

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

September 28, 2026

[REDACTED], CFO

CPF LIVING COMMUNITIES II-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 08/13/2026, 08/14/2026 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:** 08/27/2027
Address: 4750 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: CPF LIVING COMMUNITIES II-WHITEHALL LLC

Address: [REDACTED]

Phone: [REDACTED] **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:** 32 **Waking Staff:** 24

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 08/14/2026

Inspection Dates and Department Representative

08/13/2026 - On-Site: [REDACTED]
08/14/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 46 **Residents Served:** 27

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:** 26
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 5 **Have Physical Disability:** 1

Inspections / Reviews

08/13/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/12/2026

09/11/2026 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 09/28/2026
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/17/2026

Inspections / Reviews (*continued*)

09/18/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/28/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/28/2026

09/28/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/28/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 Record Confidentiality**1. 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

On 8/13/26, the resident privacy coding document, which included the names of residents #1, #2 and #3, was attached to the licensing inspection summary, dated 5/13/25, and was posted on the bulletin board at the 2nd floor lobby entrance.

Plan of Correction**Accept ([REDACTED] - 09/18/2026)**

Immediate Action: Privacy Coding Document Removed from posting in the lobby.

Surveyors shown it was removed. Posting in the "Home" did not include the privacy coding document.

POC: Administrator will ensure the Privacy Coding document is removed prior to posting.

UPDATE: Wellness Director or designee will inspect the home weekly. Audit implemented 09.11.2026 (see attached)

Licensee's Proposed Overall Completion Date: 09/17/2026

Implemented ([REDACTED] - 09/28/2026)**162c Menus Posted****2. 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 8/13/26 at 11:35am, the only menu posted in a conspicuous and public place in the home was dated 8/9/26 through 8/15/26.

Plan of Correction**Directed ([REDACTED] - 09/18/2026)**

Immediate Action: Menu dated 8/16/2026 through 8/22/2026 was posted along side of the menu dated 8/9/2026 through 8/15/2026. Surveyors shown menu posting.

POC: Administrator along with Dining Director will ensure a two-week menu is posted.

UPDATE: The Dining Service Director is responsible for developing the menus. Re-education of the Director and all cooks took place on 09.11.2026 - RE: two weeks of menus must be posted. See attached. Training will be kept in Associate's file. Dining Director or designee will audit the dining room weekly to ensure there is a two-week menu posted as well as ensure it is initially posted. (DIRECTED: The weekly audits shall begin on 9/22/26 to ensure compliance with 2600.162c. [REDACTED] 9/18/26).

Proposed Overall Completion Date: 09/17/2026

Directed Completion Date: 09/22/2026

Implemented ([REDACTED] - 09/28/2026)

185a - Implement Storage Procedures

3. 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 8/13/26 at 8:32am, resident #4's August 2026 medication administration record (MAR) indicated a blood glucose reading of 110; however, there is no blood glucose reading indicated on resident #4's glucometer for this date/time.

Plan of Correction

Directed () - 09/18/2026

Immediate Action: Administrator trained all Medication Aides on proper Glucometer/BS Documentation. See attached.

POC: Weekly glucometer calibration/Checks implemented. See attached.

Audits to continue indefinitely, by Lead Med Tech or Wellness Director

UPDATE: Training was completed 08.19.2026 (see attached). Training will be kept in the Associates file. Verbiage corrected on the weekly audit of the Blood glucose and glucometer checks. At the time there were only 2 residents to Audit. Audit updated to in the most recent 3rd resident. Wellness Director or Designee will complete this audit.

RC for the violation/Why is there a reading in Resident #4's MAR but no reading on the resident's Glucometer?

Administrator thoroughly investigated this by going back 2 months of readings on Resident 4's glucometer. All readings are present and accurate with the exception of 8.13.26. Upon further investigation, Med Aide was interviewed and surmised () must have deleted the reading accidentally. This was the morning of day one of the survey. Training of all Medication Aides was conducted on 08.19.2026 (see attached). Resident #4 does not receive insulin coverage until BS is 150 or over. No insulin was not administered on 08.13.2026 8am.

DIRECTED: Beginning on 9/23/26: The administrator/designee shall review the glucometers and blood glucose documentation for at least 2 different residents per week to ensure accurate and complete blood glucose documentation is present. () 9/18/26

Proposed Overall Completion Date: 09/17/2026

Directed Completion Date: 09/23/2026

Implemented () - 09/28/2026

187a - Medication Record

4. 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.

187a - Medication Record (continued)

11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4 was prescribed Gavilax powder-Dissolve 17 grams as indicated by line inside cap in 8 ounces of liquid and take by mouth once daily as needed. This medication was discontinued by the prescriber on 8/10/26; however, was still present on resident #4's August 2026 MAR on 8/14/26.

Repeated Violation-5/13/2025

Plan of Correction

Directed () - 09/18/2026)

Immediate Action: Administrator immediately reviewed Resident #4's MARs. Gavilax Powder found to be discontinued on 07.31.2026. See attached.

POC: Administrator or Wellness Directo will ensure all discontinued medications will be documented in a timely manner.

UPDATE: The Gavilax Powder was removed from Resident #4's MAR in July of 2025 (see attached) Additionally, MARs for June, July, August, September 2026 attached here. SYSTEM NOT ALLOWING JUNE OR JULY TO UPLOAD. Will e-mail to ()

We once used Accuflo as the EMAR, until July 2025 and this seem to have been an error when printing MARs on 08.13.2026. See attached.

DIRECTED: By 9/22/26: The administrator shall review resident #4's current MAR to ensure accuracy and completeness in accordance with 2600.187a, and to ensure only current, prescribed medications are present on resident #4's current MAR. () 9/18/26

DIRECTED: By 9/28/26: The administrator shall re-educate all staff persons qualified to administer medications on the home's medication administration procedures, which includes the home's procedures for removing medications from resident MAR's immediately upon receipt of the new order. Documentation of the staff education shall be kept. () 9/18/26

DIRECTED: Beginning on 9/23/26: The administrator/designee shall review the MAR's for at least 3 different residents per week to ensure accuracy and completeness in accordance with 2600.187a. () 9/18/26

Proposed Overall Completion Date: 09/17/2026

Directed Completion Date: 09/28/2026

Implemented () - 09/28/2026)

225a - Assessment 15 Days**5. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #5's assessment, dated (), does not include an assessment of resident #5's behavioral or cognitive needs, to include orientation to time, place and person, irritability, judgement and agitation. These sections of

225a Assessment 15 Days (continued)

resident #5's assessment are blank.

Repeated violation 5/13/2025

Plan of Correction**Directed ([REDACTED] - 09/18/2026)**

Immediate Action: Boxes checked to match inputted data on resident #5's assessment. Surveyor's shown corrected document, page 9. Chart Audit completed to ensure all resident's assessments have the accurate information in all sections of the assessment.

POC: Administrator or designee will ensure all assessments will include the necessary information in all sections.

UPDATE: Chart Audit completed 08.17.2026. A chart audit will be completed by Administrator or designee every quarter to ensure completeness of all resident Assessments and RASPs. (example attached) (DIRECTED: The chart audit shall begin on 9/25/26 and shall include a review of at least 50% of resident assessments each review to ensure accuracy and completeness in accordance with 2600.225a. [REDACTED] 9/18/26).

Proposed Overall Completion Date: 09/17/2026

Directed Completion Date: 09/25/2026

Implemented ([REDACTED] - 09/28/2026)