



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: [dmclean310@gmail.com](mailto:dmclean310@gmail.com)

MAILING DATE: May 18, 2020

Ms. Dorothy A. Whitehead  
Owner/Administrator  
Donald Whitehead  
517 South 9<sup>th</sup> Street  
Youngwood, Pennsylvania 15697

RE: Whitehead Personal Care Home II  
Certificate #: 428140

Dear Ms. Whitehead:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 3, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Jason Williams".

Jason Williams  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

# Violation Report

## Facility Information

Name: *WHITEHEAD PERSONAL CARE HOME II*  
Address: *517 SOUTH 9TH STREET,, YOUNGWOOD, PA 15697*  
County: *WESTMORELAND* Region: *WESTERN*

License Number: *42814*

## Administrator

Name: *Donna McLean* Phone: *7244339065* Email: *dmclean@gmail.com*

## Legal Entity

Name: *DONALD WHITEHEAD*  
Address: *517 SOUTH 9TH STREET, YOUNGWOOD, PA, 15697*

## Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/11/1987* Issued By: *L&I*

## Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *16* Waking Staff: *12*

## Inspection

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

## Inspection Dates and Department Representative

*01/03/2020 - On-Site: Belinda Graziano, Vicki Siegert*

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: *17* Residents Served: *16*

### Secured Dementia Care Unit

In Home:	Area:	Capacity:	Residents Served:
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### Hospice

Current Residents: *0*

### Number of Residents Who:

Receive Supplemental Security Income: <i>12</i>	Are 60 Years of Age or Older: <i>13</i>
Diagnosed with Mental Illness: <i>15</i>	Diagnosed with Intellectual Disability: <i>4</i>
Have Mobility Need: <i>0</i>	Have Physical Disability: <i>0</i>

20b3 - Written Receipts

Regulations

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

The following cash disbursements were made to resident #1:

\$39.99, \$8.46, \$46.71, and \$22.16 on 12/21/19

\$2.00 on 12/6/19

However, the home did not obtain the resident signature for the receipt of the disbursements.

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.)

*This is a relatively new service offered by facility. Signatures will be obtained within 24 hours of disbursement by Administrator. Please see attached disbursements from 01/21/2020 and 01/31/2020.*

*\*Residents Financial Records will be checked weekly by Administrator to see future compliance. See further compliance documentation (2/22/2020 & 3/29/2020). Compliance is easy to check using Tabular financial records.*

Legal Entity Representative

*[Handwritten Signature]*  
Signature

*Dorothy A Whitehead* <sup>Oles WEB</sup>  
Printed Name and Title 4-8-20  
Date

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

The above plan of correction is approved as of 5/7/20  
(Date)

Plan of correction implementation status as of 5/7/20  
(Date)

The above plan of correction was approved by JW  
(initials)

Implemented  
 Not Implemented

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The door to resident #2's bedroom was not able to be closed for privacy. The door was unobstructed by a table in the hallway.

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 table had been moved slightly while taking decorations down. It was moved during inspection to allow the door to close. We will check quarterly to be sure all doors close. The administrator will do this quarterly. Please attached picture of Room #4<sup>DOA</sup> #2 door closed.

Legal Entity Representative

*[Handwritten Signature]*  
Signature

*Dorothy A Whitehead*  
Dorothy A Whitehead  
Owner  
Printed Name and Title

*7/8-20*  
Date

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(Initials)

Implemented  
 Not Implemented

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons A and B do not have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry.

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 member A contacted his high school for his transcripts. Please see attached letter.
- Staff member B has been working on GED. Please see attached email.

In the future all new staff shall turn the required documents in prior to first day of work, this shall be checked by administrator.

\* Both staff member A & B have been terminated, per DHS orders, until they can provide documents proving Graduation. In the future all records will be check prior to first work alone day and again 30 days after hire to be sure all documents are in file.

Within 15 days of receipt of the plan of correction: A designated staff person will review staff records to ensure all direct care staff persons have a high school diploma, GED diploma or active registry status on the PA nurse aide registry and that documentation is in the record.

Legal Entity Representative

*[Handwritten Signature]*  
Signature

*Dorothy A. Whitehead*  
Owner  
Printed Name and Title

*JW* 5/7/20  
4.8.20  
Date

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The above plan of correction was approved by JW (Initials)  Implemented  Not Implemented

65g - Annual Training Content

Regulations

2600.

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

- 1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
- 3. Resident rights.

Description of Violation

Staff persons A and C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year January 1, 2019 to December 31, 2019.

Also, staff person C did not receive training in resident rights during training year January 1, 2019 to December 31, 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.)

Rebecca Durstine is a member of Whitney - Haskett FD as a volunteer. She also has ample hours of fire safety training (see attached) She will train all employees after COVID-19 since our focus is currently of infection control. The training for all shall occur within 90 days of the pandemic end. Records will be kept in each file.

Staff person C has been retrained in Residents Rights on 01-23-2020. Administrator will check files quarterly.

Legal Entity Representative

  
Signature

OWNER  
Dorothy A Whitehead  
Printed Name and Title

D.A.W.  
1/8.20  
148  
Date

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(Initials)

- Implemented
- Not Implemented

82c - Locking Poisonous Materials

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

There was an 8 ounce tube of Aloe Vesta skin protectant and a 85 gram tube of Arthritis Relief in resident #1's bedroom, with a manufacturer's label indicating "If swallowed, get medical help or contact Poison Control Center right away," which were unlocked, unattended, and accessible to residents. Not all the residents of the home, including resident #1, have been assessed capable of recognizing and using poisons safely.

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 items were removed from the residents bedroom at the time of inspection. The administrator shall check to be sure that there are no poison materials out during quarterly walk throughs. The last quarterly walk through was completed on 03/17/2020 by Donna McLean.

\* Future compliance will be made by bi-weekly walk throughs completed by administrator or designated staff. Compliance will be kept using Facility checklist and kept on file. (Please see attached) Poisons are listed under Hazards - Please see record of checklist - 3/17/2020 & 4-15-2020

Legal Entity Representative

  
Signature

*Owner*  
Dorothy A. Whitehead  
Printed Name and Title

4-8-20  
Date

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Implemented

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(Initials)

94b - Non-Skid Surface

Regulations

2600.

94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

The wooden landing at the top of the steps to the 2nd floor emergency exit in the rear of the home does not have a non-skid surface. The landing was very slippery when wet.

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.)

Shingles have been added to the porch floor. These will be assessed during quarterly walk through by the administrator. The last walk through was 03/17/2020. Please see attached photos of BOTH porches

Legal Entity Representative

  
Signature

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Printed Name and Title

4-8-20  
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- Not Implemented

100a - Exterior - Free of Hazards

Regulations

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The wooden railing at the top of the emergency exit from the 2nd floor rear of the home is deteriorating in an approximately 3 inches by 2 1/2 inches area, exposing a rusted metal screw and splintering wood, and posing a skin laceration hazard.

Also, the wooden post at the top of the emergency exit from the 2nd floor rear of the home is deteriorating in an approximately 3 1/2 inches by 1 1/2 inches area, exposing splintering wood, and posing a skin laceration hazard.


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.)

A contractor (Reeger) out of Butler PA came to the facility on 01/06/2020 to fix the porches. He had been scheduled since 01/01/2020. The administrator will assess for repairs during quarterly walk throughs. The last one was completed on 03/17/2020. Please see attached photos of some of the work completed

\* To follow future compliance this will be done using facility checklists (walk-throughs) See attached two completed 3-17-2020 & 4-15-2020. Documentation will be kept.

Legal Entity Representative

  
Signature

Dorothy A Whitehead  
Printed Name and Title

4-8-20  
Date

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103f - Refrigerator/Freezer Temps

Regulations

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:55 a.m., the temperature in the freezer section of the white refrigerator/freezer in the kitchen measured 18 degrees Fahrenheit and at 5:40 p.m. it measured 22 degrees Fahrenheit.

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.)

After the restrictions from COVID-19 is lifted, Miller Refrigeration will come to service the freezer. In the meantime that freezer will not be used. The PCH has another deep freezer with temperatures currently at -15°F. The administrator will check temperatures of all refrigerators and freezers during quarterly walk throughs. Checklists will be kept.

Legal Entity Representative

*[Handwritten Signature]*  
Signature

*Dorothy A Whitehead*  
Printed Name and Title

*4-8-20*  
Date

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(Initials)

107c - Food/Water 3 Day Supply

Regulations

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

The home serves 16 residents, requiring 48 gallons of emergency drinking water for a 3-day supply. However, the home has no emergency water on-site. The contract letter with Galliker's, dated 2/4/2019, does not guarantee that water will be delivered as a priority even in the event of a regional general emergency.

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.)

In addition to the emergency water available from Galliker's we now have 56 gallons of water onsite. The PCH will keep 56 gallons of water on site and checked at least twice a year.

Legal Entity Representative

*Dorothy A. Whitehead*  
Signature

Dorothy A Whitehead  
Printed Name and Title

4-8-20  
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(Initials)  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 record for the drills conducted on 12/15/19 at 8:30 and 5/21/19 at 2:15 do not indicate a.m. or p.m.

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 omission of AM or PM was an error. In the future all fire drill records will be checked quarterly by management staff.

\* Management staff reviewed the regulation regarding documentation. Please see documentation of training. In addition fire drill records will be reviewed quarterly by Administrator.

Legal Entity Representative

*Deborah A. Whitehead*  
Signature

*Deborah A. Whitehead* OWNER  
Printed Name and Title

*4-8-20*  
Date

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(Initials)

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:

Description of Violation

Resident #3 is prescribed Polyethylene Glycol Power 3350 NF, Dissolve 17 grams in 4-8 ounces of beverage of choice and drink orally daily as needed; however, the pharmacy label does not include "as needed."

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.)

An audit of all medications & MARs was completed 01-08-2020 by Nick McFerson (Diamond Pharmacy) & Donna McLean (Please see audit). An audit will be completed quarterly by administrator & at least yearly with an outside source, most likely Diamond Pharmacy.

\* Resident # 3 is currently out of building since 3/30/2020 due to hospitalization. All residents medications are currently on hold due to hospitalization. pending discharge. Upon readmission to facility all medications will be updated.

Future compliance issues are the same as others. Inc. checks by administration (last Medication Administration Record completed 4-14-20)

Legal Entity Representative

*[Handwritten Signature]*  
Signature

Donnelly A Whitehead  
Printed Name and Title

4-8-20  
Date

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(initials)

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**

Resident #4 is prescribed Ingrezza 40mg, take 1 capsule orally daily and Melatonin 5mg, take 1 tablet at bedtime as needed; however, these medications are not available in the home.

Resident #4 is prescribed blood glucose checks, take blood glucose once daily before dinner or as needed; however, the following readings were not indicated on the December 2019 medication administration record (MAR), and were not additional checks:

12/28/2019 at 5:36 p.m. reading 133

12/27/2019 at 5:36 p.m. reading 155

12/19/2019 at 4:55 p.m. reading 160

12/1/2019 at 9:18 a.m. reading 110

Also, the following reading was on the December 2019 MAR, but were not a reading on the glucometer:

12/6/2019 at 4:00 p.m. MAR indicated 113

In addition, the following readings were incorrectly indicated on the December 2019 MAR:

12/23/2019 at 5:27 p.m. glucometer reading 153, MAR indicated 136

12/21/2019 at 5:11 p.m. glucometer reading 156, MAR indicated 111

12/20/2019 at 5:17 p.m. glucometer reading 136, MAR indicated 137

12/14/2019 at 6:16 p.m. glucometer reading 170, MAR indicated 136

12/11/2019 at 6:18 p.m. glucometer reading 221, MAR indicated 127

12/11/2019 at 6:16 p.m. glucometer reading 252, MAR indicated 127

Resident #5 is prescribed blood glucose checks, take blood glucose once daily before dinner or as needed; however, the following readings were not indicated on the December 2019 medication administration record (MAR), and were not additional checks:

12/31/2019 at 7:26 p.m. reading 178

12/28/2019 at 5:40 p.m. reading 224

12/28/2019 at 5:39 p.m. reading 241

12/27/2019 at 5:40 p.m. reading 160

12/24/2019 at 6:03 p.m. reading 149

Also, the following readings were on the December 2019 MAR, but were not a reading on the glucometer:

12/11/2019 at 4:00 p.m. MAR indicated 142

12/6/2019 at 4:00 p.m. MAR indicated 137

In addition, the following readings were incorrectly indicated on the December 2019 MAR:

Description of Violation (continued)

12/25/2019 at 5:26 p.m. glucometer reading 243, MAR indicated 169  
 12/23/2019 at 5:29 p.m. glucometer reading 150, MAR indicated 111  
 12/21/2019 at 5:16 p.m. glucometer reading 163, MAR indicated 132  
 12/20/2019 at 5:18 p.m. glucometer reading 134, MAR indicated 114  
 12/19/2019 at 4:55 p.m. glucometer reading 130, MAR indicated "h"  
 12/14/2019 at 6:18 p.m. glucometer reading 121, MAR indicated 157  
 12/13/2019 at 6:11 p.m. glucometer reading 138, MAR indicated 137  
 12/4/2019 at 6:11 p.m. glucometer reading 129, MAR indicated 145

Repeat Violation: 12/12/2018

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 employees completed Diabetic training by Excela Health on 01-10-2020. Review of recording accurate data was completed at that time as well. We have dedicated 2 staff (House manager & assistant manager) one to double check glucometers daily.

Legal Entity Representative

  
 Signature

*owner*  
 Dorothy A Whitehead  
 Printed Name and Title  
 7-8-20  
 Date

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 (Date) (Date)

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 (Initials)

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:

Description of Violation

Resident #4 is prescribed Quetiapine 400mg, take 1 tablet at bedtime; however, this medication is not indicated on the January 2020 MAR

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 medications for all residents were audited on January 8, 2020 by Nick McFerson, a Diamond Pharmacy Representative, and Donna McLean. (Please see attached Audit) The medication recording errors were due to a new software system combined with a new pharmacy. In the future the Administrator will periodically audit MARs and keep records of audits quarterly. Please see Resident # 4's March MAR

Legal Entity Representative

*Docty A. Whitehead*  
Signature

*Docty A. Whitehead* <sup>Owner</sup>  
Printed Name and Title  
*4-8-20*  
Date

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(Initials)

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- Not Implemented

187b - Date/Time of Medication Admin.

Regulations

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 #3's January 2020 MAR indicated s/he was administered Docusate Sodium on 1/3/20 at 9:00 a.m.; however, the medication was not available in the home to be administered.

Resident #4 was administered Melatonin 5mg on 1/2/2020 at bedtime by staff person D; however, this was not indicated on the January 2020 MAR.

Resident #4's January 2020 MAR indicates s/he was administered Ingrezza 40mg on 1/3/20 at 8:00 a.m.; however, the medication was not available in the home to be administered.

Repeat Violation 12/12/2018

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 medications for all residents were audited on January 8, 2020, by Nick McFerrer & Donna McLean. Please see audit results. In the future an outside audit shall be completed every six months by an outside authority and quarterly by admin.

\* MAR Review checklists have been completed by Donna McLean 2-28-2020 - 3-18-2020 - 4-14-2020. Please see attached. These reviews are being done monthly. Documentation will be kept.

Legal Entity Representative

We will increase to weekly to biweekly.

*[Handwritten Signature]*  
Signature

Dorothy A Whitehead  
Printed Name and Title

0428-20  
Date

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(Initials)

Implemented  
 Not Implemented

190a - Completion Medication Course

Regulations

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C, who has not successfully completed the Department-approved medications administration annual practicum in order to be qualified to continue to administer medications, administered medications to residents on 12/29/2019 at 8:00 a.m. to include the following:

Sertraline Tablet 100mg to resident #4

Atorvastatin tablet 40mg, Benzotropine tablet 1mg, Divalproex tablet 250mg, Lisinopril tablet 20mg, Metformin tablet 1000mg, and Metoprolol Tartrate tablet 50mg to resident #5

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 C will retake & redo the initial training for medication administration by April 23. She will not give medications until training is successfully completed. Copy of new training results shall be forwarded when completed.

\* Staff records and training records will be reviewed quarterly by Administrator documentation for each employee will be kept on info tab 2a file.

Legal Entity Representative

*[Signature]*  
Signature

*Dorothy A Whitehead* <sup>OWNER</sup>  
Printed Name and Title 4-8-20  
Date

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251b - Record Entries Legible

Regulations

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #1's initial medical evaluation, dated 4/12/19, on the blood pressure section and "94/54" was written over top.

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 correction fluid that was used on the DME was from the physicians office. In the future we will not accept any DME's with correction fluid used. The Administrator will check all DME's when they are filed into the Residents file.

Legal Entity Representative

*[Handwritten Signature]*  
Signature

*Dorothy A Whitehead* <sup>Oweb</sup>  
Printed Name and Title  
4-8-20  
Date

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The above plan of correction is approved as of 5/7/20  
(Date)

Plan of correction implementation status as of 5/7/20  
(Date)

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

- Implemented
- Not Implemented