

Department of Human Services
Bureau of Human Service Licensing

August 27, 2021

[REDACTED], CFO
CPF LIVING COMMUNITIES - WHITEHALL LLC
2 N TAMIAMI TRAIL, 200
SARASOTA, FL 34236

RE: THE RESIDENCE AT WHITEHALL
4750 CLAIRTON BOULEVARD
PITTSBURGH, PA, 15236
LICENSE/COC#: 45021

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/18/2021, 05/19/2021, 05/20/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY**

Facility Information

Name: *THE RESIDENCE AT WHITEHALL* License #: *45021* License Expiration Date: *08/27/2021*
Address: *4750 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *4128851500* Email: [REDACTED]

Legal Entity

Name: *CPF LIVING COMMUNITIES - WHITEHALL LLC*
Address: *2 N TAMIAMI TRAIL, 200, SARASOTA, FL, 34236*
Phone: *4128851500* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *05/13/2019* Issued By: *Whitehall Borough*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *36* Waking Staff: *27*

Inspection

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *05/20/2021*

Inspection Dates and Department Representative

05/18/2021 - On-Site: [REDACTED]
05/19/2021 - On-Site: [REDACTED]
05/20/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *46* Residents Served: *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *29*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *7* Have Physical Disability: *0*

Inspections / Reviews

05/18/2021 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/05/2021*

8/16/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/18/2021*

8/18/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *08/24/2021*

8/27/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

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

Resident #2's contract, completed [REDACTED], was not signed by the resident.

Plan of Correction

Accept

Resident #2 was transferred to a SDCU on [REDACTED].

Per the regulation contracts will be signed by the resident or their designee. The administrator or their designee will verify this at the time of contract signing.

All contracts signed within a quarter will be reviewed quarterly as part of the QA process by the Administrator or their designee.

Completion Date: 08/04/2021

Document Submission

Implemented

see attached.

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, [REDACTED], was hired on [REDACTED]. However, the criminal history check for staff person A was not completed until [REDACTED].

Ancillary staff person B has worked for the home since it was licensed on 8/27/19 and turned [REDACTED] years of age on [REDACTED]. However, a criminal history check has not been completed for staff person B as of 5/20/21.

Plan of Correction

Accept

Staff person A and staff person B are no longer employed by The Residence at Whitehall.

Managers and associates involved in the hiring process have been trained on the department's requirements for staff persons working in a PCH including 6 PA Chapter 15.

Please see record of training, attached.

The Administrator or their designee will review employee files quarterly as part of the QA process.

Completion Date: 08/03/2021

Document Submission

Implemented

see attached.

54a - Direct Care Staff

1. Requirements

2600.

54a - Direct Care Staff (continued)

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 person C began working for the home on [REDACTED] and providing direct care services to residents. However, the home does not have documentation that staff person C has a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction**Accept**

Staff person C is no longer employed by The Residence at Whitehall due to not being able to provide proof of high school diploma, GED, or active status on the PA Nurse Aide Registry.

Managers and associates involved in the hiring process have been trained on regulation 5600.54.a.

Please see record of training, attached.

Employee files will be reviewed quarterly by the Administrator or their designee as part of the QA process.

Completion Date: 08/03/2021

Document Submission**Implemented**

see attached.

63a - First Aid/CPR Training**1. Requirements**

2600.

- 63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 5/8/21, there were 27 residents residing in the home. However, on 5/8/21 from 7:00 p.m. until 11:00 p.m., there was no staff on duty who is trained in first aid and certified in obstructed airway techniques and CPR.

On 5/14/21, there were 28 residents residing in the home. However, on 5/14/21 from 11:00 p.m. until 7:00 a.m. on 5/15/21, there was no staff on duty who is trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction**Accept**

Associates who work in the PCH have been trained in CPR.

See record of training, attached.

Compliance to regulation 2600.63.a will be reviewed Quarterly by the Administrator or their designee. CPR classes will be scheduled quarterly as needed to comply with the regulation. The Wellness Director or their designee will keep a calendar for CPR training and CPR re-certification and schedule classes as needed to meet the regulation.

Completion Date: 08/11/2021

Document Submission**Implemented**

see attached.

65d - Initial Direct Care Training**1. Requirements**

2600.

- 65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d - Initial Direct Care Training (continued)

Description of Violation

Direct care staff person D began working for the home on [REDACTED] and provided unsupervised personal care services to resident #3 on [REDACTED] when assisting the resident with changing a shirt. However, staff person D has not successfully completed the Department-approved direct care training course and passed the competency test.

Plan of Correction

Accept

Staff person D no longer works at The Residence at Whitehall.

The Wellness Director or their designee will utilize a check list to verify regulation 2600.65.d has been completed prior to the start of the staff persons first shift in the PCH. If the checklist is not complete the staff person will not be able to start their shift until completed.

The administrator or their designee will monitor quarterly for compliance as part of the QA process.

Completion Date: 08/03/2021

Document Submission

Implemented

see attached.

65i - Training Record

1. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i - Training Record (continued)

Description of Violation

Ancillary staff person B has worked for the home since it opened [REDACTED]. However, there is no documentation that staff person B has received training in the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Direct care staff person C began working for the home on [REDACTED]. However, staff person C has not received training in the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Direct care staff person D started working for the home on [REDACTED]. However, staff person D did not receive training in the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Agency staff person E, a registered nurse, from [REDACTED], began working shifts at the home on [REDACTED]. However, staff person E did not receive training in the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Ancillary staff person B has worked for the home since it was licensed on [REDACTED]. However, the home has no documentation that staff person B has received training in the following topics:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act
4. Reporting of reportable incidents and conditions.

Direct care staff person C began working for the home on [REDACTED] and has worked in excess of 40 hours. However, the home has no documentation that staff person C has received training in the following topics:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act
4. Reporting of reportable incidents and conditions.

Agency staff person E, a registered nurse, from [REDACTED], began working shifts at the home on [REDACTED]. Staff person E did not receive training in the following topics:

1. Resident rights.
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

65i - Training Record (continued)

Plan of Correction**Accept**

Staff persons B, C, D, and E no longer work at The Residence at Whitehall.

The Wellness Director or their designee will utilize a check list to verify regulation 2600.65.i has been completed prior to the start of the staff persons first shift in the PCH. If the checklist is not complete the staff person will not be able to start their shift until completed.

Associate files will be reviewed by the Administrator or their designee quarterly as part of the QA process to ensure compliance with regulation 65.i.

Completion Date: 08/02/2021

Document Submission**Implemented**

see attached.

82a - Poisonous Materials

1. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 3/20/21 at 2:58 p.m., there was a translucent 30oz spray bottle with "steam table sanitizer" handwritten on it setting in the top of a stack of 3 brown milk crates in the "Janitor" closet in the home's 4th floor kitchen off of the café serving area. This was no original label on the bottle.

On 5/20/21 at 3:10 p.m., there was an approximately half full translucent 30oz Ecolab spray bottle of orange liquid with "Envirox H2O orange" handwritten on it setting on the counter adjacent to the 4th floor café serving area along with table condiment holders that contained sugar packets, salt and pepper shakers and creamer. There was no original label on the bottle.

Plan of Correction**Do Not Accept**

Associates have been trained on proper storage of poisonous materials.

See record of training, attached.

The ED or their designee will monitor for compliance of regulation 82.a quarterly as part of the QA process.

Completion Date: 08/02/2021

Plan of Correction**Accept**

The translucent 30oz spray bottle with "steam table sanitizer" handwritten has been replaced with a sanitizer that has the original label on it. See picture, attached.

The 30oz Ecolab spray bottle of orange liquid with "Envirox H2O Orange" has been replaced with the original label.

Associates have been trained on proper storage of poisonous materials.

See record of training, attached.

The Maintenance Director or their designee will monitor for compliance with 82.a daily.

The ED or their designee will monitor for compliance of regulation 82.a quarterly as part of the QA process.

Completion Date: 08/04/2021

Document Submission**Implemented**

see attached.

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/20/21 at 2:50 p.m., there were used, dirty dish towels lying around the home's 4th floor kitchen in the following places:

One on the top shelf of the steam table, one on the main surface of the steam table, one on the lowest shelf of the steam table, and one hanging over the stainless steel splash guard of the hand sink.

On 5/20/21 at 3:00 p.m., there was a yellow 5 gallon bucket with mop wringer attachment partially filled with dirty water setting in the "Janitor" closet in the 4th floor kitchen off of the café serving kitchen. There was a wet mop head setting in the water and another setting in the wringer.

Plan of Correction**Do Not Accept**

Associates have been trained on maintaining sanitary conditions.

See record of training, attached.

Hooks have been hung in the janitor's closet for mops and brooms.

See pictures, attached.

Completion Date: 08/02/2021

Plan of Correction**Accept**

Associates have been trained on maintaining sanitary conditions.

See record of training, attached.

Hooks have been hung in the janitor's closet for mops and brooms.

See pictures, attached.

The Administrator or their designee will monitor sanitary conditions daily and review findings quarterly as part of the QA process.

Completion Date: 08/10/2021

Document Submission**Implemented**

see attached.

85d - Trash Receptacles

1. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/18/21 at 2:00 p.m., there was an uncovered rectangular trash can that was filled to the top with trash/boxes setting next to the flat top griddle in the home's kitchen.

On 5/20/21 at 2:45 p.m., there was an uncovered large square trash can on wheels approximately ½ full with trash to include a foil pie pan and plastic lid, used paper cups and food left overs in the 4th floor café/serving area.

85d - Trash Receptacles (continued)

Plan of Correction **Accept**

The trash can next to the flat top griddle was removed at the time of inspection. The trash can has also been covered.

See picture, attached.

The trash can on the fourth-floor kitchen has been covered.

See picture, attached.

Dining staff will monitor for compliance daily and the Administrator will verify compliance quarterly as part of the QA process.

Completion Date: 08/02/2021

Document Submission **Implemented**

see attached.

85e - Trash Outside Home

1. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/18/21 at 9:05 a.m., there was an uncovered trash can at the main entrance to home. The can is square and has rectangular openings at the top of each of four sides.

Plan of Correction **Do Not Accept**

The trash can has been replaced.

See pictures verifying compliance to regulation 85e, attached.

Completion Date: 08/06/2021

Plan of Correction **Accept**

A lid with no openings for the 32 gallon trash can at the entrance of the home was ordered on 8/17/21.

See purchase order, attached. The Administrator will provide the department with updated pictures upon receiving the new lid.

A temporary trashcan was purchased to meet regulation 85e until the new lid arrives.

See picture verifying compliance attached.

The Maintenance Director or their designee will monitor the trashcan at the entrance to the building daily to ensure regulation 85e is met.

The Administrator or their designee will review compliance quarterly as part of the QA process.

Completion Date: 08/17/2021

Document Submission **Implemented**

see attached.

88a - Surfaces

1. Requirements

2600.

88a - Surfaces (continued)

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 5/18/21 at 12:20 p.m., the fire doors near the 4th floor Wellness Center did not close completely resulting in an approximately ¾" gap between the doors. The door on the left when facing toward the dining room does not latch at the top. The home's fire safe areas are used during fire drills.

Plan of Correction**Accept**

The latch at the top of the left fire door was fixed on 5/21/21 following the completion of the licensing inspection. See picture verifying compliance, attached.

The Administrator or their designee will monitor monthly as part of the monthly fire drill.

Completion Date: 05/21/2021

Document Submission**Implemented**

see attached.

89b - Hot Water Temperature**1. Requirements**

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 5/20/21 at 2:55 p.m., the water temperature at the accessible and unattended hand sink in the 4th floor kitchen measured 128.6 degrees Fahrenheit.

Plan of Correction**Accept**

Maintenance adjusted the water temperature to the accessible and unattended hand sink in the 4th floor kitchen, so it does not exceed 120 degrees fahrenheit.

The Administrator or their designee will monitor for monthly compliance in Direct Supply TELS - Building Management.

Completion Date: 05/21/2021

Document Submission**Implemented**

see attached.

96a - First Aid Kit**1. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The home's first aid kit located in the medication room did not include a CPR breathing shield.

Plan of Correction**Accept**

A new CPR/First Aide Kit was ordered on 8/11/21.

The Administrator or their designee will check the first aid kit quarterly as part of the QA process.

Completion Date: 08/11/2021

96a - First Aid Kit (*continued*)**Document Submission****Implemented***see attached.*

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*On 5/18/21 at approximately 12:35 p.m., the lamp located on the nightstand next to bed in apartment #429 was inoperable; the lamp was not plugged in.***Plan of Correction****Accept***The lamp on the nightstand in apartment 429 was immediately plugged in upon the licensing inspectors finding it unplugged.**Care associates have been trained on regulation 2600.101.j and have been instructed the report to their supervisor anytime a light is not working.**See record of training, attached.***Completion Date:** 05/18/2021**Document Submission****Implemented***see attached.*

103c - Food Protected

1. Requirements

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation*On 5/20/21 at 2:47 p.m., there were four uncovered plated slices of cream pie with meringue setting on the steam table in the kitchen adjacent to the 4th floor café serving area.***Plan of Correction****Do Not Accept***Associates have been trained on how to cover, label and date any leftovers and refrigerate immediately. The dining services director or their designee will monitor daily for compliance.**See record of training, attached.***Completion Date:** 08/03/2021**Plan of Correction****Accept***Associates have been trained on how to cover, label and date any leftovers and refrigerate immediately.**See record of training, attached.**The Dining Services Director or their designee will monitor daily for compliance.**The Administrator will review compliance quarterly as part of the QA process.***Completion Date:** 08/03/2021**Document Submission****Implemented***see attached.*

103e - Left Overs

1. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 5/18/21 at 1:50 p.m., the following undated items were in the walk-in cooler in the home's main kitchen:

** A 3.5 quart square plastic container with green lid which had approximately 2 quarts of canned mandarin oranges in liquid.*

** A 3.5 quart square plastic container with green lid which had approximately 1 quart of canned peach halves in liquid.*

On 5/20/21 at 2:47 p.m., there were four plates with plastic dome covers each containing pasta with meat, cubed potatoes and broccoli setting on a wheeled table to the right of the sink in the kitchen adjacent to the 4th floor café serving area.

Plan of Correction**Do Not Accept**

Associates have been trained on how to cover, label and date any leftovers and refrigerate immediately.

The Dining Services Director or their designee will monitor daily for compliance.

See record of training, attached.

Completion Date: 08/03/2021

Plan of Correction**Accept**

Associates have been trained on how to cover, label and date any leftovers and refrigerate immediately.

The Dining Services Director or their designee will monitor daily for compliance.

See record of training, attached.

The Administrator or their designee will monitor for compliance quarterly as part of the QA process.

Completion Date: 08/03/2021

Document Submission**Implemented**

see attached.

103f - Refrigerator/Freezer Temps

1. Requirements

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

On 5/20/21 at 2:45 p.m., there was no thermometer in the freezer compartment of the stainless steel refrigerator/freezer unit in the 4th floor café serving area.

Plan of Correction**Accept**

Thermometers have been placed in all freezing and cooling equipment.

Logs are checked twice daily, and temperatures noted.

The Administrator or their designee will review all temperature logs quarterly as part of the QA process.

Completion Date: 08/03/2021

Document Submission**Implemented**

see attached.

103g - Storing Food

1. Requirements

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/18/21 at 2:05p.m., there was an ice cream freezer in the home's main kitchen that contained seven 3-gallon cardboard tubs of ice cream that were opened and partially used. None of the lids were securely placed on the tubs exposing the ice cream.

On 5/20/21 at 3:06 p.m., there was an uncovered (no lid at all) approximately ¼ full 1.5 quart plastic container of Blue Bunny Double swirl ice cream in the freezer section of the stainless steel refrigerator/freezer in the home's 4th floor café serving area.

Plan of Correction

Accept

Associates have been re-educated on proper food storage and handling via the safety and sanitation in-service.

See record of training, attached.

The Dining Services Director or their designee will monitor daily for compliance.

A large ice-cream cooler was provided by Hershey's Ice Cream to accommodate additional ice cream.

All ice cream containers are now sealed with plastic lids to ensure compliance.

See photo, attached.

Completion Date: 08/03/2021

Document Submission

Implemented

see attached.

103i - Outdated Food

1. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 5/18/21 a 1:30 p.m., the following unlabeled, undated items were in the walk-in freezer in the home's main kitchen:

** A 8 pancakes remaining in an undated clear package of 15 pancakes which had been removed from the original box.*

** A 6 beer battered cod patties in an undated clear bag which was removed from the original box packaging.*

** A 9 breaded cod patties in an undated clear bag which was removed from the original box packaging.*

** A large (approx. 5+ pounds) chunk of what was identified by staff as corned beef in an undated blue plastic bag which was removed from its original packaging.*

On 5/20/21 at 3:15 p.m., there was a rock hard ½ full bag of miniature marshmallows in the upper cupboard immediately to the left of the refrigerator in the 4th floor café serving kitchen.

Plan of Correction

Do Not Accept

Associates have been re-educated on proper food storage and handling via the safety and sanitation in-service.

See record of training, attached.

The Dining Services Director or their designee will monitor daily for compliance.

Completion Date: 08/03/2021

103i - Outdated Food (continued)**Plan of Correction****Accept**

All unlabeled, undated items were immediately removed from the kitchens following the inspection. Associates have been re-educated on proper food storage and handling via the safety and sanitation in-service. See record of training, attached.

The Dining Services Director or their designee will monitor daily for compliance.

The Administrator or their designee will monitor compliance quarterly as part of the QA process.

Completion Date: 08/03/2021

Document Submission**Implemented**

see attached.

141a - Medical Evaluation**1. Requirements**

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.

Description of Violation

The initial medical evaluation completed for resident #4, admitted [REDACTED], was not completed until [REDACTED].

Plan of Correction**Accept**

Resident #4 ceased to breath since this survey.

Associates have been trained on state required paperwork.

See record of training, attached.

The Wellness Director or their designee will review state paperwork monthly to verify compliance.

The Administrator or their designee will review state paperwork quarterly as part of the QA process.

Completion Date: 08/04/2021

Document Submission**Implemented**

see attached.

162c - Menus Posted**1. Requirements**

2600.

- 162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 5/18/21 at 11:05 a.m., the menu posted at the entrance to the 4th floor café dining room was for the week of 5/16/21-5/22/21.

Plan of Correction**Accept**

Current and following week menus have been posted on the wall in the foyer of the Personal Care dining room.

See picture verifying compliance, attached.

The Dining Services Director or their designee will monitor weekly for compliance.

Completion Date: 08/02/2021

162c - Menus Posted (*continued*)

Document Submission

Implemented

see attached.

181c - Self-administration Assessment

1. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

According to direct care staff person F, resident #1 self-administers a few medications including [REDACTED]. However, the resident's assessment completed on 2/18/2021 indicates that the "Resident cannot self-administer medications."

Plan of Correction

Do Not Accept

Resident #1 received an order from [REDACTED] physician on [REDACTED] allowing [REDACTED] to "keep at bedside" the following medications: [REDACTED].

See order, attached.

Resident #1 completed the Self Administration Test on 7/6/21.

Please see Self Administration Test, attached.

The Wellness Director or their designee will re-test resident #1 monthly to verify understanding.

The Administrator or their designee will monitor the Self Administration Tests quarterly as part of the QA process.

Completion Date: 08/06/2021

Plan of Correction

Accept

Resident #1 received an order from [REDACTED] physician on 7/6/21 allowing [REDACTED] to "keep at bedside" the following medications: [REDACTED].

See order, attached.

Resident #1 completed the Self Administration Test on 7/6/21.

Please see Self Administration Test, attached.

Resident #1's RASP was updated on 7/6/21 to reflect the new order. See updated RASP, attached.

The Wellness Director or their designee will re-test resident #1 monthly to verify understanding/compliance.

The Administrator or their designee will monitor the Self Administration Tests quarterly as part of the QA process.

Completion Date: 06/07/2021

Document Submission

Implemented

see attached.

183e - Storing Medications

1. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications (continued)

Description of Violation

On 5/19/21 at 2:40 p.m., There was a [REDACTED] in a clear zip bag with pharmacy label for resident #5. The Flexpen was not dated when opened.

On 5/19/21 at 3:42 p.m., there was a partially used [REDACTED] with pharmacy label for resident #2 in the medication cart. The pen was not dated when opened.

Plan of Correction**Do Not Accept**

Resident #2 was transferred to a SDCU since this inspection.

Medication Technicians have been re-trained in proper storage of Medications.

See record of training, attached.

The Wellness Director or their designee will monitor med carts monthly at change over to ensure compliance with regulation 2600.183.e.

The Administrator or their designee will monitor quarterly as part of the QA process.

Completion Date: 08/04/2021

Plan of Correction**Accept**

Resident #2 was transferred to a SDCU since this inspection.

Resident #5's [REDACTED] has been replaced and has a date opened on it. See picture, attached.

Medication Technicians have been re-trained in proper storage of Medications.

See record of training, attached.

The Wellness Director or their designee will monitor med carts monthly at change over to ensure compliance with regulation 2600.183.e.

The Administrator or their designee will monitor quarterly as part of the QA process.

Completion Date: 08/04/2021

Document Submission**Implemented**

see attached.

184a - Labeling OTC/CAM

1. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #4 is ordered [REDACTED] as needed. However, there was a blister pack of this medication for resident #4 with pharmacy label that indicates [REDACTED] by mouth every 8 hours as needed for nausea/vomiting for up to 7 days.

Resident #4 is ordered [REDACTED]. However, there was a blister pack of the medication with pharmacy label that indicates [REDACTED] – take one tablet by mouth every eight hours as needed for anxiety. The prn order was discontinued; there was no "directions changed" sticker on the medication.

184a - Labeling OTC/CAM (continued)**Plan of Correction****Accept**

Resident #4 has ceased to breath since this licensing inspection.

Medication Technicians have been re-trained on Labeling OTC/CAM mediations per regulation 184a.

See record of training, attached.

The Wellness Director or their designee will review all OTC/CAM medications monthly at change over.

The Administrator or their designee will monitor for any discrepancies quarterly as part of the QA process.

Completion Date: 08/04/2021

Document Submission**Implemented**

see attached.

185a - Implement Storage Procedures**1. Requirements**

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.

185a - Implement Storage Procedures (continued)

Description of Violation

Resident #1 is ordered blood glucose readings three times daily. The Prodigy Autocode glucometer for resident #1 only displays one reading in the history and then turns off. On 5/19/21 at 3:34 p.m., the glucometer indicated it was "5-19 3:33pm." However, the most recent and only reading in the glucometer indicated "12:08 5-28 118 [BG reading]" which was the reading entered on the resident's May 2021 MAR for 5/19/21 at 4:30 p.m. All previous readings in the glucometer had been erased/reset. Also, the resident's May 2021 medication administration record (MAR) only has an entry for BG reading to be entered at 4:30 p.m. The resident's 7:30 a.m. and 11:00 a.m. readings are not recorded in the resident's MAR or elsewhere. The resident's glucometer history only has a reading that was taken on 5/19/21 at 3:34 p.m.

Resident #2 is ordered blood glucose readings before meals and at bedtime. On 5/19/21 at 3:42 p.m., there was only one reading in the resident's Prodigy Autocode glucometer that indicates "11:45am 5-19 171 [blood glucose reading]." The resident's May 2021 MAR has BG entries for 8:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m. from 5/1/21 – 5/18/21. However, all of these readings had been erased/reset from the resident's glucometer.

Resident #5 is ordered Accuchecks three times daily before meals with sliding scale coverage with Novolog Flexpen as follows: < 140 = 0 units; 141-180 = 1 unit; 181-220 = 2 units; 221-260 = 3 units; 261-300 = 4 units; 301-340 = 5 units; 341-400 = 6 units; 401-450 = 8 units; 451-500 = 10 units; > 500 – Call M.D. Resident #5's glucometer was calibrated to date/time only for the first reading in glucometer of 136 taken on 5-19 at 11:49 a.m.. However previous readings did not correlate to the medication administration record (MAR) entry dates/times indicating that the glucometer had not been calibrated to date/time as follows:

- * Glucometer reading of 119 taken on 5-14 1:19pm - entered on MAR 5/19/21 at 6:30 a.m.
 - * Glucometer reading of 235 taken on 5-13 at 10:50 p.m. – entered on MAR 5/18/21 at 4:30 p.m.
 - * Glucometer reading of 200 taken on 5-13 at 6:38 p.m. – entered on MAR 5/18/21 11:30 a.m.
- All previous readings in the glucometer had been erased/reset.

Resident #6 is ordered blood glucose checks daily. On 5/19/21 at 3:48 p.m., there was only one reading in the resident's Prodigy Autocode glucometer that indicates "5-19 6:29am 154 [blood glucose reading]." All previous readings in the glucometer had been erased/reset.

The deletion of glucometer histories precludes the home from being able to review the histories to ensure that glucose readings are being documented accurately and that glucometer sharing is not occurring.

Plan of Correction**Do Not Accept**

Medication Technicians have been re-trained on proper storage procedures as well as re-certified in administering diabetic medications, insulin, and insulin administration.

See certificates, attached.

The Wellness Director or their designee will monitor for compliance monthly and schedule diabetic education as needed to meet the regulations.

Completion Date: 08/04/2021

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept

Medication Technicians have been re-trained on proper storage procedures as well as re-certified in administering diabetic medications, insulin, and insulin administration.

See certificates, attached.

The Wellness Director or their designee will monitor for compliance monthly and schedule diabetic education as needed to meet the regulations.

The Administrator or their designee will monitor quarterly for any discrepancies in regulation 185.a as part of the QA process.

Completion Date: 08/04/2021

Document Submission

Implemented

see attached.

187a - Medication Record

1. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

- 4. Strength.

Description of Violation

Resident #4 is ordered [redacted] by mouth daily. However, the entry on the resident's May 2021 medication administration record (MAR) indicates [redacted] tablet [for [redacted] tablet] – take one tablet by mouth daily.

Plan of Correction

Do Not Accept

Medication Technicians have been re-trained on regulation 187a.

See record of training, attached.

The Wellness Director or their designee will review all medications monthly at change over.

The Administrator or their designee will monitor for any discrepancies quarterly as part of the QA process.

Completion Date: 08/04/2021

Plan of Correction

Accept

Resident #4 has CTB since this inspection.

Medication Technicians have been re-trained on regulation 187a.

See record of training, attached.

The Wellness Director or their designee will review all medications monthly at change over.

The Administrator or their designee will monitor for any discrepancies quarterly as part of the QA process.

Completion Date: 08/04/2021

Document Submission

Implemented

see attached.

190b - Insulin Injections

1. Requirements

2600.

190b - Insulin Injections (continued)

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Direct care and medication technician staff person G has not successfully completed a Department-approved diabetes patient education program. However, according to resident #5's May 2021 medication administration record (MAR), staff person G administered insulin to resident #5 on 5/12/21, 5/13/21 and 5/14/21.

Plan of Correction**Accept**

Staff person G completed a department approved diabetes education program on 8/4/21.

See record of training and certificate of completion, attached.

The Wellness Director or their designee will monitor all diabetic education needs and ensure compliance with 190b.

The Administrator or their designee will review quarterly for compliance.

Completion Date: 08/04/2021

Document Submission**Implemented**

see attached.

225c - Additional Assessment**1. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

Description of Violation

Resident #1's diet was changed to Mechanical Soft – Chopped, Diabetic Diet and thin liquids as of 3/10/21. However, the resident's annual assessment completed 2/18/21 was not updated to reflect this change.

There are numerous documentations by staff in Resident Service Notes about finding resident #5 trying to make his way out of the building or trying to leave the personal care unit (4th floor) and staff redirecting him to remain in the personal care part of the building and not go outside. Some entries indicate that staff sometime sit with him or walk him around the building. The resident's annual assessment completed 11/12/2020 indicates that resident's level of supervision is "Moderate – Resident requires some supervision in the home and needs attendance when outside the home and/or tends to wander." However, the Behavioral or Cognitive Need section of resident #5's assessment has all topics coded "A = No Problem" to include: Orientation to time, place and person; judgement; agitation; understanding instructions; short-term memory; and long-term memory."

Plan of Correction**Accept**

Resident #1's annual assessment has been updated to reflect the change in diet to mechanical soft.

See updated RASP, attached.

Resident #5's annual assessment has been updated to reflect the change in supervision needs.

See updated RASP, attached.

The Administrator has re-trained all associates and managers involved in state required paperwork.

See record of training, attached.

The Administrator or their designee will review RASPs quarterly for compliance as part of the QA.

Completion Date: 08/04/2021

225c - Additional Assessment (continued)

Document Submission

Implemented

see attached.

227g -Support Plan Signatures

1. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's support plan completed [REDACTED] was not signed by the assessor.

Plan of Correction

Accept

The assessor who completed Resident #1's support plan is no longer employed at The Residence at Whitehall.

The Support Plan has been updated by the current Administrator.

See RASP, attached.

The Administrator has re-trained all associates and managers involved in state required paperwork.

See record of training, attached.

The Wellness Director or their designee will monitor RASPs monthly to ensure compliance with regulation 227.g.

The Administrator or their designee will review RASPs quarterly for compliance as part of the QA process.

Completion Date: 08/04/2021

Document Submission

Implemented

see attached.