (see photo attachment #1). Residents and staff have been educated on this addition. The residents were educated at the resident council meeting on 10/29/19 (attachment #3) and staff educated during general staff meetings and at QA meeting on 10/29/19. In cases of fire emergencies, the door automatically releases. Letter verification on release of lock. (attachment #2).

Legal Entity Representative

Signature

Kelly Conroe-Henning — Printed Name and Title

10-31-19 — Date

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

The above plan of correction is approved as of 11/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 11/6/19 (Date)

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's fire safe evacuation time, designated in writing by a fire safety expert, on 9/9/18, is 7 minutes and 44 seconds. The home exceeded this evacuation time for the fire drills conducted on the following dates and times:

Date & Time of Drill	Evacuation Time
11/9/18 at 6:09 a.m.	7 minutes, 58 seconds
12/16/18 at 11:00 p.m.	7 minutes, 58 seconds
2/28/19 at 6:42 p.m.	7 minutes, 48 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.)

Administrator/Designee will speak with the residents during their monthly resident council meetings on fire drills and fire safety topics. Information discussed during the October 29, 2019 resident council meeting (attachment #3). Information to be included in the monthly resident newsletter (attachment #4).

If a fire drill does not meet the required evacuation time set forth by the Fire Marshall another drill will be conducted during that month. Staff has been educated on the facility's fire drill procedure. (see attachment #5). After each drill, maintenance technician will meet with staff to review the fire drill (areas of accommodation and areas of improvement).

Fire drills conducted from March to October 2019 were in compliance with safe evacuation time.
The October fire drill was conducted on 10/25/19 at 2:17p.m. with an evacuation time of 7 minutes and 15 seconds. - JRW 11/6/19

Legal Entity Representative

Signature

Kelly Covode-Henning — Printed Name and Title

10-31-19 — Date

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

The above plan of correction is approved as of 11/6/19 (Date)

Plan of correction implementation status as of 11/6/19 (Date)

X Implemented

The above plan of correction was approved by (Initials)

Not Implemented

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation for resident #1, dated 8/28/19, indicates "see attached" for a medication list; however, nothing is attached.

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 medical evaluation for R-1 dated 8/28/19 while not attached to the medical evaluation during survey was subsequently located in the chart and is now placed appropriately. (see attachment #6a/b). Nursing did a random chart audit of 6 charts and reviewed the medical evaluations to ensure that if "see attachment" was indicated then the attachment was indeed attached. All medical evaluations met the regulatory standard. (see audit attachment #7). To prevent future occurrences and remain in compliance, all medical evaluations over the next three months will be reviewed by the LPN/designee on the attached audit tool to ensure compliance. Any deficient practice will be immediately corrected.

Legal Entity Representative

Signature

Kelly Covowe-Hennings — Printed Name and Title

10-31-19 — Date

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

The above plan of correction is approved as of 11/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 11/6/19 (Date)

X Implemented

☐ Not Implemented

141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The annual medical evaluation, dated 4/27/19, for resident #2 is blank in the sections for height, weight, pulse rate, blood pressure, temperature, and cognitive functioning.

The annual medical evaluation, dated 6/1/19, for resident #3 is blank in the sections for health status and cognitive functioning.

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.)

Annual medical evaluation for R-2 has been updated on 10/28/19 by residents PCP obtaining residents' height, weight, pulse rate, blood pressure, temperature and cognitive functioning. (see attachment #8)

Annual medical evaluation for R-3 has been updated on 10/24/19 by residents PCP obtaining residents health status and cognitive functioning. (see attachment #9)

Nursing completed a random chart audit reviewing medical evaluations to ensure that all sections were completed. Six charts were audited, all were in compliance (see audit attachment #10).

To prevent future occurrences and remain in compliance with accurate completion of medical evaluations, all medical evaluations over the next three months will be reviewed by LPN/designee to verify compliance and ensure accuracy. Any deficient practice will be immediately corrected.

Legal Entity Representative

Signature

Kelly Conde-Henning
Printed Name and Title

10-31-19
Date

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

The above plan of correction is approved as of 11/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 11/6/19 (Date)

X Implemented

Not Implemented

184b - Resident's Meds Labeled

Regulations

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #4 is ordered aspirin chew 81mg and Melatonin 5mg. The resident's name is not indicated on the medication bottles.

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.)

R-4 is no longer taking aspirin provided by her family. The resident does have a prescription for the aspirin provided by the facility pharmacy. (see photo attachment #11). The melatonin was corrected by charge nurse on 10/10/19 with a sticker added to include the resident's name (see photo attachment #12)

Nurse completed a random medication audit to ensure that the resident's name was on medication and ensure compliance with residents with regulation. Five resident medications were audited, all were in compliance (see audit attachment #13).

To prevent future occurrences and follow the regulation, for the next three months the LPN/designee will audit a 20% random sample of the medication bottles or the stickers to ensure residents names are listed. Any deficient practice will be immediately corrected.

Legal Entity Representative

Signature

Kelly Carroll-Herring
Printed Name and Title

10-31-19
Date

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

The above plan of correction is approved as of 11/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 11/6/19 (Date)

X Implemented

Not Implemented

187a - Medication Record

Regulations

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 #3 is ordered Polyethelene Glycol Powder every other day in the morning as needed; however, the medication administration record indicates two times a week on Monday and Thursday.

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 discrepancy on recent R-3's medication between the label and the MAR was corrected by placing a direction change sticker on the bottle on 10/10/19 by charge nurse (see photo attachment #14). New order sticker obtained from pharmacy was placed on the bottle on 10/24/19 (see photo attachment #15).

Charge nurse did random medication audit to ensure labels on medication bottles were/are accurate with what is showing on the MARS. Four resident medication bottle labels/MARS were audited, all were in compliance (see attachment #16). To prevent future occurrences and remain in compliance, over the next three months a random audit of medications labels will be reviewed by LPN/designee to ensure compliance. Any deficient practice will be immediately corrected.

Legal Entity Representative

Signature

Kelly Crouse-HSDON/DC — Printed Name and Title

10-31-19 — Date

187a - Medication Record *(continued)*

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

The above plan of correction is approved as of 11/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 11/6/19 (Date)

[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

Resident #1 was admitted on 9/9/19. There is a preadmission screening form completed, however, it is not dated. Therefore it is unable to be determined if the form was completed timely.

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 screen for R-1 was completed on 8/15/19 but was not dated at the time of assessment. The missing date was verified and added to the preadmission screen on October 15, 2019 by the Director of Resident Care, who completed the preadmission screen. (see attachment #17).

The Director of Resident Care was re-educated to ensure that all forms for admission including the pre-admission screen are thoroughly completed.

Personal Care Home Administrator reviewed the pre-admission screens of 8 charts of all residents who were admitted in 2019. (see audit attachment #18). All eight charts were in compliance.

To prevent future occurrence and remain in compliance with regulation, all new residents admitted over the next three months will have their preadmission screen reviewed by LPN/designee to ensure date of assessment is documented accordingly. Any deficient practice will be immediately corrected.

Legal Entity Representative

Signature

KELLY COOKE-HEDWING
Printed Name and Title

10-31-19
Date

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

The above plan of correction is approved as of 11/6/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 11/6/19 (Date)

X Implemented

Not Implemented