MAILING DATE: October 31, 2019

Ms. Danielle Bryce
Administrator
Vincentian De Marillac
5300 Stanton Avenue
Pittsburgh, Pennsylvania 15206

RE: Schenley Gardens
3890 Bigelow Boulevard
Pittsburgh, Pennsylvania 15213
License / COC #: 44986

Dear Ms. Bryce:

As a result of the Department's Bureau of Human Services Licensing inspection on September 26, 2019; September 27, 2019 and September 30, 2019, of the above facility, the citations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Jon B Kimberland

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: SCHENLEY GARDENS — License Number: 44986
Address: 3890 BIGELOW BOULEVARD,, PITTSBURGH, PA 15213
County: ALLEGHENY — Region: WESTERN

Administrator

Name: Danielle Bryce — Phone: 4125087807 — Email: dbryce@vcs.org

Legal Entity

Name: VINCENTIAN DE MARILLAC
Address: 5300 STANTON AVENUE, PITTSBURGH, PA, 15206

Certificate(s) of Occupancy

Type: I-2 — Date: 05/12/1998 — Issued By: City of Pittsburgh

Staffing Hours

Resident Support Staff: 0 — Total Daily Staff: 102 — Waking Staff: 77

Inspection

Type: Full — BHA Docket #: — Notice: Unannounced
Reason: Provisional,Incident

Inspection Dates and Department Representative

09/26/2019 - On-Site: Scott Klein, Deb McConnell, Mike Marini

09/27/2019 - On-Site: Scott Klein, Deb McConnell, Mike Marini

09/30/2019 - Off-Site: Scott Klein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 164 — Residents Served: 71

Secured Dementia Care Unit

In Home: Yes — Area: 5th Floor — Capacity: 32 — Residents Served: 10

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0
Are 60 Years of Age or Older: 69
Diagnosed with Mental Illness: 32
Diagnosed with Intellectual Disability: 0
Have Mobility Need: 31
Have Physical Disability: 1

17 - Record Confidentiality

Regulations

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 9/26/19 at approximately 12:55 p.m. in the lobby of the "T" floor behind the reception desk to the left side, the license inspection summary dated 5/14/19 is posted publicly and conspicuously. However, the privacy coding sheet with resident #1's name was attached.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The privacy coding document of the inspection summary was removed immediately when identified by the Department Representative. The document was shredded. The Administrator was educated by the Department Representative regarding the violation.

The Administrator is responsible for posting the licensing inspection summaries. The privacy coding document will be removed by the Administrator prior to posting the results of the 9/26 and 9/27/19 inspection summary upon receipt of the approved Plan of Correction in the binder behind the reception desk. The Administrator will ensure that the privacy coding document is also removed prior to posting any future licensing inspection summary results.

A Record Confidentiality Audit was completed by the LPN Manager of Resident Services on 10/22/19 (see attached). The audit will be completed by the Administrator (or designee) weekly until no violations are found for three consecutive audits.

Legal Entity Representative

Signature

Danielle Bryce PCHA — Printed Name and Title

10/22/19 — Date

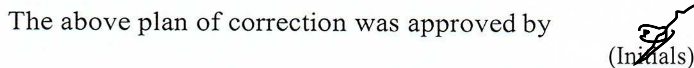
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 10/22/19 (Date)

Plan of correction implementation status as of (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

The above plan of correction was approved by (Initials)



18 - Compliance With Laws

Regulations

2600.

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

Description of Violation

On 9/26/19 at approximately 12:20 p.m. the carbon monoxide detector located in the 3rd floor service area has 2 AA batteries labeled "12/23/17." In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

On 9/26/19 at approximately 12:35 p.m. the carbon monoxide detector located in the 2nd floor service area has 2 AA batteries labeled "12/23/17." In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

Repeat Violation 5/14/19

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 9/30/19, the Environmental Services Manager replaced and dated the batteries in all battery operated CO detectors. See attached "CO Detector Survey Sheet" for documentation of battery replacement. All new batteries were labeled with the 9/30/19 date. See attached photo.
The Environmental Services Manager will complete monthly CO detector tests and the batteries will be replaced annually, or sooner as needed. This will be documented on the attached "CO Detector Survey Sheet."

Legal Entity Representative

Signature

Danielle Bryce PCHA 10/16/19

Printed Name and Title — Date

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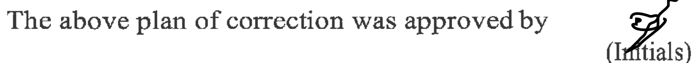

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/26/19 at approximately 12:30 p.m. the toilet in the private bathroom of resident room #320 is covered in what appears to be dried fecal matter. The inner bowl of the toilet has what appears to be feces splattered around the entire inner surface above the water line, and what appears to be feces are smeared on the rear upper side of the toilet seat as well. Resident #2 resides in room #320.

On 9/26/19 at approximately 12:30 p.m. the private bathroom of resident room #320 has toilet tissue, yellow gauze, and a taped cotton ball with what appears to be blood stains sitting on the lid of the trash can next to the toilet and on top of the slender countertop that runs the length of the wall behind the toilet beginning with the vanity. There is also dried tissue and what appears to be blood and hair stuck to the inner bowl of the resident's sink, and what appears to be blood on a small piece of wadded up tissue on the floor in front of and to the right of the toilet. Resident #2 resides in room #320.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Please see attached 85a Plan of Correction.

See Page 4A of 12

Legal Entity Representative

Signature

Danielle Bryce PCHA 10/16/19

Printed Name and Title Date

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85a – Sanitary Conditions – Plan of Correction

When the violation was identified by the Department Representative, the housekeeping team was called to clean the bathroom. The specific issue cited was corrected at the time of the inspection.

All resident bathrooms are cleaned by housekeeping weekly. The housekeeping team has a list of "target bathrooms" that are cleaned daily. Room 320 was added to the daily target list to be checked on by a housekeeper daily.

The housekeepers are given a daily assignment sheet with the resident rooms that are to be cleaned that day. The housekeeping staff will now be instructed to sign off on their assignment sheets daily, including the time that each bedroom/bathroom was cleaned. Education was provided to the housekeeping team by the Housekeeping Supervisor. See attached Record of Training.

The Housekeeping Supervisor put together a cleaning caddy (see attached photo) that will be stored at the front desk. The front desk is staffed with a receptionist 24/7. This caddy will be available to the resident aides. A mandatory Plan of Correction in-service was held on Friday, October 11, 2019 for resident aides, med techs, and LPN's (see attached agenda and Record of Training). A handout was given out with resident aide, med tech and LPN paychecks on Friday, October 11, 2019 to provide the information to the staff unable to attend the in-service (see attached). Staff was educated on the caddy of cleaning supplies stored in the cupboard behind the front desk. Staff instructed to get the caddy and immediately wipe up any urine/fecal matter/tissue/gauze/cotton balls that are observed in a resident bathroom. They were also instructed to call the front desk to notify the housekeeping team that the bathroom needs to be cleaned. While the housekeeping team is responsible for doing a deep clean/sanitize, the aides are responsible for doing the initial clean up to make the bathroom usable for the resident.

At the October 29, 2019 Resident Council meeting, residents will be asked to communicate when their bathroom needs to be cleaned by calling the front desk.

Danielle Bue 10/16/19 10/22/19

91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 9/26/19 at approximately 11:15 a.m. the telephone on the 5th floor in the secured dementia care unit "High Side" activity room does not have any of the emergency telephone numbers posted on or near the phone.

Repeat Violation - 5/14/19

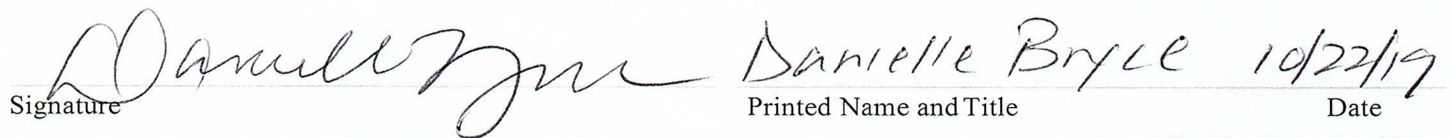
Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

An emergency telephone number sticker was placed on the phone during the inspection, correcting the violation immediately. See attached photo.

Emergency Telephone Number Audit was completed throughout the building by the management team – see attached. Audit will be completed weekly by the management team for three months.

Legal Entity Representative



Signature — Danielle Bryce — Printed Name and Title — 10/22/19 — Date

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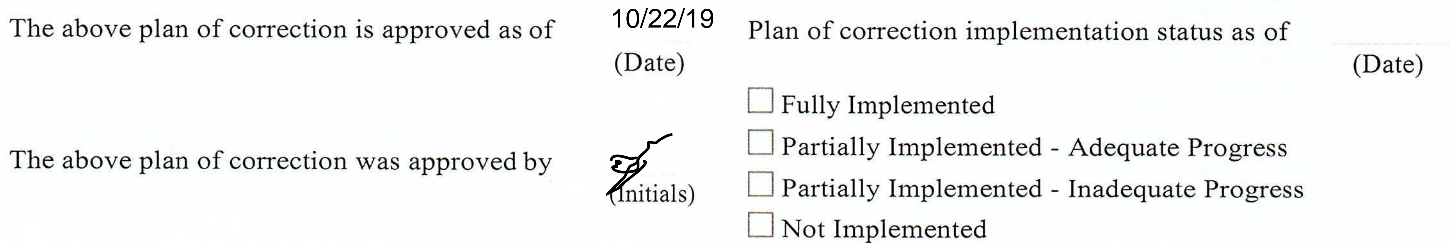

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of (Date)

☐ Fully Implemented
☐ Partially Implemented - Adequate Progress
☐ Partially Implemented - Inadequate Progress
☐ Not Implemented

95 - Furniture and Equipment

Regulations

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 9/26/19 at approximately 11:25 a.m. in resident room #525, the enabler bar for the resident is not secured to the bed frame causing the entire bed to move when grasping the bar. When grasping the enabler bar from the mattress side, it tilts away from the bed at approximately a 50 degree angle which creates a fall risk for resident#3.

On 9/26/19 at approximately 12:40 p.m. in resident room #222, the enabler bar for resident #4 is mounted to the right side of the resident's bed and has an uncovered opening measuring approximately 10 inches wide by 5 inches high. The enabler bar swings out and back towards the resident's bedside table creating a risk of limb entanglement for resident #4.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attached Plan of Correction

See Page 6A of 12

Legal Entity Representative

Danielle Bryce (signature) — Danielle Bryce PCHA — 10/16/19

Signature — Printed Name and Title — Date

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☐ Not Implemented

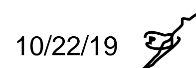
95 Plan of Correction.

Room 525: The administrator called resident #3's POA on 10/2 and 10/4/19 without response or return call. Proceeded to remove enabler bar from the bed for the safety of the resident. See attached documentation in Point Click Care and before and after photographs of the bed.

Room 222: The administrator contacted resident #4's daughter and informed her of the entrapment risk posted by the enabler bar on her mother's bed. Informed daughter that the enabler bar would be removed from the bed. Resident was receiving rehab at Vincentian Home at the time of the inspection. Spoke with the therapy director to inform her that the resident would no longer have an enabler bar attached to her bed when she returned to Schenley Gardens. Therapy agreeable to working with resident on transfers and bed mobility without an enabler bar during her rehabilitation stay at Vincentian Home. Enabler bar removed. See attached documentation in Point Click Care and before and after photographs of the bed.

Enabler bar audits were preformed throughout the facility by the management team. Four additional residents had enabler bars that were determined to be an entrapment risk. Notified residents and families. Bars removed on Monday, October 14, 2019. Conversations documented in Point Click Care. The Administrative Assistant was instructed to discourage new admissions from bringing in any type of bed attachment that may serve as an entrapment risk. If a new admission would like to bring any type of bed attachment into Schenley Gardens, it must be approved by the Administrator and Manager of Environmental Services to determine that it is safe and mounted securely to the bed.

10/16/19



10/22/19

102h - Toilet Paper

Regulations

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 9/26/19 at approximately 12:28 p.m. there was no toilet paper in the private bathroom of resident room #320. Resident #2 resides in room #320.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The housekeepers restock the resident rooms with toilet paper when the room is cleaned (daily or weekly depending on the need of the resident). At the time of the survey, the housekeepers were stocking each resident room with a roll in the mounted toilet paper holder and one extra roll. The housekeepers will now stock the resident rooms with one roll in the mounted toilet paper holder and two extra rolls in each room. Housekeepers were all educated by the Lead Housekeeper on Monday, October 14, 2019 (see attached record of training.)

Toilet paper is always available on the linen cart on each floor and at the front desk. A mandatory plan of correction meeting was held on Friday, October 11, 2019 for aides, med techs and LPN's. A handout was given out with resident aide, med tech and LPN paychecks on Friday, October 11, 2019 to provide the information to the staff unable to attend the in-service (see attached). Staff informed that extra rolls are always available on the linen carts on each floor and at the front desk. When they are working with a resident in their bathroom and observe that a resident is out of toilet paper, they should bring them another roll from the linen cart or front desk. Staff instructed to notify the housekeeper if they run out of toilet paper on the linen cart or at the front desk. See attached agenda and record of training.

Legal Entity Representative

Danielle Byrne

Signature

Danielle Bryce PCHA 10/16/19

Printed Name and Title — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 10/22/19 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 9/26/19 at approximately 12:20 p.m. in the 3rd floor service area laundry room, the lint catcher of the dryer has a partial layer of lint less than 1/8th of an inch think covering approximately ½ of the surface of the lint catcher. The dryer has no clothes in it and is cold to the touch.

On 9/26/19 at approximately 12:40 p.m. in the 2nd floor service area laundry room, the lint catcher of the dryer has a partial layer of blue lint less than 1/8th of an inch think covering approximately 1/3rd of the surface of the lint catcher. The dryer has no clothes in it and is cold to the touch.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The lint traps on the second and third floor service areas were cleaned at the time of the inspection to correct the violation immediately.
A housekeeper or maintenance person is assigned to empty the "back of house" trash every morning and afternoon on each floor. This staff member has been assigned to check the lint trap on each floor every morning and afternoon during trash rounds. All housekeeping staff were educated on the importance of emptying the link trap after each use. See attached record of training.
A mandatory plan of correction meeting was held on Friday, October 11 for all aides, med techs and LPNs. A handout was given out with resident aide, med tech and LPN paychecks on Friday, October 11, 2019 to provide the information to the staff unable to attend the in-service (see attached). Staff were informed that dryer fires are the third most common source of fires in personal care homes. Staff must empty the lint trap every time you use the dryer. Staff were instructed to date and sign the posted sign off sheet above the dryer every time they empty the lint trap. See attached meeting agenda and record of training.
Some residents utilize the washers and dryers independently to do their own personal laundry. At the resident council meeting scheduled for October 22, 2109, the Administrator will educate the residents on the requirement to empty the lint trap after each use. Resident will be encouraged to ask a staff member to empty the dryer lint if they are unable.

Legal Entity Representative

[signature] Danielle Boyce PCHA 10/16/19

Signature | Printed Name and Title | Date

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The above plan of correction was approved by [initials] (Initials)

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- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 7/29/19, the home's fire safety expert specified a safe evacuation time of 13 minutes and 0 seconds. However, on 9/19/19 at 4:56 a.m., the home conducted a fire drill and evacuated the residents in 20 minutes and 52 seconds.

On 8/22/19 at 6:39 p.m. the home conducted a fire drill with 70 residents present in the home. However, only 68 residents were evacuated.

On 9/19/19 at 4:56 a.m. the home conducted a fire drill with 72 residents present in the home. However, only 69 residents were evacuated.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Fire drill held on 10/11/19 at 5:31 AM with 74 residents present in the home. 74 resident were evacuated in 10 minutes and 25 seconds.

In the future, when a resident refuses to evacuate during a fire drill, the resident will be informed by the Administrator (or designee) that if they do not evacuate in the next fire drill, they will be given a 30 day discharge notice for documented, repeated violation of the home rule.

The fire marshal is scheduled to come to Schenley Gardens on October 22, 2019 and do two fire safety presentations – one for residents and one for staff.

See Page 9A of 12

Legal Entity Representative

[signature] Danielle Bryce PCHA 10/16/19

Signature | Printed Name and Title | Date

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132d Evacuation – Plan of Correction

Fire drill held on 10/11/19 at 5:31 AM with 74 residents present in the home. 74 residents were evacuated in 10 minutes and 25 seconds.

In the future, when a resident refuses to evacuate during a fire drill, the resident will be informed by the Administrator (or designee) that if they do not evacuate in the next fire drill, they will be given a 30 day discharge notice for documented, repeated violation of the home rule.

The fire marshal is scheduled to come to Schenley Gardens on October 22, 2019 and do two fire safety presentations – one for residents and one for staff.

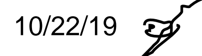
The importance of fire drills and the evacuation requirement will be discussed with the residents at the resident council meeting scheduled for October 29, 2019.

For future Schenley Gardens admissions: mandatory participation in fire drills is included in the resident-home contract signed by all new residents upon admission to Schenley Gardens. The Administrator or administrative assistant (or designee presenting the contract) will stress the importance of this home rule when presenting the contract to the resident.

Two fire drills will be conducted each month during the months of October, November and December 2019.

By 11/30/19: The administrator or designated direct care staff person shall evaluate the capabilities of the resident to evacuate and the staffing on each shift. The administrator shall schedule the appropriate number of staff on each shift to ensure the residents are safely evacuated within the safe evacuation time specified by the home's fie safety expert.

10/22/19

10/22/19 

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #5 is ordered Humalog KwikPen Solution Pen-Injector 100 UNIT/ML (insulin Lispro) on 7/29/19 – Inject 5 units subcutaneously one time a day and inject as per sliding scale: if 141 – 180 = 1 unit; 181 – 220 = 2 units; 221 – 260 = 3 units; 261 – 300 = 4 units; 301 – 340 = 5 units; > 341+ = 6 units; < 70 - < 340 = Notify MD, subcutaneously four times a day.

Resident #5's September 2019 medication administration record does not include the dosage of Humalog insulin administered to include the following dates and times:

Date	Time of Day
9/22/19	Evening
9/21/19	Evening
9/20/19	Afternoon
9/10/19	Bedtime
9/9/19	Bedtime
9/5/19	Evening
9/5/19	Bedtime

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attached Plan of Correction for 187a.

See Page 10A of 12

Legal Entity Representative

Signature | Danielle Bryce PCHA | 10/16/19

Printed Name and Title | Date

187a Plan of Correction

The Administrator and LPN Manager of Resident Services worked with team at Vincentian Collaborative System that manages our PointClickCare account to determine the best way for sliding scale insulin orders to be entered into the system. We reviewed multiple order entry options to determine how to ensure that the dosage of insulin administered is documented in the MAR for every administration. On October 10, 2019 Resident #5's sliding scale insulin order was updated in Point Click Care to reflect the units of Humalog Insulin administered if the blood sugar is above 341 (Resident #5's MAR reflecting order entry on October 10, 2019 attached).

All residents currently ordered sliding scale insulin have been updated to document the units administered if the blood sugar is above the limit and the MD is to be contacted on the MAR.

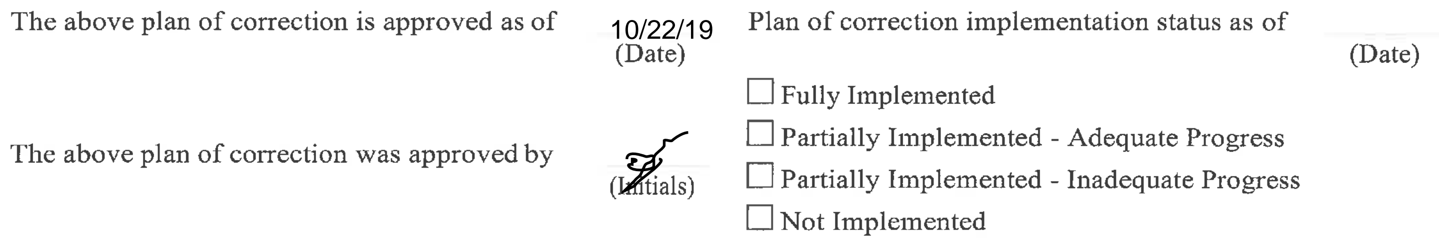
LPN Manager of Resident Services developed a guide for "Entering a Sliding Scale Insulin Order into PointClickCare" (see attached). On October 16, 2019 LPN Manager provided the handout to Schenley Gardens nurses and reviewed the process with them. See attached Record of Training. The handout was also posted in the nurse's station for reference for agency nurses.

Audits of residents MAR's on sliding scales will be completed by the Manager of Resident Services for the next 3 months.

[signature] 10/16/19

187a - Medication Record (continued)

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!



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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

225c - Additional Assessment

Regulations

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

Description of Violation

The home's most recent assessment for resident #6 was completed on 12/7/17.

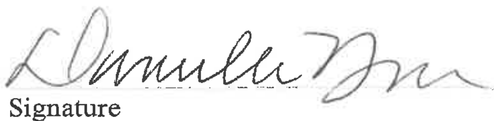
Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

A new assessment was completed for resident #6 at the time of the inspection to correct the violation immediately. See attached.

A "Plan of Correction Audit for RASPs" was completed by the LPN Manager of Resident Services and lead med tech on October 10, 2019. See attached audit. A new assessment was completed for residents with assessments that were identified to be over one year old by the LPN Manager of Resident Services and Lead Med Tech. The audit will be completed monthly by the LPN Manager of Resident Services (or designee). The audit will be discontinued after no violations are found for three consecutive months.

Legal Entity Representative



Signature

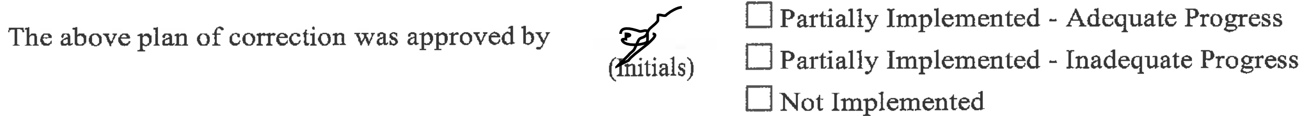
Danielle Bryce PCHA 10/16/19

Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 10/22/19 (Date)

The above plan of correction was approved by (Initials)



Plan of correction implementation status as of (Date)

☐ Fully Implemented
☐ Partially Implemented - Adequate Progress
☐ Partially Implemented - Inadequate Progress
☐ Not Implemented