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

July 8, 2025

[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 05/13/2025 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**: *08/27/2025*

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**: *Boro of Whitehall*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *50* **Waking Staff**: *38*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/13/2025*

Inspection Dates and Department Representative

05/13/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *46* **Residents Served**: *34*

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**: *34*

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

Have Mobility Need: *16* **Have Physical Disability**: *1*

Inspections / Reviews

05/13/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/24/2025*

05/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/04/2025*

Inspections / Reviews *(continued)*

06/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/03/2025*

06/23/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/03/2025*

07/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/03/2025*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The license inspection summary, dated 8/21/24, is not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed (- 06/05/2025)***

License and previous License Inspection Summary dated 08/21/2024 were posted, however, in a locked frame. Frame has been unlocked since 05/13/2025, day of survey and will remain so. Home Administrator will post current license and license inspection summary as it pertains to 2600.3c. All items specific to 2600.3c will be reviewed/monitored during next QA/QI meeting on July 3rd, 2025, and will continue until December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 6/5/25).

DIRECTED: Beginning on 6/15/25: The administrator/designee shall inspect the home monthly to ensure compliance with 2600.3c. 6/5/25

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented (- 07/08/2025)

18 - Compliance With Laws

2. 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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires carbon monoxide detectors to be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance. At 10:40am, there were 2 carbon monoxide detectors located in the 4th floor laundry room; however, 1 of them was installed approximately 5 feet from the gas dryer and 1 of them was installed approximately 1 foot from the gas dryer.

REPEAT VIOLATION: 11/28/2023, et. al.

Plan of Correction ***Directed (- 06/05/2025)***

Carbon Monoxide detector was present. Carbon monoxide detector was moved at the Surveyors advice to the other side of the 4th floor laundry room, by the door. Photo attached. Corrected day of survey 05/13/2025. Maintenace Director or designee will monitor the CO detector monthly, change batteries April and October. (DIRECTED: The monthly audits of all carbon monoxide detectors shall begin on 6/15/25 to ensure compliance with the Care Facility Carbon Monoxide Alarms Standards Act. 6/5/25). All items pertaining to 2600.18 will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 and will continue through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the

18 - Compliance With Laws (continued)

quality management review shall be kept. [redacted] 6/5/25).

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

65a - FS Orientation 1st Day

3. 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.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person C, hired on [redacted], did not receive orientation on any of the required topics specified in 600.65a.

REPEAT VIOLATION: 11/28/2023, et. al.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

Staff member C's hire date was [redacted] start date was [redacted] First Day Fire Training was completed see attached sign-in sheet CORRECTED. All additional trainings all began on 02/05/2025. See attached Relias Trainings. Corrected 05/13/2025, day of Survey.
(DIRECTED: By 6/12/25: The administrator shall provide education to staff person C on all topics specified in 2600.65a. Documentation of the training shall be kept in accordance with 2600.65i. [redacted] 6/5/25).
Wellness Director completed an audit of staff files on 05/14/2025 (all trainings present), and all required training pertaining to 2600.65a will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25).
Wellness Director will follow current plan and notify Maintenance Director of all newly hired staff persons to ensure first day Fire Training is completed day one.

DIRECTED: By 6/12/25: The administrator shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive education on all the topics specified in 2600.65a prior to or during their first workday. The completed checklists, as well as documentation of the staff education in accordance with 2600.65i shall be kept in each staff person's record. [redacted] 6/5/25

Proposed Overall Completion Date: 06/03/2025

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

Directed Completion Date: *07/03/2025*

Implemented (- 07/08/2025)

65b - Rights/Abuse 40 Hours

4. 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

Direct care staff person C, hired on did not receive orientation on any of the topics specified in 2600.65b.

REPEAT VIOLATION: 11/28/2023, et. al.

Plan of Correction ***Directed (- 06/05/2025)***

Staff Member C was hired on , start date was Staff Member completed Relias trainings attached, as well. POC:
(DIRECTED: By 6/12/25: The administrator shall provide education to staff person C on all topics specified in 2600.65b. Documentation of the training shall be kept in accordance with 2600.65i. 6/5/25).
Wellness Director or designee will ensure all new staff members receive "within 40 working hours" training by utilizing an audit for. Audit form attached. First Audit Completed 05/14/2025 by Wellness Director. 2600.65b will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through Dember 2025 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 6/5/25)

DIRECTED: By 6/12/25: The administrator shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive education on all the topics specified in 2600.65b within 40 scheduled working hours. The completed checklists, as well as documentation of the staff education in accordance with 2600.65i shall be kept in each staff person's record. 6/5/25

Proposed Overall Completion Date: 05/26/2025
Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented (- 07/08/2025)

65f - Training Topics

5. Requirements

2600.

65f - Training Topics *(continued)*

65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

Description of Violation

Direct care staff person D, hired on [redacted] did not receive medication self-administration training during the 2024 training year.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: All staff members will receive "Medication Self-Administration" training each year. CORRECTED - Staff Member D received/completed the training on 07/17/2024 and 08/18/2025 see attached training record. Wellness Director or designee will ensure the training is completed, as well as complete staff training audit, audit form attached. First audit complete 05/14/2025. See attached. 2600.65f will be reviewed and monitored during quarterly QA/QI meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25).

DIRECTED: Beginning on 6/15/25: The administrator/designee shall review all training documents and the home's staff training plan at least quarterly to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. [redacted] 6/5/25

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

82a - Poisonous Materials

6. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At 10:19am, there was an unknown green liquid present in an Aquafina water bottle in the cabinet of the men's common bathroom across from the TV room.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: Maintenance Director or designee will ensure all containers in public bathrooms are in original containers with label. Audit completed 05/14/2025, tool attached. 2600.82a will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25).
- Bottle removed day of survey 05/13/2025, by Maintenance Director, with Surveyor present.
Maintenance Director to provide training on 2600.82a during first day training and a on a quarterly basis. This will be monitored at Quarterly QA/Qi meeting next meeting 07/03/2025 through December 2025

82a - Poisonous Materials (continued)

DIRECTED: By 6/20/25: The administrator shall re-educate all current staff persons that poisonous materials shall be kept in their original containers. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25

DIRECTED: Beginning on 6/12/25: The Maintenance Director/designee shall inspect the home weekly to ensure all poisonous materials are kept in their original containers. [redacted] 6/5/25

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

85d - Trash Receptacles

7. 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

At 10:55am, there was a partially filled uncovered trash can next to the griddle in the 1st floor main kitchen.

At 11:15am, there was an uncovered Rubbermaid wheeled trash dumpster, which contained numerous large bags of garbage, present in the 1st floor main kitchen.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: All trash receptacles in kitchens and bathrooms will have a lid. Maintenance Director or designee to complete weekly audit and reeducation to all staff persons in the kitchen and Personal Care staff. Audit began 05/14/2025 and re-education began 05/30/2025. (DIRECTED: The weekly audits shall include a weekly inspection of all bathrooms and kitchens to ensure compliance with 2600.85d. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25). 2600.85d will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25) Corrected day of survey - Trash can replaced on 05/13/2025 See attached photo.

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

89a - Water Pressure

8. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

89a - Water Pressure *(continued)*

Description of Violation

At 10:24am, there was no hot water at the sink in the men's common bathroom located across from the TV room.

At 10:17am, there was no hot water at the sink in the women's common bathroom located across from the TV room.

Plan of Correction ***Directed (- 06/05/2025)***

POC: Maintenance Director or designee will check water temps weekly to ensure it is within acceptable range. See attached Audit tool. Audits began 05/14/2025. (DIRECTED: At least 5 different sinks shall be included in each weekly audit. 6/5/25). 2600.89a will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 6/5/25)
Maintenance director adjusted the water mixing valve on 05/13/2025. Water temps within acceptable range. Audit began 05/14/2025. Re-education began 05/30/2024, by Maintenance Director. (DIRECTED: All staff persons shall be educated on 2600.89a by 6/20/25. Documentation of the staff education shall be kept in accordance with 2600.65i. 6/5/25).

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented (- 07/08/2025)

101j7 - Lighting/Operable Lamp

9. 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

Resident #2 did not have an operable lamp or other source of lighting that can be turned on/off at bedside.

REPEAT VIOLATION: 11/28/2023, et. al.

Plan of Correction ***Directed (- 06/05/2025)***

Resident #2 was provided a touch lamp on 04/04/2025 (day of move-in), as did not want a lamp on the nightstand. Touch lamp was found to be missing during survey. Resident #2 was then provided a bedside lamp on 05/13/2025, Corrected day of survey. See attached photo. POC: Each resident will have a bedside lamp. Wellness Director or designee will do a resident apartment audit to include 3 resident apartments per week. See attached. Audits began 05/14/2025. Re-education began 05/30/2025, by Wellness Director. (DIRECTED: All staff persons shall be educated on 2600.101j7 by 6/20/25. Documentation of the staff education shall be kept in accordance with 2600.65i. 6/5/25).
2600.101j will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 6/5/25)

Proposed Overall Completion Date: 06/03/2025

101j7 - Lighting/Operable Lamp *(continued)*

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

103d - Storing Food Off Floor

10. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At approximately 10:30am, numerous cases of water were stored on the floor in the 4th floor storage closet.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: Maintenance Director or designee will ensure that emergency water will be stored up off the floor. Corrected day of survey. See attached. Additionally, see attached audit form to be completed by Maintenance Director or designee. Audit began 05/14/2025. (DIRECTED: Each weekly audit shall include an audit of all food/beverage storage areas to ensure compliance with 2600.103d. [redacted] 6/5/25). Re-education began 05/30/2025, by Maintenance Director or designee. (DIRECTED: All staff persons shall be educated on 2600.103d by 6/20/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25).
2600.103dwill be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

103f - Refrigerator/Freezer Temps

11. 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

At 10:05am, the temperature in the 4th floor kitchen refrigerator was 50 degrees Fahrenheit, and at 2:19pm, the temperature in this refrigerator was 44 degrees Fahrenheit.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

At time of temp check at 10:05am, the fourth-floor kitchen refrigerator had just been restocked. At the time of temp check at 2:19pm, the fourth-floor refrigerator had been in and out of for lunch. Maintenance Director rechecked the temperature again at 2:45pm and it read 38 degrees. Thermometer present each time.
POC: Maintenance Director AND dining staff member will check the temperature of the fourth-floor refrigerator

103f - Refrigerator/Freezer Temps (continued)

twice daily to ensure in the readings are at or below 40 degrees Fahrenheit. See attached audit tool. Audit began 05/14/2025 by Maintenance Director. (DIRECTED: Beginning on 6/10/25: The maintenance director/designee shall inspect all refrigerators/freezers daily for 1 month then weekly thereafter to ensure compliance with 2600.103f. Documentation of the daily audits shall be kept, which includes the daily temperatures of each refrigerator and freezer. [redacted] 6/5/25). Re-education began 05/30/2025 by Maintenace Director. Education to include dining and Personal Care Staff persons. (DIRECTED: All staff persons shall be educated on 2600.103f by 6/20/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25).
2600.103f will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

103g - Storing Food

12. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 11:00am, there were numerous open and unsealed food items present in the 1st floor main kitchen walk-in freezer, to include the following:

- *A bag of Ore Ida hash browns, approximately 1/2 full*
- *A box of ground beef patties, approximately 3/4 full*
- *A bag of breaded fish, approximately 1/4 full*
- *2 pizzas*

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: Director of Dining or designee to ensure all foods are stored/sealed properly.
2600.103g will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)
Director of Dining or designee will complete audit of freezer daily for four weeks. Then weekly indefinitely. Audit began 05/14/2025. (DIRECTED: All food storage areas shall be checked during each audit to ensure compliance with 2600.103g. [redacted] 6/5/25).
Dining Director completed re-education on 05/30/2025 and 06/02/2025 to all Dining Staff Members. (DIRECTED: All staff persons shall be educated on 2600.103g by 6/20/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25).

Corrected day of survey - see attached

103g - Storing Food (continued)

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *06/03/2025*

Implemented ([redacted] - 07/08/2025)

123b - Emergency Procedures Posted

13. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The emergency procedures for the home and the municipality in which the home is located are not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

The Home and the Municipality's Emergency Procedures were present on day of survey. Maintenance Director placed the binder in the hallway across from the elevator, by the sign-in/out binder, for easy access. Additional copies are and have been at the front desk and with each Department Head.
POC: Emergency Procedures will be kept in a conspicuous and public area. Maintenance Director to ensure placement each month when Fire Drill is completed. (DIRECTED: The Maintenance Director's monthly audits shall begin on 6/12/25 to ensure compliance with 2600.123b. [redacted] 6/5/25).
2600.123b will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

185a - Implement Storage Procedures

14. 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

Resident #1 is currently prescribed, "Tramadol HCL 50mg tablet-Take 1 tablet by mouth every 12 hours as needed"; however, this medication was not present and available in the home for administration.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

DIRECTED: Within 24 hours of receipt of the plan of correction: Unless discontinued in writing by the prescriber,

185a - Implement Storage Procedures (continued)

the administrator shall ensure resident #1's Tramadol is present in the home and available for administration. [redacted] 6/5/25

POC: Monthly Medication Cart Audit to be completed by Pharmacy. Additionally, Wellness Director or Designee to complete a medication audit on the residents per week for 90 days to ensure all medications are present and available. Audits began 05/14/2025. (DIRECTED: At least 6 different residents shall be included in each weekly audit. [redacted] 6/5/25). See attached tool and May 1st, 2025, audit completed by Pharmacy. Audits to include, See attached.
Weekly Audit by Wellness Director or designee to include - Resident's name, Medication Name, Issue/non-compliance, and resolution and date. See attached.
This will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025 documentation will be kept in Wellness Director's office. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

DIRECTED: By 6/20/25: The administrator shall re-educate all staff persons qualified to administer medications on the home's medication procedures, which includes ensuring all prescribed medications are present in the home and available for administration in accordance with prescribers' orders. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

187a - Medication Record

15. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

Description of Violation

Resident #1 is prescribed, "Lorazepam 0.5mg tablet-Take 1 tablet by mouth every 6 hours as needed"; however, this medication is not indicated on resident #1's May 2025 medication administration record (MAR).

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: Monthly Medication Cart Audit to be completed by Pharmacy. Additionally, Wellness Director or Designee to

187a - Medication Record (continued)

complete a medication audit on the residents per week for 90 days to ensure that all medications prescribed are listed on the MAR. Audits began 05/14/2025. See attached tool and May1st, 2025 audit completed by Pharmacy. (DIRECTED: At least 6 different resident MAR's shall be included in each weekly audit. [redacted] 6/5/25).
Corrected day of Survey, 05/13/2025. Wellness Director contacted [redacted] Hospice, obtained a new order and sent it to Rx Partners Pharmacy to have added to MAR. (DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator shall review resident #1's MAR to ensure all prescribed medications are present on the MAR. [redacted] 6/5/25)
Re-education completed 05/30/2025 and 06/02/2025 by Wellness Director.
2600.187a will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

DIRECTED: By 6/20/25: The administrator shall re-educate all staff persons qualified to administer medications on the home's medication procedures, which includes the home's procedures for updating resident MAR's immediately upon receipt of a new order. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

187d - Follow Prescriber's Orders

16. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is currently prescribed, "Lidocaine patch 4%-Apply 1 patch to the right shoulder in the morning and remove at bedtime"; however, this medication was not administered to resident #1 on the morning of 5/13/25, because the medication was not available in the home for administration.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

POC: Monthly Medication Cart Audit to be completed by Pharmacy. Additionally, Wellness Director or Designee to complete a medication audit on the residents per week for 90 days to ensure all medications are present and available. (DIRECTED: At least 6 different resident medications shall be reviewed during each weekly audit. [redacted] 6/5/25).
This medication was ordered; however, Pharmacy had not delivered in time for administration. Audits began 05/14/2025. See attached tool and May audit completed by Pharmacy.
Corrected day of Survey, 05/13/2025. Wellness Director followed up with Rx Partners to find out the delay, as the medication was ordered 4 days prior. Medication was delivered on 05/13/2025.
Re-education began 05/30/2025 and 06/02/2025 by Wellness Director.
2600.187.d will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in

187d - Follow Prescriber's Orders (continued)

2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

DIRECTED: By 6/20/25: The administrator shall re-educate all staff persons qualified to administer medications on the home's medication procedures to ensure compliance with 2600.187d. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 6/5/25

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

225a - Assessment 15 Days

17. 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 #2's medical evaluation, dated [redacted] includes a diagnosis of Dysphasia; however, this diagnosis is not indicated on resident #2's assessment, dated [redacted].

Resident #3's medical evaluation, dated [redacted] includes numerous diagnoses not indicated on resident #3's assessment, dated [redacted] to include: Hypertrophy of prostate, Irritable Bowel Syndrome, Generalized Osteoarthrosis, Cerebrovascular Disease, History of a stroke and Macular Degeneration Syndrome.

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

Resident #2's Diagnosis of Dysphagia was listed on assessment dated [redacted] under dietary recommendations on page 7, diagnosis moved to page 6. See attached. Corrected day of Survey.
Resident # 3's Diagnosis' on page 6 of RASP corrected day of survey see attached.
POC: All resident diagnosis' to be listed on initial assessment. Wellness Director or designee to audit all Resident RASPs and DMEs to ensure all are listed. Audit completed began 05/14/2025 and completed 05/21/2025 - see attached.
Wellness Director or designee will an additional audit on a quarterly basis. (DIRECTED; At least 10 different resident assessments shall be included in each quarterly audit. [redacted] 6/5/25)
2600.225a will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *07/03/2025*

Implemented ([redacted] - 07/08/2025)

225c - Additional Assessment

18. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted] indicates numerous diagnoses not included on resident #1's most recent assessment, dated [redacted] to include Diarrhea and Lactose Intolerance.

REPEAT VIOLATION: 8/21/2024

Plan of Correction ***Directed ([redacted] - 06/05/2025)***

Resident #1's diagnosis of Lactose Intolerance was listed under dietary recommendations on page 7 of RASP. See attached. Diagnosis moved to page 6 to include Diarrhea. Corrected day of survey.
POC: All resident diagnosis' to be listed on initial assessment. Wellness Director or designee to audit all Resident RASPs and DMEs to ensure all are listed. Audit began 05/14/2025 and completed 05/21/2025 - see attached. Wellness or designee will ensure compliance completed a Quarterly basis. (DIRECTED; At least 10 different resident assessments shall be included in each quarterly audit. [redacted] 6/5/25)
2600.225c will be reviewed/monitored during quarterly QA/QI Meeting. Next meeting 07/03/2025 through December 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 6/5/25)

Proposed Overall Completion Date: 06/03/2025

Directed Completion Date: *06/03/2025*

Implemented ([redacted] - 07/08/2025)