



Sent via email to: natiyeh@yahoo.com
MAILING DATE: March 2, 2020

Ms. Nimita Kapoor-Atiyeh
Co-Administrator/President
Whitehall Manor, Inc.
1177 Sixth Street
Whitehall, Pennsylvania 18052

RE: Whitehall Manor
License #216650

Dear Ms. Kapoor-Atiyeh:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 23, 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 that reads "Anne Graziano". The signature is written in a cursive style.

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: WHITEHALL MANOR

License Number: 21665

Address: 1177 SIXTH STREET, WHITEHALL, PA 18052

County: LEHIGH

Region: NORTHEAST

Administrator

Name: Monica Burger / Nimita Kapoor-
Atiyeh Phone: 6104033500

Email: NATIYEH@YAHOO.COM

Legal Entity

Name: WHITEHALL MANOR, INC

Address: 1177 SIXTH STREET, WHITEHALL, PA, 18052

Continuance of Occupancy

Type: C-2 LP

Date:

Issued By:

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 270

Waking Staff: 203

Inspection

Type: Partial

BHA Docket #:

Notice: Unannounced

Reason: Incident

Inspector Date and Department Representative

~~1-23-2020~~ - On-Site: Jason Harvey, Corey Pica

1-23-2020

Resident Demographic Data as of Inspection Date

General Information

License Capacity: 195

Residents Served: 177

Secured Dementia Care Unit

In Home: Yes

Area: 2 units

Capacity: 78

Residents Served: 56

Hospice

Current Residents: 27

?

Number of Residents Who

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 177

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 93

Have Physical Disability: 0

2505.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

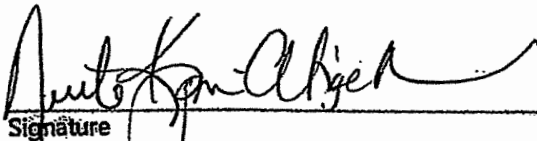
On 12/15/2019 at approximately 1:30 am resident #1 was going in and out resident's rooms, shift supervisor A redirected resident #1 back to bed. At approximately 1:50 am resident #1 was found back in the hallway in the home's Secured Dementia Care Unit by staff person B, who notified shift supervisor A that resident #1 is irritable and verbal with staff. Resident #1 had spots of blood on his/her shirt and when staff person A went to assess resident #1, resident #1 swung at staff person A and missed. Shift supervisor A called for an ambulance to send resident #1 to the ER for an evaluation. Staff person B found resident #2 in their wheel chair in the dining room with a laceration on the resident's face and blood on resident head. The EMT that arrived to assess resident #1 was advised of resident #2's condition and called for another ambulance. Staff initiated an investigation and found a lamp that was broken in to pieces and had blood on the lamp shade. Blood was found on the floor and blood spatter was also on the wall in resident #2's bedroom. The home reported the incident to the Department as apparent resident to resident assault between residents #1 and #2. Resident #1 was diagnosed with a subdural hematoma.

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.)

Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the License Inspection Summary. This Plan of Correction is prepared and submitted to meet requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to 55 Pa. Code Pa. Code 20 et seq. and 2600.26² Pg. 1

Legal Entity Representative


Signature

Nimita Kapoor Atiyeh
Printed Name and Title

Co-Admin
Date
2/11/2020

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The above plan of correction is approved as of 2-25-2020
(Date)

Plan of correction implementation status as of 2-25-2020
(Date)

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

Implemented
 Not Implemented

500.

2.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

On 12/15/2019 at approximately 1:30 am resident #1 was going in and out resident's rooms, shift supervisor A redirected resident #1 back to bed. At approximately 1:50 am resident #1 was found back in the hallway in the Home's Secured Dementia Care Unit by staff person B, who notified shift supervisor A that resident #1 is irritable and verbal with staff. Resident #1 had spots of blood on his/her shirt and when staff person A went to assess resident #1, resident #1 swung at staff person A and missed. Shift supervisor A called for an ambulance to send resident #1 to the ER for an evaluation. Staff person B found resident #2 in their wheel chair in the dining room with a laceration on the resident's face and blood on resident head. The EMT that arrived to assess resident #1 was advised of resident #2's condition and called for another ambulance. Staff initiated an investigation and found a lamp that was broken in to pieces and had blood on the lamp shade. Blood was found on the floor and blood spatter was also on the wall in resident #2's bedroom. The home reported the incident to the Department as apparent resident to resident assault between residents #1 and #2. Resident #1 was diagnosed with a subdural hematoma.

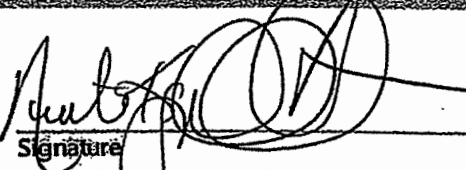
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We strongly disagree with this violation. We strongly believe this is the wrong violation. As this incident was not witnessed and was based on assumptions. Resident #1 was checked on and monitored twice in a 20 minute time period during the assumed situation. Direct care staff and Administration immediately acted and contacted the ambulance and sent resident #1/#2 to the emergency room to be evaluated and get medical treatment if needed, as well as to ensure

pg. 2

Legal Entity Representative


Signature

Nimita Kapoor Arora
Printed Name and Title

Co-Admin
Pres.
2/11/2020
Date

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2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

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safety of all residents. Administration verbally notified Area Agency on Aging, and completed written reports regarding the incident to Area Agency on Aging/ Department of Human Services, also Family and Dr. were notified in a timely manner. This Personal Care Home acted immediately and followed all Proper Reporting Procedures.

pg. 3

Legal Entity Representative


Signature

Nimta Kapoor Atiyeh
Printed Name and Title
C. Aden Pres.
Date 2/11/2020

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Regulations

2600. 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

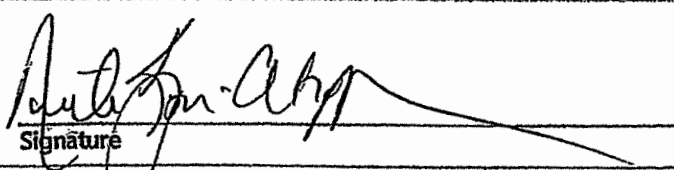
On 12/15/2019 at approximately 1:30 am resident #1 was going in and out resident's rooms, shift supervisor A redirected resident #1 back to bed. At approximately 1:50 am resident #1 was found back in the hallway in the home's Secured Dementia Care Unit by staff person B, who notified shift supervisor A that resident #1 is irritable and verbal with staff. Resident #1 had spots of blood on his/her shirt and when staff person A went to assess resident #1, resident #1 swung at staff person A and missed. Shift supervisor A called for an ambulance to send resident #1 to the ER for an evaluation. Staff person B found resident #2 in their wheel chair in the dining room with a laceration on the resident's face and blood on resident head. The EMT that arrived to assess resident #1 was advised of resident #2's condition and called for another ambulance. Staff initiated an investigation and found a lamp that was broken in to pieces and had blood on the lamp shade. Blood was found on the floor and blood spatter was also on the wall in resident #2's bedroom. The home reported the incident to the Department as apparent resident to resident assault between residents #1 and #2. Resident #1 was diagnosed with a subdural hematoma.

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To ensure continued compliance with Regulation 2600.42b, all lamps were removed out of resident's room in the Secured Units, and were replaced with wall touch lights. Direct care staff will continue with doing regular rounds/checks on all residents, and continue to redirect residents as needed, as well as continuing to monitor for any status changes that may occur with residents such as behavioral, mental status, physical changes. Nursing Supervisors/ Administration will continue to notify Primary Care Physician, Psychiatrist, and POA's. pg. 4

Legal Entity Representative


Signature

Nimita Kapoor - Atyret
Printed Name and Title

CG - Admin
Pres
2/11/2020
Date

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Administration will continue to follow proper reporting procedures to Department Of Human Services and Area Agency on Aging. Direct care staff will continue to do checks daily on all three shifts.

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Legal Entity Representative


Signature

N. Anita Kagoak-Archer
Printed Name and Title

Co-Adm -
Presy
2/11/2020
Date

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