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

November 2, 2026

[redacted], CEO
JEWISH HOME AND HOSPITAL FOR AGED AT PITTSBURGH
200 JHF DRIVE
PITTSBURGH, PA, 15217

RE: AHAVA MEMORY CARE RESIDENCE
200 JHF DRIVE
PITTSBURGH, PA, 15217
LICENSE/COC#: 44858

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/14/2026 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: *AHAVA MEMORY CARE RESIDENCE* **License #**: *44858* **License Expiration**: *08/18/2027*

Address: *200 JHF DRIVE, PITTSBURGH, PA 15217*

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

Administrator

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

Legal Entity

Name: *JEWISH HOME AND HOSPITAL FOR AGED AT PITTSBURGH*

Address: *200 JHF DRIVE, PITTSBURGH, PA, 15217*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/21/2017* **Issued By**: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/14/2026*

Inspection Dates and Department Representative

09/14/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served**: *27*

Special Care Unit

In Residence: *Yes* **Area**: *Full license* **Capacity**: *30* **Residents Served**: *27*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *27*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *27*

Have Physical Disability: *0*

Inspections / Reviews

09/14/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/09/2026*

10/09/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/01/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/12/2026*

Inspections / Reviews *(continued)*

10/14/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/01/2026*

11/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/01/2026*

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

133.1 Exit signs

1. Requirements

2800.
133.1. Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

At 10:43 a.m., there was no exit sign over the exit door to the gated courtyard near the television room. The residence currently serves 27 residents.

Repeated Violation 7/29/25

Plan of Correction ***Accept (- 10/09/2026)***

Plan of Correction
55 Pa. Code § 2800.133(a)(1) (Exit Sign)
1.Corrective Action
• On the day of inspection, the Ahava Administrator immediately mounted a compliant "EXIT" sign directly on the exterior door leading to the gated courtyard near the television room. (9/14/2026)

• The Ahava Administrator contacted Facilities Director to have permanent illuminated signage installed on 9/14/202. The installation was initiated and completed on October 2, 2026.

• The installed signage complies with 55 Pa. Code § 2800.133(a)(3), featuring plain, legible lettering at least 6 inches in height with principal strokes at least 3/4 inch wide.

2.Audit
The Ahava Administrator or designee completed a 100% facility-wide physical site audit of all exit doors, emergency egress points, courtyards, and common living areas across the residence (which serves 27 residents).09/14/2026
• The audit confirmed that:
o Every designated exit door has a compliant "EXIT" sign posted.
o If any courtyard door or gate is not intended as an egress path, it is clearly marked "Not an Exit" in accordance with 55 Pa. Code Chapter 2800 courtyard safety guidelines.
A comprehensive exit and signage inventory checklist was completed on 09/15/2026, and signed by the Administrator to document full facility compliance.

3.Staff Education & Communication

(To start training on October11th)
• The Ahava Administrator and the DON will re-educate maintenance personnel and Ahava staff on the regulatory requirements under 55 Pa. Code § 2800.133 (Exit Signs).
• Direct care staff and supervisors will be instructed to immediately report any missing, loose, or damaged emergency exit signage in maintenance request log maintain in the nurse's station.
• The Ahava Administrator and/or DON will immediately notify the Facilities Director via email upon receiving notice of any missing, loose, or damaged emergency exit signage.
• All signed attendance records and educational documentation will be completed and placed into the staff development file by.

133.1 Exit signs (continued)

4.Monitoring
• Every other day for one week (09/21/2026, 09/23/2026)
• Weekly Audits: Once a week x2 (October 05th 2026 to October 31st 2026)

5. Implementation Summary
• Persons Responsible: Ahava Administrator and Director of Nursing (DON)
• Evidence Submitted with Plan:
1. Date stamped photographs showing the newly installed illuminated exit sign above the courtyard near the television room courtyard exit door.
2. Completed facility wide exit signage audit checklist signed by the Facilities Director.
3. Staff education and training attendance sign in sheets.

Licensee's Proposed Overall Completion Date: *10/31/2026*

Implemented ([redacted] - 11/02/2026)

184a Resident meds labeled

2. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #1 is ordered Klor Con 10mEq tablet, extended release (1) tablet oral two times daily. However, at 2:10 pm., the pharmacy roll pack for this medication indicated Potassium Chloride ER 10mEq 1 tablet twice daily.

Resident #2 is ordered insulin aspart 100 unit/mL Inject as per sliding scale if 131 180, 0 units; 181 240, 2 units; 241 300, 4 units; 301 350, 6 units; 351 400, 8 units three times daily. However, at 2:40 p.m., the pharmacy label for this medication indicated insulin aspart 100 unit/mL inject SQ as per sliding scale three times daily 131 180 2 units; 181 240 4 units; 241 300 6 units; 301 350 8 units; 351 400 10 units for type 2 diabetes mellitus.

Plan of Correction ***Accept ([redacted] - 10/14/2026)***

PLAN OF CORRECTION
Deficiency where Klor Con 10 meq extended release was ordered twice daily
DON identified deficiency ,reviewed physicians order,MAR and pharmacy medication packaging.
Pharmacy notified of labeling discrepancy and requested corrective packaging that accurately identifies the medication consistent with current orders and meet facilities labeling requirements.
Medication packaging will be verified upon delivery to verify: Name (should have both brand and generic name),strength, dosage, route and frequency for accuracy.
DON or designee will conduct a 100% audit of current resident's to verify that orders reflect both Brand and generic labeling and any discrepancies will be immediately corrected with the pharmacy.

184a Resident meds labeled (continued)

ALL new admission orders will include both Name Brand as well as Generic in their orders unless otherwise noted.
Staff Education to include:
demonstrating they have compared the pharmacy label with current orders and MAR before administrating
verify medication name, strength, dose, route, and frequency
reporting any discrepancies to nursing supervisor and pharmacy
Obtain corrected labeling when packaging does not correspond with current orders.
Clarify with nursing supervisor or pharmacy if there are any questions prior to administration.
Monitoring to include:
DON or designee will conduct medication label Audits weekly for 4 weeks followed by monthly audits for 3 months
Packaging will be verified to correspond with current orders and MARs
Discrepancies will be immediately corrected and will result in additional staff education and/ or pharmacy notification and correction
Audits will be reviewed by Administrator or designee and maintained.

Resident#2 PLAN OF CORRECTION
Deficiency where, insulin aspart 100 unit/mL Inject as per sliding scale if 131 180, 0 units; 181 240, 2 units; 241 300, 4 units; 301 350, 6 units; 351 400, 8 units three times daily.
DON identified deficiency, reviewed physicians order, MAR and pharmacy medication packaging.
Pharmacy notified of labeling discrepancy and requested corrective packaging that accurately identifies the medication consistent with current orders and meet facilities labeling requirements.
Medication packaging will be verified upon delivery to verify: Correct Name of medication, Correct dose, sliding scale matching the MAR.
DON or designee will conduct a 100% audit of current resident's to verify that orders reflect both Brand and generic labeling, and sliding scale. Any discrepancies will be immediately corrected with the pharmacy.
ALL new admission orders will include both Name Brand as well as Generic in their orders unless otherwise noted.
Staff Education to include:
demonstrating they have compared the pharmacy label with current orders and MAR before administrating
verify medication name, strength, dose, route, and frequency
reporting any discrepancies to nursing supervisor and pharmacy
Obtain corrected labeling when packaging does not correspond with current orders.
Clarify with nursing supervisor or pharmacy if there are any questions prior to administration.
Monitoring to include:
DON or designee will conduct medication label Audits weekly for 4 weeks followed by monthly audits for 3 months
Packaging will be verified to correspond with current orders and MARs
Discrepancies will be immediately corrected and will result in additional staff education and/ or pharmacy notification and correction
Audits will be reviewed by Administrator or designee and maintained.

Licensee's Proposed Overall Completion Date: *10/31/2026*

Implemented ([redacted] - 11/02/2026)

185a Storage procedures

3. Requirements

185a Storage procedures *(continued)*

2800.
185.a. The residence 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 #2 is ordered insulin aspart 100 unit/mL – Inject as per sliding scale if 131-180, 0 units; 181-240, 2 units; 241-300, 4 units; 301-350, 6 units; 351-400, 8 units - three times daily. However, on the following dates, the blood glucose readings entered into the resident's September 2026 medication administration record were not in the resident's glucometer as follows:
9/11/26 Afternoon; 102
9/11/26 AM; 116
9/9/26 AM; 106
9/5/26 AM; 107
9/2/26 AM; 178

Plan of Correction ***Accept (- 10/09/2026)***

VIOLATION OF BLOOD GLUCOSE READING READINGS

-ALL care staff being reeducated on Diabetic Care by Staff Development

-ALL staff members responsible for blood glucose monitoring ,medication administration and documentation will receive education regarding:

using only the designated residents glucometer,accurately documenting the glucose reading and before administering any insulin for a sliding scale

-Administer insulin strictly according to the physicians current orders

-Individual glucometers were monitored for concurrency with documentation in Residents chart

-Not documenting or transcribing a blood glucose that was not actually obtained

-Immediately report any discrepancy for it to be investigated and addressed and additional education will be provided as necessary

-Secondary check system was initiated to have documentation of all blood sugars (Insulin Worksheet) and will be reviewed weekly

-Physicians orders, and insulin administration records will be reviewed for discrepancies

-Batteries on all glucometers will be changed every 6 months basis to maintain accuracy

-weekly audits will be reviewed by DON or designee to make sure compliance is maintained for 1 month and if there are any discrepancq1ies additional corrective action will be employed.

Licensee's Proposed Overall Completion Date: *10/31/2026*

185a Storage procedures *(continued)*

Implemented (- 11/02/2026)

231b Medical evaluation

4. Requirements

2800.
231.b. Medical evaluation. A resident or potential resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission.

Description of Violation

Resident #2 was admitted to the special care unit on . However, the resident's medical evaluation completed did not indicate that the resident's needs can be met safely at the Assisted Living Residence. The check box was left blank.

Plan of Correction ***Accept (- 10/09/2026)***

Plan of Correction:
55 Pa. Code § 2800.231(b) (DME)
1. Immediate Corrective Action
• The facility contacted Resident #2's evaluating medical practitioner to address the incomplete Documentation of Medical Evaluation (DME) completed on
• An updated/corrected DME was obtained with the evaluating medical practitioner's direct verification certifying that Resident #2's needs can be met safely at the Memory Care secured Special Care Unit in October 8th2026, with a signature from the physician where the changes were made. (Note: In accordance with § 2800.141(a), residence staff did not alter the form directly, ensuring changes were validated and documented with the medical practitioner.
• A clinical review of Resident #2's current Assessment and Support Plan (ASP) was conducted by the RN/Director of Nursing (DON) to ensure the care provided in the Special Care Unit fully aligns with the medical practitioner's documented findings.
2. Audit & Scope Review (Identification of Others at Risk)
• A comprehensive audit of all current resident medical evaluations-initiated October 5th2026 to ensure:
1. The DME was completed within the required 60-day timeframe prior to admission.
2. All required checkboxes and fields are completed in full, specifically the certification that the resident's care needs can be safely accommodated by the residence.
3. Required Special Care Unit diagnoses and placement justifications are documented.
4. Staff Education & Training

• Mandatory re-training will be conducted for the Director of Nursing and Administrator involved on the intake and admission process.
• Training Content: Review of 55 Pa. Code § 2800.231(b) and § 2800.141(a), with emphasis on complete Document of Medical Evaluation requirements, identifying missing safety certifications, and protocols for obtaining certified practitioner addenda before move-in. Resident pre-move in checklist updated to include dual verification, Clinical verification from DON and Administrative Verification from Administrator (or Designee) of completion of DME form.
• Signed attendance logs will be retained in facility records.

4. Monitoring

231b Medical evaluation (continued)

• The Director of Nursing (or designee) will conduct a 100% pre-admission audit of all incoming resident DMEs prior to day of move-in.
• Last week of every Month: A review will be conducted to assure all new admissions are following admission process.

5. Implementation Details
• Individual Responsible: [redacted] *(RN/DON)* [redacted] *(Administrator)*
• Evidence Submitted with Plan: Copy of Resident #2's corrected/verified DME, Pre-Admission Clinical Checklist, and staff training attendance logs.

Licensee's Proposed Overall Completion Date: *10/31/2026*

Implemented ([redacted] - 11/02/2026)