pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: dbryce@vcs.org
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MAILING DATE: May 22, 2020

Mr. Nick Vizzoca
Chief Executive Officer
Vincentian De Marillac
5300 Stanton Avenue
Pittsburgh, Pennsylvania 15206

RE: Schenley Gardens
3890 Bigelow Boulevard
Pittsburgh, Pennsylvania 15213
License #: 449860

Dear Mr. Vizzoca:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 10, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Suzy Quinn
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
5/13/20
Western Region Field Office
Bureau of Human Services Licensing

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-1* **Date:** **Issued By:**
Type: *I-2* **Date:** *11/08/2000* **Issued By:** *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *115* **Waking Staff:** *86*

Inspection

Type: *Partial* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Complaint,Incident*

Inspection Dates and Department Representative

03/10/2020 - On-Site: Barbara Barone

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *164* **Residents Served:** *76*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *5th Floor* **Capacity:** *32* **Residents Served:** *12*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *1*
Are 60 Years of Age or Older: *76*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *39*
Have Physical Disability: *0*

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #1 was on a leave of absence from the home from 1/12/2020 through 1/25/2020. Although the home was informed by the resident on 1/10/2020, the home only requested enough medication from the pharmacy to last through 1/20/2020. Resident#1 did not have her medications available from the morning of 1/21/2020, through the evening of 1/25/2020 to include: Xifaxan 550MG, Sertraline 100MG, Trazodone100MG, and Gabapentin 300MG.

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.)

At the time of the leave of absence in January 2020, the resident was utilizing the "house" pharmacy to have her medications filled. Grane pharmacy provides one week of straight order medications at a time. The weekly medication delivery to the facility occurs every Tuesday night. On February 6, the resident's pharmacy was changed to CVS per resident preference. CVS provides a 30-day supply of medications at a time, instead of a 7 day supply. Facility is currently working with resident and POA to receive a 90-day supply of medications through Express Scripts.

On 5/7/2020, the Administrator and LPN Manager of Resident Services developed a "Resident Leave of Absence Medication Request Policy" that includes a "Leave of Absence Medication Request Form" that will be provided to the resident (or designated person) upon notification to the facility of an upcoming leave of absence. See attached policy and form. This form will be shared with families and residents within 60 days after the Governor lifts the "Disaster Proclamation." See attached notification to residents and families. All Schenley Gardens Med Techs and nurses were educated on the new policy and form on 5/8-5/12/2020 by the LPN Manager of Resident Services (or designee). Please see attached record of training. Moving forward, all new med techs and nurses will be trained on the policy and form during their orientation. The training will be completed by the LPN Manager or LPN/med tech designated to provide their on-the-job training.

Legal Entity Representative

Signature

Danielle Bryce PCMA 5/13/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by SE (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

☑ Implemented
☐ Not Implemented

188b - Medication Error Reporting

Regulations

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

From the morning of 1/21/2020 through 1/25/2020, none of resident #1's prescribed medications were available to her, to include: Xifaxan 550MG, Sertraline 100MG, Trazodone100MG, and Gabapentin 300MG. However, the home did not inform the resident's physician.

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 5/8/2020, the Administrator left a message with the resident's physician office as notification of the medication error that occurred during the resident's leave of absence. On 5/8/2020, the Administrator notified the resident's designated person of a plan put in place to assure medication availability during future leave of absences. Communication was documented in the resident's medical record.

Regulation 2600.188b was reviewed by the administrator to ensure that medication errors are handled appropriately. Education was provided to the LPN Manager of Resident Services on 5/8/2020 regarding the medication error reporting regulation. See attached record of training.

The Administrator and LPN Manager of Resident Services (or designee) report medication errors identified at the facility.

Legal Entity Representative

Signature

Danielle Bryce RHA 5/13/20
Printed Name and Title Date

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