pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: October 12, 2022

[redacted]
CA Senior McCandless II Operator, LLC
[redacted]
[redacted]

RE: Anthology of McCandless
8651 Carey Lane
Pittsburgh, Pennsylvania 15237
License/COC #: 449981

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 12, 2022, July 13, 2022, July 14, 2022, and July 18, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 449980) dated August 28, 2022 – August 28, 2023, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 11, 2022 April 11, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ANTHOLOGY OF MCCANDLESS* **License #:** *44998* **License Expiration:** *08/28/2022*

Address: *8651 CAREY LANE, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *4123927000* **Email:** [redacted]

Legal Entity

Name: *CA SENIOR MCCANDLESS II OPERATOR LLC*

Address: [redacted]

Phone: *4123927000* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *03/18/2019* **Issued By:** *Township of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *113* **Waking Staff:** *85*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *08/05/2022*

Inspection Dates and Department Representative

07/12/2022 - On-Site: [redacted]
07/13/2022 - On-Site: [redacted]
07/14/2022 - On-Site: [redacted]
07/18/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served:** *83*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *4th Floor* **Capacity:** *37* **Residents Served:** *25*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *83*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *30* **Have Physical Disability:** *0*

Inspections / Reviews

07/12/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/24/2022*

08/25/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/31/2022*

09/12/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/25/2022*

09/30/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type**: *Exception* **Follow-Up Date**:

42b - Abuse

1. Requirements

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 [redacted]/22 at approximately [redacted] pm, resident #1 was found by a visitor of the home [redacted] positioned directly in the sun, on the 4th floor secured dementia care unit (SDCU) outdoor patio. The door to the patio had been left unlocked since the morning of [redacted]/22. According to resident #1's most recent assessment, dated [redacted] 21, resident #1 required extensive supervision in the home, and resident #1's most recent support plan, dated [redacted]/21, indicates "Staff to provide regular supervision in the home, know [redacted] location at all times and attendance outside of the home. Staff to monitor and report any changes or concerns to the nurse." Staff member A reportedly last saw resident #1 walking in the hallway at approximately [redacted] pm; however, no staff persons report seeing resident #1 between [redacted] pm and [redacted] pm. Emergency services were contacted and transported resident #1 to the hospital, where resident #1 passed away on resident #1's date of death. According to resident #1's death certificate, resident #1's cause of death was [redacted]

Plan of Correction ***Directed***

Immediate: In-service on monitoring residents, resident hydration, and wandering or walking about is being completed for all team members working in the secured dementia care unit. Completion date is set for 9/6/22. Documentation will be kept on the employee files.

Audit: An audit of all employee files was completed for those team members working in memory care to ensure each individual has received education on monitoring residents, resident hydration, and residents wandering/walking about upon hire. An audit was completed by 8/31/22 for all team members to ensure that appropriate abuse/neglect training has been received and is documented.

Systemic: At the time of hire, all new team members working in memory care will be educated on the following polices and procedures: monitoring residents, resident hydration, residents wandering/walking about, and abuse/neglect reporting. All team members will be in serviced bi-annually thereafter and as needed. Record of trainings will be kept on employee files.

Monitoring: The Director of Memory Care will monitor the employee files in conjunction with the Business Office Director to ensure ongoing compliance. The Director of Health and Wellness and Executive Director will conduct random audits to ensure training has been completed. In accordance with resident rights and applicable regulations, Memory Care residents are able to access the Secured Dementia Care Unit courtyard as desired to ensure maximum physical freedom within a safe environment. The Director of Memory Care or designee will routinely inspect the courtyard both visually and physically, and ensure the safety of any residents using the courtyard.

DIRECTED: By 9/20/22: A designated staff person shall develop and implement policies and procedures for resident access the courtyard, located in the home's SDCU. The policies and procedures shall include the times the courtyard will be accessible to residents, and shall also ensure residents are appropriately supervised in accordance with resident assessments and support plans. The policies and procedures shall also ensure residents are checked by a designated staff person at least every 30 minutes while residents are in the SDCU courtyard to ensure resident safety. Documentation of the policies and procedures shall be kept. All staff persons shall be educated on the new policies and procedures by 9/25/22. Documentation of the education shall be kept. LM 9/12/22

42b - Abuse (continued)

Completion Date: *09/06/2022* Licensee's Proposed Date for POC Implementation

9/30/22

Not Implemented

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 7/12/22 at 10:41am, the hot water temperature at the sink in the 1st floor lounge was 122.6 degrees Fahrenheit.

Plan of Correction ***Directed***

Immediate: The hot water system that supplies the 1st floor lounge was reviewed and the temperature adjusted at the water heater unit on 7/12/22 to ensure the temperatures in areas accessible to residents will not exceed 120 degrees F.

Audit: An audit of hot water temperatures was conducted on 7/18/22 where residents gain access to hot water.

Systemic: The Director of Plant Operations and/or designee will monitor a 10% random sampling of resident accessible areas each week and document findings appropriately. (DIRECTED: The weekly hot water testing shall begin within 5 calendar days of receipt of the plan of correction. LM 9/1/22).

Monitoring: The Director of Plant Operations and/or designee will monitor a 10% random sampling of resident accessible areas each week. The Executive Director and/or designee will review the documentation randomly to ensure ongoing compliance.

Completion Date: *08/31/2022* Licensee's Proposed Date for POC Implementation

9/30/22

Document Submission ***Implemented***

Immediate: The hot water system that supplies the 1st floor lounge was reviewed and the temperature adjusted at the water heater unit on 7/12/22 to ensure the temperatures in areas accessible to residents will not exceed 120 degrees F.

Audit: An audit of hot water temperatures was conducted on 7/18/22 where residents gain access to hot water.

Systemic: The Director of Plant Operations and/or designee will monitor a 10% random sampling of resident accessible areas each week and document findings appropriately. (DIRECTED: The weekly hot water testing shall begin within 5 calendar days of receipt of the plan of correction. LM 9/1/22).

Monitoring: The Director of Plant Operations and/or designee will monitor a 10% random sampling of resident accessible areas each week. The Executive Director and/or designee will review the documentation randomly to ensure ongoing compliance.

132b - Safety Inspection/Fire Drill

1. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection and fire drill conducted by a fire safety expert was held on 5/19/22; however, the previous fire safety inspection and fire drill conducted by a fire safety expert was held on 10/21/19.

Plan of Correction ***Accept***

Immediate: The next fire inspection is scheduled for January 25, 2023 at 11am with the area Fire Marshal.

Audit: An audit of fire inspection documentation was completed as well as system review to ensure any and all require inspections has been completed and/or scheduled.

Systemic: The Community will schedule an annual fire inspection and fire drill to be conducted by a fire safety expert no later November of each year.

Monitoring: The Director of Plant Operations will review fire safety expert inspection and drills documentation every six months to determine compliance and to schedule the next annual visit, as needed.

9/30/22

Completion Date: *08/25/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

132d - Evacuation

1. Requirements

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 did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert until 5/19/22. The home exceed the maximum safe evacuation time of 2 minutes, 30 seconds during the following fire drills:

- *1/25/22 at 3:40pm-Evacuation was completed in 7 minutes, 56 seconds*
- *3/15/22 at 3:21pm-Evacuation was completed in 7 minutes, 35 seconds*
- *3/24/22 at 1:30pm-Evacuation was completed in 6 minutes, 19 seconds*
- *4/22/22 at 6:50am-Evacuation was completed in 7 minutes, 58 seconds*

According to the home's fire drill records, during the fire drill conducted on 3/15/22 at 3:21pm, 80 residents were present in the home at the time of the fire drill; however, only 79 residents were evacuated.

Plan of Correction ***Directed***

Immediate: The home conducted a fire inspection on 5/19/2022 as well as scheduled the next fire inspection for January 25, 2023 at 11am by a fire safety expert. Education was provided to the residents regarding participation

132d - Evacuation (continued)

of fire safety drills as well as the requirement to evacuate or move to a fire-safe area designated in writing. Additional staff training on monthly fire drills in ongoing and will be completed by 9/6/22, documentation of this training will be kept in the home's fire safety binder.

Audit: An audit of fire inspection documentation was completed on 8/31/22 as well as system review to ensure any and all required inspections have been completed and/or scheduled.

Systemic: A fire drill will be conducted at least annually by a fire safety expert to include all residents. The home will schedule an annual fire inspection and fire drill to be conducted by a fire safety expert no later November of each year. A monthly drill will be conducted by the onsite community team to ensure appropriate safe evacuation is noted and concerns addressed. The Director of Plant Ops will ensure that all residents participate in the monthly fire drill. Bi-annually all residents will be educated on the importance of safe evacuation and their need to participate in such drills

Monitoring: The Director of Plant Operations will monitor all required drills and submit evidence to the executive director monthly. The Executive Director will [redacted]-(UNACCEPTABLE PORTION OF PLAN OF CORRECTION LM 9/1/22). to ensure ongoing compliance. (DIRECTED: Within 5 calendar days of receipt of the plan of correction: The Executive Director shall monitor all fire drill records monthly to ensure all residents evacuated 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 during each fire drill. LM 9/1/22). The Director of Plant Ops and/or the Executive Director will ensure all residents have participated in the monthly drills and have evacuated to a designed fire safe area.

9/30/22

Completion Date: *09/06/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

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:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #2's pharmacy label indicates Ipratropium Bromide 0.06% nasal solution-Take 1 spray in each nostril once daily; however, resident #2 is prescribed Ipratropium Bromide 0.06% nasal solution-Take 2 sprays in each nostril daily.

Resident #2's pharmacy label indicates Levothyroxine 125mcg-Take 1 tablet by mouth daily; however, resident #2 is prescribed Levothyroxine 125mcg-Take 1 tablet by mouth daily, except Sundays and take 1.5 tablets weekly on Sunday.

Resident #4's pharmacy label indicates Pantoprazole Sodium 40mg tablet-Take 1 tablet by mouth every day as needed; however, resident #4 is prescribed Pantoprazole Sodium 40mg tablet-Take 1 tablet by mouth in the morning.

184a - Labeling OTC/CAM (continued)

Plan of Correction ***Directed***

Immediate: The labels and orders were reviewed for resident #2 and #4. Corrections noted/approved with the physician, these changes were made on 7/13/22.

Audit: The DHW and the Resident Care Coordinator (RCC) conducted a preliminary audit of the medication cart to medication record to identify others as risk, this was done the week of 7/13/22. The community has requested an audit to be scheduled by their partner pharmacy, this is scheduled for 9/6/22.

Systemic: All individuals accepting medication arrivals will be trained/education and appropriate methods and requirements for checking in medications. All medications (Regardless of pharmacy) will be reviewed and compared to ensure the physician orders, medication attendance record, and medication label match. A monthly audit will be conducted taking a random 5% sampling of residents to ensure ongoing compliance. (DIRECTED: The monthly audits shall begin on 9/15/22. Documentation of the monthly audits shall be kept. LM 9/12/22). The Director of Health & Wellness did a verbal coaching with all med techs and nurses on this on 7/13/22. A written training will be completed by 9/6/22, training will be kept on the employee files.

Monitoring: The director of health and wellness and/or designee will conduct a monthly audit to check a random 5% sampling of residents to ensure ongoing compliance. The executive director will randomly audit the documentation to ensure success. (DIRECTED: The monthly audits shall begin on 9/15/22. Documentation of the monthly audits shall be kept. LM 9/12/22).


9/30/22

Completion Date: *09/06/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

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:

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.

187a - Medication Record *(continued)*

Description of Violation

Resident #2 is prescribed Lispro 100 unit/ml-Inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 200-250=1 unit; 251-300=2 units; greater than 301=3 units. However, the number of units of insulin that were administered to resident #2 are not recorded on resident #2's July 2022 medication administration record (MAR) daily from 7/1/22 through 7/13/22.

Resident #3 is prescribed Tramadol 50mg-Take 1 tablet by mouth every 12 hours as needed; however, this medication is not on resident #3's July 2022 MAR.

Resident #5's July 2022 MAR includes Morphine Sulfate 100mg/5ml oral solution-Take 0.5ml (10mg) every one hour as needed; however, this medication was discontinued on [redacted]/22.

Plan of Correction ***Directed***

Immediate: Resident #2's MAR was reviewed to identify number of units given of insulin. Immediate verbal coaching/training on where to place information was provided to those assisting with this medication. An additional written training will be presented and reviewed by 9/6/22.
Resident#3 had orders sent to pharmacy and placed on the MAR immediately. Resident #5 had a review of the MAR completed and updated as needed. This medication was removed on 7/18/22.

Audit: The DHW and the Resident Care Coordinator (RCC) conducted an audit of the medication car, to medication record to identify others as risk and corrected any potential discrepancies identified. This was done by 7/15/22. The community has also requested an audit to be scheduled by their preferred pharmacy, this is scheduled for 9/6/22.

Systemic: The Director of Health and Wellness did individual verbal trainings with all individuals accepting medication on appropriate methods and requirements for checking in medications. All medications (Regardless of pharmacy) will be reviewed and compared to ensure the physician orders, medication attendance record, and medication label match. An additional written training is ongoing and will be completed by 9/6/22. A record of this training will be kept on the employee files.

Monitoring: The Director of Health and Wellness and/or designee will conduct a monthly audit to check a random 5% sampling of residents to ensure ongoing compliance. The Executive Director will randomly audit the documentation to ensure success. (DIRECTED: The monthly audits shall begin on 9/15/22. Documentation of the monthly audits shall be kept. LM 9/12/22).

9/30/22

Completion Date: *09/06/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

233c - Key-Locking Devices

1. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Violation

On 7/12/22 at 11:19am, the exit door to the 4th floor north stairwell, located in the home's SDCU, could not be opened with the code that was posted near the door.

Plan of Correction ***Accept***

Immediate: The code on all doors of the secured dementia care unit were reset on 7/12/22 to ensure appropriate access/egress was available with the posted egress code.

Audit: An audit of all other doors was completed on 7/13/22 to ensure egress codes were available and successful when used.

Systemic: The Director of Plant Operations and/or designee will audit the doors weekly to ensure compliance. Records will be maintained in TELS, the maintenance work order system. Audits started the week of 7/12/22.

Monitoring: The director of plant operations and/or designee will monitor the doors weekly to ensure compliance. The executive director will audit the documentation randomly to monitor success.

9/30/22

Completion Date: *08/31/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**