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

February 5, 2024

[redacted], CFO
CPF LIVING COMMUNITIES - WHITEHALL LLC
[redacted]

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 11/28/2023, 11/29/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE RESIDENCE AT WHITEHALL* **License #**: *45021* **License Expiration**: *08/27/2024*

Address: *4750 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*

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

Administrator

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

Legal Entity

Name: *CPF LIVING COMMUNITIES - WHITEHALL LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/18/2019* **Issued By**: *Borough of Whitehall*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *37* **Waking Staff**: *28*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/29/2023*

Inspection Dates and Department Representative

11/28/2023 - On-Site: [redacted]

11/29/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *46* **Residents Served**: *35*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *35*

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

11/28/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/13/2024*

01/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/26/2024*

Inspections / Reviews *(continued)*

01/29/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/02/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/05/2024*

02/05/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/02/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 11/28/23 at approximately 11:00 a.m., agents of the Department requested the record for staff person A, the home's administrator. However, staff person A's record was not provided to the Department until 11/29/23 at 5:41 p.m.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

Staff Member A was out of the office 11/27/2023 – 12/01/2023 at Grace Management Home Office. The Designee's record [redacted]) was given to Surveyor, [redacted] Surveyor [redacted] insisted on using Staff member A's record, which was kept in [redacted] office.
POC – Moving forward, both The Administrator and Designee's Record will be kept at the front desk with the Survey Entrance Binder and will be updated as needed.
An Education for Department heads and Customer Service Experience Reps was completed on 12/11/2023 - see attached. No specific policy, however, this will be monitored with Quarterly QI/QM by the Administrator or Designee.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] - 02/05/2024)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The "Chart Room" near the TV room on the fourth floor does not lock. However, on 11/29/23 at 10:21 a.m., the room was unattended and there were several binders setting on the desktop in the Chart Room including one labeled "24 hour Communication Log" which included the following resident information:
[redacted]
Resident #1 – resident had stomach runs in the morning. [redacted] was given [redacted]
[redacted] evening shift
Resident #2 – 3-11 shift refused shower. [redacted] said [redacted] couldn't poop.
Resident #3 – I got a call from secretary downstairs; she was trying to go out the front doors on 1. Left message with daughter [name] and a text. No response back yet
[redacted] 7a-3p
Resident #4 – dressing changed late leave on till AM to change then.
Resident #5 - to stay in [redacted] room because of cold like symptoms. Tell [redacted] [staff person] wants [redacted] to stay in room.
[redacted]
Resident #4 – stomach folds so raw. It was washed and creamed with [redacted] powder. [redacted] has two sores on [redacted] butt.

17 - Record Confidentiality (continued)

Does not let morning aides clean it to put cream on so we end up putting new cream on old cream.
** [redacted] 3p-11p*
Resident #4 – underbelly fold is severely raw again. [redacted] applied.

Plan of Correction ***Directed ([redacted] 01/29/2024)***

On 11/29/2023 House Physician was using the chart room to see and chart on Residents. This area is always kept clear of any HIPAA information.
POC – Corrected 11/29/2023. All staff were educated on the importance of keeping any and all HIPAA related information locked. The Staff Communication Log is and will continue to be locked in the Medication Room, just off the Chart Room.
Monitoring began 11/29/23 - By all PC staff persons, daily, to ensure the Communication Log is securely locked in the Medication room. This will be monitored through Quarterly QI/QA process.

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure compliance with Regulation 2600.17. 1/29/24[redacted]

Directed Completion Date: *01/30/2024*

Implemented ([redacted] - 02/05/2024)

18 - Compliance With Laws

3. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Care Facility Carbon Monoxide Alarms Standards Act of June 23, 2016, P.L. 357, No. 48, Section 3(a)(1) "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance." However, on 11/28/23, at approximately 12:15 p.m., there were no carbon monoxide alarms located in proximity to the natural gas fueled boilers in the boiler room nor near the gas fueled dryers in the first-floor laundry room. According to staff person B, [redacted], the smoke detectors in the above locations are not also carbon monoxide detectors.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

POC – Corrected during survey 11/29/2023. See attached.
Monitoring will occur during the Quarterly QI/QA process, and began 11/29/23, by the Maintenance Director. Education on 2600.18 was provided by the Maintenance Director, to the Maintenance Director and Dining Services Director and was completed on 11/29/23. This will be monitored through the QI/QA process.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented ([redacted] - 02/05/2024)

42s - Privacy

4. Requirements

42s - Privacy *(continued)*

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 Department's Regulatory Compliance Guide (RCG) clarifies the Department's expectations regarding Audio and Video Monitoring as it pertains to a resident's privacy of self and possession. The RCG indicates that "Residents may video record in their private rooms or with the written permission of all roommates in shared rooms." and "Residents may install "hidden cameras" in private rooms without the home's knowledge." However, on [redacted] at [redacted]., there was a sign outside resident room #420 that stated, "Smile you're on camera." There were similar signs observed on [redacted] at approximately [redacted]., outside of rooms [redacted] and [redacted]

The home's Electronic Monitoring Devices policy indicates the following:

6. Notice to Community

a. Authorized electronic monitoring may begin only after a notification and consent form in accordance with this policy has been completed and submitted to the community.

b. A copy of the completed notification and consent form shall be placed in the resident's and any roommate's administrative record.

7. Notice to Visitors

a. If a resident uses an authorized electronic monitoring device, a sign shall be clearly and conspicuously posted at the entrance of the apartment. The notice must state, in large, easy to read type, "Notice – This Area Is Under Surveillance"

...

8. Dissemination of Recordings

a. The community may request access to a specific recording created by an authorized electronic monitoring device to address or investigate concerns related to the health, safety, or welfare of a resident. The resident or authorized representative is required to allow the community to review or to provide copies of such recording to the community upon request. If the community obtains a specific recording, the community may only disseminate the recording for the purpose of addressing concerns related to the health, safety, or welfare of a resident or as allowed under law. ...

11. Consequences of Noncompliance with this Policy. The use of an electronic device with audio or video recording capabilities in violation of this policy may result in the community:

a. sending a cease-and-desist letter to the individual utilizing the device,

b. requesting that the footage recorded by the electronic device be destroyed, and

c. removing the device at resident's expense. At the community's discretion, the community may initiate action to remove and/or bar an offending individual from the community's premises including discharging the resident.

i. This policy will not infringe upon residents' rights.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

POC- Company policy has been reviewed and revised by Jody Boedigheimer at Grace Corporate Office. See attached. Residents with Electric Monitoring, #420, #432 & #436, charts have been updated with the removal of the previous policy, by the Wellness Director on 11/30/23. Updated Policy dated 01/17/2024. This will be monitored through the Quarterly QI/QA process.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented ([redacted] - 02/05/2024)

51 - Criminal Background Check

5. Requirements

2600.

51 - Criminal Background Check *(continued)*

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, the home's administrator, was hired on [redacted] However, staff person A did not have a criminal background check in in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults.).

Ancillary staff person C was hired [redacted]. However, ancillary staff person B did not have a criminal background check in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults.)

Direct care staff person D was hired on [redacted]. However, direct care staff person D did not have a criminal background check in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults.)

Plan of Correction ***Directed [redacted] - 01/29/2024)***

Staff Person A, the Home's Administrator, did have a Criminal Background Check – Dated [redacted]; Attached POC – All newly hired Personal Care Associates will have a PA Criminal Background Check completed through https://epatch.pa.gov/home All current Personal Care Associates have been run to include staff persons C & D. See Attached. Also attached is the New Hire Check List used beginning 11/30/2023
All PC Staff Criminal Background checks were completed on 01/09/2024, and placed in their personnel files. All completed by the Business Office Manager, Jessica Hess.
Will be monitored through Quarterly QI/QA process.

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all new staff records to ensure compliance with Regulation 2600.51. 1/29/24 [redacted]

Directed Completion Date: *01/30/2024*

Implemented ([redacted] - 02/05/2024)

65a - FS Orientation 1st Day

6. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
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.

65a FS Orientation 1st Day *(continued)*

7. Telephone use and notification of emergency services.

Description of Violation

Ancillary staff person C, hired [redacted], did not receive general orientation in fire safety and emergency preparedness that included the following:
(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, hired [redacted], did not receive general orientation in fire safety and emergency preparedness that included the following:
(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 E, hired [redacted], did not receive general orientation in fire safety and emergency preparedness that included the following:
(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.

Plan of Correction ***Directed [redacted] - 01/29/2024)***

POC Entire Staff, to include staff persons, C, D, & E Received Fire Safety and Emergency Preparedness Training by the Maintenance Director. See attached. Training dates 12/12, 13, 14, 15, 19, 29, by Shane Daly, MD, and January 10th and 25th by Harold Hicks, Fire Protection Engineer.
All newly hired Associates will receive Fire Safety and Emergency Preparedness Training on their first day of employment by the Maintenance Director. This will be monitored during the Quarterly QI/QA process began on 12/08/2023

65a FS Orientation 1st Day (continued)

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all new staff hires to ensure compliance with Regulation 2600.65(a). 1/29/24

Directed Completion Date: *01/30/2024*

Implemented - 02/05/2024)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Ancillary staff person C, hired did not receive an orientation within 40 working hours that included the following:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101 10225.5102).
(4) Reporting of reportable incidents and conditions.

Direct care staff person D, hired , did not receive an orientation within 40 working hours that included the following:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101 10225.5102).
(4) Reporting of reportable incidents and conditions.

Direct care staff person E, hired 3, had worked an excess of 40 hours as of but did not receive an orientation that included the following:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101 10225.5102).
(4) Reporting of reportable incidents and conditions.

Plan of Correction ***Directed - 01/29/2024)***

POC Staff persons C 1/09/24 & D 01/16/24 have completed the training See attached. Staff person E did have

65b Rights/Abuse 40 Hours (continued)

the training completed prior to being hired See attached. Staff person E resigned on 11/30/2023.
All newly hired Personal Care Associates will complete said trainings within the first 40 hours of employment.
Personnel file audit occurred 12/04/23 by M. McCarthy CER.
This will be reviewed during the Quarterly QI/QA monitoring process beginning 12/08/23.

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all new staff hires to ensure compliance with Regulation 2600.65(b). 1/29/24 JK

Directed Completion Date: *01/30/2024*

Implemented ([redacted] - 02/05/2024)

65i - Training Record

8. 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.

Description of Violation

Direct care staff person F's record of training does not include the full date of each course for required annual trainings to include:

**Resident Rights/OAPSA February 2022*
** Falls and Accident Prevention March 2022*
** MI/MR residents (if served) May 2022*
** Caring for residents with cognitive Impairments and dementia June 2022*
** Personal Care Service Needs of the Resident August 2022*

Plan of Correction ***Accept ([redacted] - 01/29/2024)***

POC Corrected 11/29/2023 Attached is Staff Person F's Relias transcript. Wellness Director will plan to always have transcripts of Personal Care Associates available to include full date of each course.
Personnel Files were audited on 12/04/23 by [redacted] CER. This will be monitored during Quarterly QI/QA process beginning 12/08/23

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented ([redacted] - 02/05/2024)

82c - Locking Poisonous Materials

9. Requirements

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

On [redacted] at [redacted]., there was a canister of [redacted] and [redacted] with warning if swallowed call a poison center/doctor. Not all residents have been assessed as being safe with poisons to include resident #9.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Directed [redacted] - 01/29/2024)***

POC – This was corrected on 11/28/2023, the cleaner was removed and locked up. Daily monitoring has occurred, see attached.
Education was provided to All PC Staff to include ancillary staff persons by the Wellness and Maintenance Director on Regulation 2600.82(c). monitoring began 12/04/23 by the Wellness Director, Med Techs and Care Aides and will be monitored during Quarterly QI/QA process beginning 12/08/2023.

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a weekly audit of the home to ensure compliance with Regulation 2600.82(c). 1/29/24[redacted]

Directed Completion Date: *01/30/2024*

Implemented ([redacted] - 02/05/2024)

89b - Hot Water Temperature

10. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 11/28/23 at approximately 11:15 a.m., the water temperature at the kitchenette sink in room #400 measured 129.1 degrees Fahrenheit.

On 11:15 a.m., the water temperature at the bathroom sink in room #400 measured 128 degrees Fahrenheit.

On 11/28/23 at approximately 11:20 a.m., the water temperature at the bathroom sink in room #426b measured 126.4 degrees Fahrenheit.

Plan of Correction ***Directed [redacted] - 01/29/2024)***

POC – Weekly random water temp checks implemented 12/05/23 by the Maintenance Director, to include room 400 and 426 by the Maintenance Director. – See attached. Plan is to not have the water temperature above 120 degrees by having the boiler blower motor was repaired on 12/13/23, and the mixing valve replaced on TBA
All PC Staff persons (Aides, Med Techs, Activity Assistant, and WD) were educated by the Maintenance Director on 2600.89(b) on 12/04/23. This will be monitored through Quarterly QI/QA monitoring.

Proposed Overall Completion Date: 01/26/2024

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a weekly audit of the home to ensure compliance with Regulation 2600.89(b). 1/29/24[redacted]

Directed Completion Date: *01/30/2024*

Implemented [redacted] - 02/05/2024)

101j7 - Lighting/Operable Lamp

11. 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 11/28/23 at approximately 10:50 a.m., there was no operable lamp or source of lighting for the bed in room #420.

Plan of Correction ***Directed (- 01/29/2024)***

POC - Resident living in apartment 420 refused a bedside lamp upon move-in, she did so again when asked by Surveyor on 11/28/23 as well. A touch lamp was placed at bedside on 11/29/23 Corrected – see attached.
Education was provided on 01/22/24 to all PC staff persons (Aides, Med Techs, Wellness Director) on 2600.101(j)(7) by the Administrator and will be monitored through Quarterly QI/QA process to begin 01/22/24.

Proposed Overall Completion Date: 01/26/2024

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a weekly audit of the home to ensure compliance with Regulation 2600.101(j)(7). 1/29/24

Directed Completion Date: *01/26/2024*

Implemented (- 02/05/2024)

132c - Fire Drill Records

12. Requirements

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 4th floor personal care home level of the building has three fire safe zones in addition to two stairwells. Documentation of "the exit routes used" for the following fire drills only indicates "safe zone." It does not specify which safe zone(s) was used for evacuation:
** 3/11/23 4:00 a.m.*
** 4/26/23 10:30 a.m.*
** 5/30/23 8:30 p.m.*
** 6/30/23 11:30 a.m.*
** 7/21/23 4:00 p.m.*
** 8/10/23 11:06 a.m.*
** 9/27/23 3:10 p.m.*
** 10/30/23 1:00 p.m.*
** 11/20/23 6:00 p.m.*

Plan of Correction ***Directed - 01/29/2024)***

POC – All Fire Drills will indicate which exit route was used. See attached – Dec 2023 and Jan 2024 Drill
Education was provided to all PC staff (Med Techs, Aides, Activity Assistant, Wellness Director) and residents on exit routes and safe zones by the Maintenance Director and , Fire Protection Engineer on 1/10/24 and 1/25/2024 and will be monitored through Quarterly QI/QA process.

132c - Fire Drill Records (continued)

Proposed Overall Completion Date: 01/26/2024

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home's fire drill record monthly to ensure compliance with Regulation 2600.132(c). 1/29/24

Directed Completion Date: *01/30/2024*

Implemented - 02/05/2024)

132e - Fire Drill Sleeping Hours

13. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The most recent fire drill conducted during sleeping hours was on 3/11/23 at 4:00 a.m.

Plan of Correction ***Accept - 01/29/2024)***

POC – An asleep fire drill shall be held every six months per regulation. See Attached, Drill completed 12/14/2023, next scheduled 04/2024 and 10/2024.
Education on 2600.132(e) was provided to all PC staff persons (Med Techs, Aides, Activity Assistant, Wellness Director, and Maintenance Director) By the Administrator on 12/04/23.
This will be monitored through Quarterly QI/QA process beginning 12/08/23.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented (- 02/05/2024)

183e - Storing Medications

14. 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.

Description of Violation

On at ., there was an pen in a clear zip top bag with resident #7's name in the medication cart. There was a sticker on the pen that indicated pen was opened on which would have expired on . However, the insulin pen was used to administer insulin to the resident at . from .

REPEAT VIOLATION 4/13/22 et al

Plan of Correction ***Directed (- 01/29/2024)***

POC – Weekly med cart audit implemented on 12/04/23 to check expiration dates by Wellness Director or Designee. RxPartners to completed Cart Audit – date TBD
Education was provided by the Wellness Director on 12/04 and 12/05 to Medication Techs on 2600.183(e). See attached policy. This will be monitored through the Quarterly QI/QA process.

183e Storing Medications (continued)

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall dispose of the expired medication. 1/29/24

Directed Completion Date: *01/30/2024*

Implemented (- 02/05/2024)

184a - Resident's Meds Labeled

15. 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

On at ., there was an Asparte insulin pen in the medication cart for resident #7 in a clear zip top bag that did not have a pharmacy label. The bag only had the resident's name on the bag.

Resident #7 is ordered inhale two puffs every 4 hours as needed. However, on at there was a box that contained a canister of albuterol sulfate with pharmacy label that indicates inhale two puffs by mouth every six hours as needed for wheezing or shortness of breath.

Plan of Correction ***Accept - 01/29/2024)***

POC Corrected on 11/28/2023 with "Direction Change Sticker see attached. This will fall under med cart audit completed weekly. Wellness Director and Med Techs will ensure proper labels with proper instructions are on all medications.
Education was provided by the Wellness Director on 12/04 & 12/05/23.
This will be monitored during Quarterly QI/QA Process.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented (- 02/05/2024)

185a - Implement Storage Procedures

16. 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.

Description of Violation

On resident #8's was not calibrated to the correct time. Also, the following glucometer readings were incorrectly documented on resident #8's November 2023 medication administration record (MAR):

185a - Implement Storage Procedures (continued)

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*

REPEAT VIOLATION 4/13/22 et al

Plan of Correction ***Directed - 01/29/2024)***

POC – Weekly Glucometer checks implemented – see attached. Wellness Director Educated Medication Techs 12/04 & 1205 on the importance of entering the correct readings into and regulation 2600.185(a).
This will be monitored through Quarterly QI/QA process beginning 12/08/23.

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall audit all glucometers and glucometer documentation weekly to ensure accuracy and completeness. 1/29/24

Directed Completion Date: *02/03/2024*

Implemented - 02/05/2024)

191 - Resident Right to Refuse

17. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

There was no documentation that resident #7 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

There was no documentation that resident #8 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

There was no documentation that resident #9 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

Plan of Correction ***Directed - 01/29/2024)***

POC – Corrected 11/29/2023 – see attached. Each Resident was educated during the December Resident Council Meeting. All new Residents will be educated on the Right to Refuse Medications
This will be monitored during Quarterly QI/QA process.

Proposed Overall Completion Date: 01/26/2024

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all new resident admissions to ensure compliance with Regulation 2600.191. 1/29/24

Directed Completion Date: *01/30/2024*

191 Resident Right to Refuse *(continued)*

Implemented (- 02/05/2024)

227a Support Plan 30 Days

18. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #7's initial assessment, dated indicates Minimal (Mobile) needs with evacuating in an emergency. However, the support plan completed only indicates "DCS [direct care staff] will assist with the evacuation in the event of an emergency." The support plan does not indicate what type of assistance direct care staff are to provide the resident for evacuation purposes.

Resident #8's initial assessment, dated indicates Minimal (Mobile) needs with evacuating in an emergency. However, the support plan completed only indicates "DCS [direct care staff] will provide assistance with evacuating in an emergency." The support plan does not indicate what type of assistance direct care staff are to provide the resident for evacuation purposes.

Plan of Correction ***Accept - 01/29/2024)***

POC – Corrected 12/04/2023 – see attached. All Immobile Resident's RASP will indicate what type of assistance is required for them to evacuate in an emergency.
Wellness Director completed a chart audit beginning 12/05/2023 through 12/20/23 for accuracy of the resident support plans. This will be monitored through Quarterly QI/QA process.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented - 02/05/2024)

227c Support Plan Revision

19. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #9's annual assessment, dated indicates Minimal (Mobile) needs with evacuating in an emergency. However, the support plan completed indicates "DCS [direct care staff] will assist with evacuating in an emergency." The support plan does not indicate what assistance direct care staff are to offer to the resident for evacuation purposes.

Resident #10 uses a bedside mobility device attached to the bed to assist with turning and positioning in bed. However, the resident's annual support plan completed does not reflect the following:
** The intended use and any risks associated with the use.*
** The resident's ability to use the device safely for the purpose it was intended.*
** Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.*
The home's "Bedside Mobility Device Evaluation" completed for resident #10 on 10/13/23 also does not address the

227c - Support Plan Revision (continued)

above required information.

Plan of Correction ***Accept ([redacted] - 01/29/2024)***

POC – Corrected 12/04/2023 – see attached. All Immobile Resident's RASP will indicate what type of assistance is required for them to evacuate in an emergency. All supports plan will be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.
Wellness Director completed a chart audit beginning 12/05/2023 through 12/20/23 for accuracy of the resident support plans. This will be monitored through Quarterly QI/QA process

POC – Resident #10 bedside mobility device was removed until proper documentation of need, use, and care is obtained and can be added to the support plan.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented ([redacted] 02/05/2024)