



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to NORBERT INC
LEGAL ENTITY

To operate NORBERT RESIDENTIAL CARE FACILITY
NAME OF FACILITY OR AGENCY

Located at 2413 ST. NORBERT DRIVE, PITTSBURGH, PA 15234
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

To provide Personal Care Homes
TYPE OF SERVICE TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 102
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller
MAXIMUM CAPACITY

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from March 12, 2020 until June 12, 2020,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **430512**

Robert E. Robinson
ISSUING OFFICER

[Signature]
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: March 12, 2020

Mr. Hal K. Waldman
President
Norbert, Inc.
1326 Freeport Road, Suite 100
Pittsburgh, Pennsylvania 15238

RE: Norbert Residential Care Facility
2413 Norbert Drive
Pittsburgh, Pennsylvania 15234
Certificate #: 430512

Dear Mr. Waldman:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 17, 2019, June 22, 2019, June 23, 2019, August 23, 2019, August 26, 2019, August 27, 2019, October 22, 2019 and October 25, 2019, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department issues you a **SECOND PROVISIONAL** license to operate the above facility. A **SECOND PROVISIONAL** license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your **SECOND PROVISIONAL** license is enclosed and is valid from March 12, 2020 to June 12, 2020.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
15a	II	74	\$5	\$370	5 calendar days from mailing date of this letter
42b	II	74	\$5	\$370	5 calendar days from mailing date of this letter
187d	III	74	\$3	\$222	15 calendar days from mailing date of this letter
225c	III	74	\$3	\$222	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

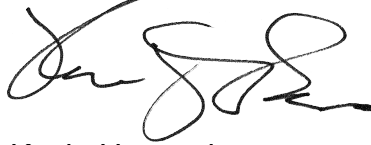
Mr. Waldman

3

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written in a cursive style.

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

Violation Report

RECEIVED
9/4/19
Western Region Field Office
Bureau of Human Services Licensing

Facility Information

Name: *NORBERT RESIDENTIAL CARE FACILITY*
Address: *2413 ST. NORBERT DRIVE,, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

License Number: *43051*

Administrator

Name: *Janet Torregrosso* Phone: *4128855202* Email: *JTORREGROSSO@norbertpersonalcare.com*

Legal Entity

Name: *NORBERT INC*
Address: *1326 FREEPORT ROAD, SUITE 100, PITTSBURGH, PA, 15238*

Certificate(s) of Occupancy

Type: *I-2* Date: *03/09/2010* Issued By: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *128* Waking Staff: *96*

Inspection

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

Inspection Dates and Department Representative

07/17/2019 - On-Site: Desmond Grace, Lisa Flinner-Altman
07/22/2019 - On-Site: Desmond Grace, Lisa Flinner-Altman
07/23/2019 - On-Site: Desmond Grace, Lisa Flinner-Altman

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *102* Residents Served: *88*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *87*
Diagnosed with Mental Illness: *8* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *40* Have Physical Disability: *1*

15a - Resident Abuse Report

Regulations

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 7/10/19, at approximately 8:00 a.m., resident #1 reported to staff person A that she was thrown to the floor by staff person B causing injuries to her forearm and leg. The home failed to immediately report the allegation of abuse until 12:40 p.m. on 7/10/19.

Repeat Violation: 2/11/19

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 7/30/19, the outside organization protective services came and did an educational series with staff regarding when to report abuse, abuse, and financial exploitation (see attached A)
- Abuse training is completed with all new hires (see attached B)
- Administrator/DON and/or designee will ensure reporting occurs immediately

Legal Entity Representative

Within 30 days of receipt of these plans of correction, the administrator or designated staff person will interview at least 2 staff members per month regarding resident care and abuse reporting. Documentation will be kept.

1/17/20

Signature Christ Tanguino

Printed Name and Title Janet Torregrosso 9/4/19
Administrator Date

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

The above plan of correction is approved as of

1/17/20
(Date)

Plan of correction implementation status as of

1/17/20
(Date)

The above plan of correction was approved by

JT
(Initials)

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

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 7/10/19, at approximately 8:00 a.m., staff person B was assisting resident #1 to put on her pants. Prior to standing, the resident instructed the staff person to hold on to her tightly. Upon standing, resident #1 told staff person B that she felt dizzy and was about to fall. The staff person let go of the resident and as a result the resident fell to the floor in front of her wheelchair. The physician's assessment of the resident completed 7/10/19, indicated that the resident sustained bruising to the forearm and tenderness to her right leg.

Repeat Violation: 1/8/19, 8/8/18

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 mandatory staff re-education with our therapy department will occur on September 10th addressing proper transfer technique and safety during transfers. (Sign-in sheet to follow).
- Upon admissions of new residents staff will be educated to residents individual need to ensure resident safety.
- Staff will be reminded to pay attention to residents during transfers.
- Spot checks of transfers will occur by Administrator and/or Respite to ensure proper technique.

Within 30 days of receipt of these plans of correction, then monthly. The administrator will interview ten residents regarding transfers to ensure the staff are listening to resident's concerns and ensuring safety. 1/17/20

Legal Entity Representative

All staff received training on prevention of elder financial exploitation and abuse and when to report from protective services on 7/30/19. 1/17/20

[Signature]
Signature

Janet Torregrosso 9/4/19
Printed Name and Title Administrator Date

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

The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's initial medical evaluation, completed 6/19/19, did not include the resident's medical diagnoses. The medical evaluation indicated that the resident's medical diagnoses were attached on a form signed by the physician; however, the document was not 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.)

- Residents DX added to a separate sheet and verified by doctor.
- DX sheet added to MME dated 6/19/19 to ensure compliance.
- Administrator and/or designee will conduct quarterly audits to ensure on going compliance.
- results to be reported at QM mtg (see attach C)

Legal Entity Representative

Signature James Torregrosso

Printed Name and Title James Torregrosso Administrator Date 9/4/19

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

The above plan of correction is approved as of 1/17/20 (Date)

Plan of correction implementation status as of 1/17/20 (Date)

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

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

143a - Emergency Medical Plan

Regulations

2600.

- 143.a. The home shall have a written emergency medical plan that includes the following:
 - 3. An emergency-staffing plan.

Description of Violation

On 7/14/19, at approximately 4:15 a.m., resident #2 fell from his bed to the floor while trying to transfer to his wheelchair. The fall resulted in thoracic spine closed fractures of the T6 vertebrae, T8 vertebrae, T12 vertebrae, a fractured rib on the left side of his chest and a soft tissue injury to the bridge his nose. At approximately 5:30 a.m., staff person C responded to the resident's room to find the resident face down on the floor of his room, with blood on his face, in pain and calling for help. Staff person C cleaned the resident's face, left the room and called 911 at approximately 5:45 a.m. Emergency Medical Services (EMS) arrived at the home at 6:01 a.m. to find the resident alone and calling for help. At approximately 6:15 a.m., staff person C returned to the resident's room to assist EMS. The home failed to follow its Emergency Care and Notification Policy included in its Emergency Medical Plan, which states that "when it is apparent that the resident is in need of emergency help the staff will stay with the resident until stable or help arrives."

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 mandatory staff re-education of our Policies & Procedures for emergency care & notification will take place the weeks of 9/2 → 9/7 + 9/8 - 9/14 to ensure all staff receive the education (see attached D)
- All med-techs and by management will respond to falls to ensure compliance of policy

Legal Entity Representative

The administrator or designated staff person will interview 2 staff members per month for the next 6 months regarding any incidents occurring in the home requiring the assistance of emergency services to ensure that the home's written emergency medical plan was followed. Documentation will be kept.

1/17/20

Quint Taneagno
Signature

Janet Torreyrosso 9/4/19
Printed Name and Title Administrator Date

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The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The following medications belonging to resident #2 were discontinued on 7/16/19; however, remained in the home on 7/23/19:

*Mirtazapine 15 mg tablets-take one half table by mouth daily at bedtime.

*Salonpas Lidocaine 4% patch-apply topically to rib area every morning, remove at 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.)

- Immediately upon notification medications were removed and returned to pharmacy.
- An internal audit was conducted on 7/25/19 by med techs to ensure compliance.
- Our Pharmacy conducted an audit on 8/30/19 (see attached E)
- Pharmacy will conduct monthly audits on 9/26/19, 10/21/19, 11/11/19 to ensure on-going compliance. Then audits will be as necessary.
- Cards will be audited on Thursday by the med-techs to ensure compliance with results to DON.
- results will be reported at QM mtg.

Legal Entity Representative



Signature

James Torreyrosso 9/1/19
Printed Name and Title Administrator Date

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

The above plan of correction is approved as of 1/17/2020
(Date)

Plan of correction implementation status as of 1/17/2020
(Date)

The above plan of correction was approved by 
(Initials)

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

184a - Labeling OTC/CAM

Regulations

2600.

- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
 - 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 was prescribed ABHR 0.5/12.5/0.5/10 mg/ml- apply 1 syringe to wrist for nausea/vomiting or restlessness. However, the medication label indicates apply to side of neck behind ear. The resident was also prescribed Acetaminophen 325 mg tablets-take 2 tablets every 6 hours as needed for pain. However, the medication label indicates give 2 tablets every 4 hours.

Resident #3 was prescribed Furosemide 40 mg tablets- take 1 tablet by mouth twice daily. However, the medication label indicates one daily. The resident was also prescribed Potassium CL ER 20 MEQ tablets- take 1 tablet by mouth twice daily. However, the medication label indicates one daily.

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.)

- RES # 2
- Immediately upon notification direction change stickers were applied to medications.
 - Pharmacy was called and new labels were obtained. both orders and cards are now compliant. (see attached F)
 - med cart audits for all pharmacy and med techs will be done.
 - results reported @ QM mtg.
- (Res #3 mtg page)

Legal Entity Representative

See page 7a of 10 1/17/20

Signature Amel Taneqneuo

Printed Name and Title Tamara Torregrossa 9/4/19
Date Administrator

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The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

184a - Labeling OTC/CAM

Regulations

2600.

- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
 - 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 was prescribed ABHR 0.5/12.5/0.5/10 mg/ml- apply 1 syringe to wrist for nausea/vomiting or restlessness. However, the medication label indicates apply to side of neck behind ear. The resident was also prescribed Acetaminophen 325 mg tablets-take 2 tablets every 6 hours as needed for pain. However, the medication label indicates give 2 tablets every 4 hours.

Resident #3 was prescribed Furosemide 40 mg tablets- take 1 tablet by mouth twice daily. However, the medication label indicates one daily. The resident was also prescribed Potassium CL ER 20 MEQ tablets- take 1 tablet by mouth twice daily. However, the medication label indicates one daily.

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.)

CONTINUED
 Res #3 - immediately upon notification direction change stickers were applied.
 - Med cart audits of carts have been and will continue to ensure compliance.
 - Resident no longer at facility unable to attach proof as meds were all returned upon discharge.

Legal Entity Representative

Janet Torreyrosso
Signature

Janet Torreyrosso 9/4/19
Printed Name and Title *Administrator* Date

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The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

The above plan of correction was approved by *JT*
(Initials)

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

185a - Implement Storage Procedures

Regulations

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 7/23/19, at 4:46 p.m., resident #2's glucometer was calibrated to 7/4/19 at 12:05 a.m.

Resident #3 was prescribed Lorazepam 1mg/0.5ml by mouth sublingually every 2 hours as needed for agitation/restlessness and Morphine 5mg/0.25ml by mouth sublingually every hour as needed for pain. However, on 7/23/19, neither of the medications were available in the home.

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.)

- Res # 2 - immediately GM was calibrated to reflect correct date + time
- all GM meters were put into individual cases to ensure resident specific use.
- Audits of all GM will be conducted by DON starting 9/1/19 and will continue bi-weekly x 6 months to ensure compliance and then monthly (see attached G)
- Results reported at QM mtg.

See page 8a of 10
1/17/20

Res # 3
(can't report)

Legal Entity Representative

Signature Paul Tancogne

Printed Name and Title Janet Torregrossa 9/4/19
Administrator Date

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

The above plan of correction is approved as of 1/17/20 (Date)

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

Plan of correction implementation status as of 1/17/20 (Date)

Fully Implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

185a - Implement Storage Procedures

Regulations

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 7/23/19, at 4:46 p.m., resident #2's glucometer was calibrated to 7/4/19 at 12:05 a.m.

Resident #3 was prescribed Lorazepam 1mg/0.5ml by mouth sublingually every 2 hours as needed for agitation/restlessness and Morphine 5mg/0.25ml by mouth sublingually every hour as needed for pain. However, on 7/23/19, neither of the medications were available in the home.

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.)

- Res #3 - call out to doctor for order changes on 7/24/19.
 - Resident medication was D/C'd as it was not needed
 - All hospice agencies were notified that medication is not to be ordered until necessary.
 - Cart audits by pharmacy and med-techs will ensure compliance.
 - results will be reported at am mtg.
- (see attached #)

Legal Entity Representative

Signature Janet Torregrosso

Printed Name and Title Janet Torregrosso 9/4/19
Administrator Date

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

The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

07/17/2019

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed Humalog 100u/ml-Kwikpen- before meals via sliding scale

70-140=0 units

141-180=1 unit

181-220=2 units

221-260=3 units

261-300=4 units

301-340=5 units

>340=6 units CALL MD

On 7/18/19, at 5:00 p.m., the resident's blood glucose reading was 300; however, the resident was administered 5 units instead of 4 units.

Repeat Violation: 4/26/19

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.)

- re-education & discipline with med-tech involved occurred (see attached F)
- a reportable incident was filed with DHS on 7/25/19.
- a mandatory med-tech mtg occurred 8/5/19 that covered proper documentation among other stuff (see attached J)

Legal Entity Representative

Within 30 days of receipt of these plans of correction, then at least monthly, the administrator or designated staff person will audit glucometers for all residents receiving insulin via sliding scale and compare to medication administration records to ensure that the correct units of insulin are being administered. Documentation will be kept.

Signature *[Handwritten Signature]*

[Handwritten Signature] 1/17/2020
Printed Name and Title *James Torregrosso Administrator* Date *9/4/19*

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

The above plan of correction is approved as of 1/17/2020
(Date)

Plan of correction implementation status as of 1/17/2020
(Date)

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

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

224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening, dated 5/28/19, does not include a determination that the needs of the resident can be met by the home. This section of the form is blank.

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.)

- Residents pre-screen was corrected on 8/28/19 to reflect the needs can be met.
 - Upon admission all pre-screens will be reviewed to ensure all areas are completed appropriately. This will be completed by the Administrator and/or designee.
 - All non-completion items will be corrected immediately to ensure compliance.
- (see attached 5)

Legal Entity Representative

Justin Tanegno
Signature

Janet Torregrosso 9/4/19.
Printed Name and Title Administrator Date

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

The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

Violation Report

Facility Information

Name: NORBERT RESIDENTIAL CARE FACILITY
Address: 2413 ST. NORBERT DRIVE,, PITTSBURGH, PA 15234
County: ALLEGHENY Region: WESTERN

License Number: 43051

Administrator

Name: JANET TORREGROSSO Phone: 4128855202 Email: HWALDMAN@WALDMANINC.COM

Legal Entity

Name: NORBERT INC
Address: 1326 FREEPORT ROAD, SUITE 100, PITTSBURGH, PA, 15238

Certificate(s) of Occupancy

Type: I-2 Date: Issued By:

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 118 Waking Staff: 89

Inspection

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

Inspection Dates and Department Representative

08/23/2019 - On-Site: Lisa Flinner-Alman, Karen Georgoulis, Amy Duncan
08/26/2019 - On-Site: Lisa Flinner-Alman, Karen Georgoulis, Amy Duncan
08/27/2019 - On-Site: Lisa Flinner-Alman, Karen Georgoulis, Amy Duncan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 102 Residents Served: 83

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 11

Number of Residents Who:

Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 82
Diagnosed with Mental Illness: 9 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 35 Have Physical Disability: 1

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 8/20/19, after lunch, resident #1 asked staff person A for pain medication. Staff person A told the resident that she could not give him a pill for two hours and took his left hand and dug her thumb into the palm of his hand and pounded on the top of his left hand with her right hand, saying, "I will show you two hours! I will show you pain!" Resident #1 yelled out in pain and told staff person A that it was painful and to stop. The resident's hand and wrist were red and swollen and could not make a fist, and required and x-ray and medication for the swelling.

REPEAT VIOLATION: 1/8/2019 et al, 8/8/18

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.)

- Immediately upon notification on 8/21/19 by hospice nurse the resident was interviewed by SON/Administrator
- Resident stated that he could identify the staff person she was working today. Resident identifies JAE A as the person.
- Staff person A immediately removed from building pending further investigation. → Emp terminated 8/21/19 @ 2:47 PM. (See attached A)

Legal Entity Representative

See page 2a of 18

1/17/20

(CONTINUED)

Janet Tomegrosso
Signature

Janet Tomegrosso Adm. 11/26/19
Printed Name and Title

Date

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The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

2600.42b.

- ACT 13 + reportable incident filed per regulation.
- ON 7/30/19 all staff were inserviced by outside agency - Protective Services. (see attached B)
- Resident interviews are conducted by Administrator monthly to ensure no harm is occurring.
- Results reported @ QM mtg.

Within 30 days of receipt of these plans of correction, then monthly thereafter, the administrator will interview 10 residents a month regarding care and treatment by the staff. Documentation of interviews will be kept.

[Signature] 1/17/20

11/26/19 *[Signature]*
Janet Torregrosso Administrator

57c - 2 Hours/Day

Regulations

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 7/28/19, the home served 84 residents, including 38 residents with mobility needs. Accordingly, on this date, the home was required to provide a minimum of 122 hours of personal care services; however only 97.5 hours of personal care services were provided.

On 8/19/19, the home served 81 residents, including 35 residents with mobility needs. Accordingly, on this date, the home was required to provide a minimum of 116 hours of personal care services; however only 96.5 hours of personal care services were provided.

On 8/20/19, the home served 80 residents, including 34 residents with mobility needs. Accordingly, on this date, the home was required to provide a minimum of 114 hours of personal care services; however only 92 hours of personal care services were provided.

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 reconsider. Attached are timeclock records to show lot hours for each day stated above.
- A worksheet for hours was developed to ensure compliance. This is also attached for each day.

See page 3a of 18

Legal Entity Representative

[Signature] 1/17/20

[Signature]
Signature

Janet Torregrosso / Administrator
Printed Name and Title
1/26/19 Date

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

The above plan of correction is approved as of 1/17/20
(Date)

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

Plan of correction implementation status as of 1/17/20
(Date)

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

2600.57c

- DON is responsible to ensure staffing hours are according to regulation and building census via schedule.
- DON/ADON - will fill in whenever staff is needed to meet hours when no staff are available.
- Since inspecting DON/ADON will be listed on schedule as they do not punch in.
- See attachments for each day:
 - a work sheet calculating hours needed and actual hours.
 - timeclock sheet with total hrs.

7/28/19 Attach "C"

8/19/19 Attach "D"

8/20/19 Attach "E"

The worksheet used to calculate staffing hours will be updated to reflect deductions for lunches and breaks as well as time spent doing ancillary duties if applicable. Only direct care hours will be considered. 1/17/20

Within 30 days of receipt of these plans of correction, all staff responsible for scheduling and ensuring appropriate staffing levels will be trained on properly calculating staffing hours. Documentation will be kept. 1/17/20

Janet Torregrosso 11/26/19
Janet Torregrosso / Administrator

57d - Waking Hours

Regulations

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

The home is required a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs, of which, 75% of these hours must be provided during waking hours. On the following dates, the home did not provide the minimum number of hours of personal care services:

On 7/28/19, there were 84 residents residing in the home, including 38 residents with mobility needs, requiring a total minimum of 91.5 direct care staffing during waking hours. On this day, only 76.5 hours of direct care staffing were provided during waking hours.

On 8/19/19, there were 81 residents residing in the home, including 35 residents with mobility needs, requiring a total minimum of 87 direct care staffing during waking hours. On this day, only 85.5 hours of direct care staffing were provided during waking hours.

On 8/20/19, there were 80 residents residing in the home, including 34 residents with mobility needs, requiring a total minimum of 85.5 direct care staffing during waking hours. On this day, only 57.5 hours of direct care staffing were provided during waking hours.

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 reconsider. Attached are time clock records to show tot. hrs for each day stated above.
- A work sheet for hours was developed to ensure compliance this is also attached for each day.

See 4a of 18

[Signature] 1/17/20

Legal Entity Representative

[Signature]
Signature

Janet Torregrosso / Adm. 11/26/19.
Printed Name and Title Date

2600.57d.

- DON IS responsible to ensure staffing hours are met according to regulation and body census using the schedule.
- DON/ADON will fill in whenever staff is needed to meet hours - when staff not available.
- SINCE inspection DON/ADON will be listed on schedule as they do not punch in.

See attachments for each day:

- a work sheet calculating hours needed and actual hours.
- time clock sheet with total hrs.

7/28/19 Attach "C"

8/19/19 Attach "D"

8/20/19 Attach "E"


The worksheet used to calculate staffing hours will be updated to reflect deductions for lunches and breaks as well as time spent doing ancillary duties if applicable. Only direct care hours will be considered. *[Signature]* 1/17/20

Within 30 days of receipt of these plans of correction, all staff responsible for scheduling and ensuring appropriate staffing levels will be trained on properly calculating staffing hours. Documentation will be kept. *[Signature]* 1/17/20

Janet Torregrosso 11/26/19
Janet Torregrosso / Administrator

57d - Waking Hours (continued)

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The above plan of correction was approved by	<u></u> (Initials)	<input type="checkbox"/> Fully Implemented	<input checked="" type="checkbox"/> Partially Implemented - Adequate Progress
		<input type="checkbox"/> Partially Implemented - Inadequate Progress	<input type="checkbox"/> Not Implemented

60a - Staff/Support Plan

Regulations

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's staffing schedule indicates that 4 staff persons work on the 11:00 p.m. – 7:00 a.m. shift. In the event of an emergency evacuation, the home's night staffing is inadequate to meet the needs of the residents for physical assistance and supervision. On 4/25/19, the home served 80 residents, 31 with mobility needs, 6 of whom require 2-person assistance in transferring, 4 of whom require assistance with a hoier lift. Also, 5 residents require assistance of 1 staff with the use of a sit-to-stand device.

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.)

- DON/ADON TO ensure staffing levels meet the needs not just based on required staffing hrs but also care needs.
- census decreased home last visit ↓ to 26 mobility needs
- Rehab depart. to conduct screens to ensure accuracy of transferring devices being used. To be completed by 12/31/19.
- consults to therapy for proper transferring devices with status change to ensure appropriate device is used.

Legal Entity Representative

DON/ADON TO review mobility needs daily to ensure proper staffing. Documentation will be kept. 1/17/20

Signature *[Handwritten Signature]*

Printed Name and Title James Torreygrosso 11/26/19
Date

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

The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

60c - Housekeeping/Maintenance

Regulations

2600.

60.c. Additional staff hours, or contractual hours, shall be provided as necessary to meet the laundry, food service, housekeeping and maintenance needs of the home.

Description of Violation

The home serves meals during the following times:

Breakfast: 8:30 a.m. – 9:30 a.m.

Lunch: 12:00 p.m. – 1:00 p.m.

Dinner: 4:30 p.m. – 5:15 p.m.

According to staff and resident interviews, residents are seated approximately a half hour prior to being served.

The home does not have dietary staff; therefore, direct care staff serve the meals. Staff interviews indicated there is not enough staff in the home to assist the residents during meal times. Multiple residents stated they wait so long for their meals, that they left without eating and did not eat until the next meal and staff take them to the dining room for breakfast at approximately 6:00 a.m. and they are not served for hours. On 8/23/19, at 11:22 a.m., inspectors observed multiple residents, including some residents that were sleeping at their tables in the dining room waiting for lunch. At 12:10 p.m., residents had still not been served lunch and the meal had not yet been put on plates.

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.)

- We have added DS. Staff to assist with meal delivery, bussing, dishwashing.
- Residents are served as seated.
- Residents are escorted to meals 15 mins prior to start time.
- Nursing staff assist with meal delivery when necessary.
- DS. Director ensured smooth operation and will seek help from Nursing when necessary.

Legal Entity Representative


The administrator or designated staff person will observe at least 1 meal a day for 30 days to ensure that the staffing is adequate to serve meals to the residents within reasonable time frames.

Signature Janet Torrey

Janet Torrey 1/17/20
 Printed Name and Title Administrator Date 11/26/19

60c - Housekeeping/Maintenance (continued)

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The above plan of correction was approved by	 (Initials)	<input type="checkbox"/> Fully Implemented	
		<input checked="" type="checkbox"/> Partially Implemented - Adequate Progress	
		<input type="checkbox"/> Partially Implemented - Inadequate Progress	
		<input type="checkbox"/> Not Implemented	

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/23/19, 8/26/19 and 8/27/19, there was a very pungent odor of urine on the 2nd floor.

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 care conference with son & resident took place and explained that resident should wear pull-ups to help control incontinence.
- Resident was non-compliant however. Since making she has maintained compliance.
- Housekeeping does daily checks of room to ensure compliance.
- Staff check resident during routine rounds to ensure clean & dry.

Legal Entity Representative

Signature

Janet Torregrosso

Printed Name and Title

Janet Torregrosso Adm. 11/26/19

Date

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The above plan of correction is approved as of

1/17/20

(Date)

Plan of correction implementation status as of

1/17/20

(Date)

The above plan of correction was approved by

JS
(Initials)

- 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

The 4th drawer from the top of resident #2's bedroom dresser was missing.

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.)

- Immediately upon notification drawer was inserted into dresser
- A maintenance request log has been initiated to insure prompt identification of necessary repairs. See attached "IF"
- Monthly audits are performed by maintenance director to ensure on going compliance and results reported at QM mtg.

Legal Entity Representative

James Torregrossa
Signature

James Torregrossa Adm 11/26/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/17/20 Plan of correction implementation status as of 1/17/20
(Date) (Date)

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

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

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 7/26/19 at 1:13 does not indicate a.m. or p.m.

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.)

- maintenance Director re-educated to include all areas on fire drill log. Time corrected by maintenance Director.
- log turned into Administrator monthly to ensure on-going compliance.
- log reflects am / pm currently. see attached "6"

Legal Entity Representative

[Signature]
Signature

Jane Torregrosso Adm 11/26/19.
Printed Name and Title Date

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

The above plan of correction is approved as of 1/17/20
(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

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

181c - Self-administration Assessment

Regulations

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2 self-administers medications, including eye drops and nasal spray. However, the resident's medical evaluation, dated 5/6/19, indicates resident #2 cannot self-administer medications. On 8/25/19, the resident told staff person B that she self-administered medication and may have put nasal spray into her eyes instead of eye drops. On 8/27/19, a prescription bottle of 44 Deep Sea 65% nasal spray and three packaged vials of Carboxymethylcellulose sodium 0.5% eye drops and two bottles of nasal spray with aloe, were stored in the resident's bedside table drawer.

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.)

- Verified with doctor resident is not to self-administer meds.
- Doctor made aware of possible mistake order to monitor since no way to verify it in fact nasal gels went into eye.
- Daughter & resident aware resident not able to self-administer and all medications were removed from room & placed in cart for staff to administer.

Legal Entity Representative - Currently in process of auditing all rooms to ensure on-going compliance to be completed by DON/med techs. by 12/31/19.

[Handwritten Signature]
Signature

Janet Torregrosso Adm 11/26/19.
Printed Name and Title Date

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The above plan of correction is approved as of 1/17/20 (Date) Plan of correction implementation status as of 1/17/20 (Date)

The above plan of correction was approved by [Signature] (Initials) Fully Implemented Partially Implemented - Adequate Progress Partially Implemented - Inadequate Progress Not Implemented

184a - Labeling OTC/CAM

Regulations

2600.

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

Description of Violation

Resident #3 is ordered Ondansetron HCL 4mg, 1 tablet every 8 hours as needed, however, the medication label indicates 1 tablet every 6 hours as needed.

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.)

- Immediately upon notification a direction changed sticker was applied to medication.
- order was re-ordered to pharmacy to ensure next delivery label would be correct
- Pharmacy conducted CART audits see attached "H"

Legal Entity Representative

- med techs will conduct CART audits monthly to ensure on-going compliance begins 11-27-19.
- results reported at QM mtg.

Frank Tanegmo
Signature

Jane Torregrossa / Adm 11/26/19.
Printed Name and Title Date

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

The above plan of correction is approved as of 1/17/2020
(Date)

Plan of correction implementation status as of 1/17/2020
(Date)

The above plan of correction was approved by *AT*
(Initials)

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

185a - Implement Storage Procedures

Regulations

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 8/27/19, resident #2's glucometer was not calibrated to the correct date and time.

Resident #4's glucometer indicates 539 on 8/20/19 at 5:00 p.m. However, the MAR indicates a blood glucose reading of 388 on this date and time.

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 med tech mta was held on 9-3-19 (see attached I) regarding glucometers, DIC meds, labels, etc...
- Glucose monitors initially done on 9/2/19 to ensure correct information. (see attached I)
- Monitors will then be done bi-weekly until end of year than monthly to ensure on-going compliance. (see attached I)
- results will be reviewed at QM mtg

Legal Entity Representative

Janet Tanegynuo
Signature

James Torregrosso Adm 11/26/19
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of 1/17/2020
(Date)

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

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

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is ordered Humalog 100u/MI Kwikpen, inject Humalog sliding scales sub-q three times daily (6:30am, 11:30am and 4:30pm) before meals as follows: 70-140=0u; 141-180=1u; 181-220=2u; 221-260=3u; 261-300=4u; 301-340=5u; greater than 340 give 6 units and call MD.

On 8/21/19 at 6:30 am, staff did not record the blood glucose reading, units of insulin administered or staff initials.

Resident #2 is ordered Serum Eye Drops, use in the left eye every 2 hours while awake. The August MAR indicated the medication was administered on 8/26/19 at 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m. However, staff person C, medication technician, indicated the eye drops were not administered.

Resident #5 is ordered Systane 0.6% Eye Drops, instill 1 drop into each eye 4 times daily; 9:00 a.m., 1:00 p.m., 5:00 p.m., 9:00 p.m. The August MAR indicates the drops were administered on 8/26/19, at 9:00 a.m. and 1:00 p.m. However, staff person C indicated the eye drops were not administered.

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.)

- Staff person C was re-educated to proper documentation and administration of medication.
- A medication observation was conducted on staff person C on 8/26/19. See attached "J"
- Glucometer and MAR audits are being conducted to ensure compliance. and results will be reported

Legal Entity Representative

at QM mtg

Signature: James Torregrossa

Printed Name and Title: James Torregrossa/Adm Date: 11/26/19

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Plan of correction implementation status as of 1/17/20 (Date)

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

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

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #2 is ordered Serum Eye Drops, use in the left eye every 2 hours while awake. The medication was not administered on 8/26/19, at 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m. Staff person C, medication technician, indicated the eye drops were not administered as the medication was not available in the home.

Resident #5 is ordered Systane 0.6% Eye Drops, instill 1 drop into each eye 4 times daily; 9:00 a.m., 1:00 p.m., 5:00 p.m., 9:00 p.m. The medication was not administered on 8/26/19 at 9:00 a.m. and 1:00 p.m. Staff person C indicated the eye drops were not administered because the resident was sleeping during these times.

Repeat Violation - 4/26/19

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.)

- Serum eye gtt's were not available as daughter took them from us. This was explained at survey. Due to the nature of the gtt's residents blood is used to make them a last scheduled appointment to do that.

- Staff person C was re-educated to proper documentation of medications and administration.

Legal Entity Representative

- a med observation was conducted see attached "J"
- MAA audits are conducted monthly & results reported at OM.

Janet Tanegrosso
Signature

Janet Torregrosso Adm 11/26/19.
Printed Name and Title Date

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 Fully Implemented
 Partially Implemented - Adequate Progress
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 Not Implemented

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

The assessment, dated 7/19/19, for resident #1 indicates the resident has no hearing needs, however, the resident has hearing loss and uses hearing aids. Also, the assessment does not include the diagnoses of wheezing, shortness of breath (SOB), depression and edema, as indicated on the medical evaluation, dated 7/19/19.

REPEAT VIOLATION: 9/13/2018 et al

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.)

- Resident's assessment was completed on 9/2/19 and reflects hearing loss + additional diagnosis, see attached "L".
- DON/ADON will ensure on-going compliance cross referencing medication list DME, and past hx if available to ensure all diagnosis are listed to ensure proper picture

Legal Entity Representative of resident.

- after completion of RASP it will be reviewed to ensure proper completion to maintain compliance.

Signature Christine Tanegno

Printed Name and Title Janet Torregrosso Date 11/26/19

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(Date)

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(Date)

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

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

RECEIVED

1/14/20

Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *NORBERT RESIDENTIAL CARE FACILITY*
Address: *2413 ST. NORBERT DRIVE, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

License Number: *43051*

Administrator

Name: *Janet Torregrosso* Phone: *4128855202* Email: *JTORREGROSSO@norbertpersonalcare.com*

Legal Entity

Name: *NORBERT INC*
Address: *1326 FREEPORT ROAD, SUITE 100, PITTSBURGH, PA, 15238*

Certificate(s) of Occupancy

Type: *I-2* Date: *03/09/2010* Issued By: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *103* Waking Staff: *77*

Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
Reason: *Renewal, Incident*

Inspection Dates and Department Representative

10/22/2019 - On-Site: Desmond Grace, Karen Georgoulis, Babara Barone

10/25/2019 - On-Site: Desmond Grace, Karen Georgoulis

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *102* Residents Served: *74*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *73*
Diagnosed with Mental Illness: *9* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *29* Have Physical Disability: *0*

15a - Resident Abuse Report

Regulations

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 10/19/19 at approximately 2:00 p.m., staff person A grabbed and pulled resident #1's hair at the nape of her neck causing the resident to yell out in pain after the resident used a racial slur. The staff person then stated, "I am not one of your street bitches" to the resident. This incident was observed by staff person B; however, the home did not report the incident to the Area Agency on Aging until 10/22/19.

Repeat Violation: 2/11/19

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.)

- 10/22/19 Administrator meet with staff A & B and removed them from schedule pending investigation.
 - DON filed ACT 134 reportable incident on 10/22/19.
 - Administrator terminated staff A & B on 10/23/19 Survivors notified on 10/25/19.
 - Abuse training was held on 1-8-20 by Protective services & Administrator (see attached record "A")
 - Administrator will conduct 2 state & 2 resident interviews begin 1/14/20 and continue on going to ensure compliance
- Records will be retained by administrator and reviewed at quarterly QM mtg in April.

Legal Entity Representative

Janet Tanegrosso
Signature

Janet Tanegrosso Administrator
Printed Name and Title

Date 1/13/2020

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(Date)

Plan of correction implementation status as of 1/17/20
(Date)

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

Fully Implemented
 Not Implemented

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/19/19 at approximately 2:00 p.m., staff person A grabbed and pulled resident #1's hair at the nape of her neck causing the resident to yell out in pain after the resident used a racial slur. The staff person then stated, "I am not one of your street bitches" to the resident. This incident was observed by staff person B; however, the home did not report the incident to the Department until 10/22/19.

Repeat Violation: 2/11/19, 9/13/18

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 10/22/19 after notification Administrator met a staff and removed from schedule pending investigation.
- DON filed ACT 13 + reportable incident on 10/22/19
- On 10/23/19 both staff were terminated + DHS superior ordered 10/25/19
- Staff training by protective services + Administrator was held on 1/8/20 (see attached training record "A")
- Administrator and/or designee will conduct 2 staff interviews and 2 resident interviews monthly beginning 1/14/20 and on-going results will be maintained by Administrator and reviewed during quarterly QM mtg in April

Legal Entity Representative

[Handwritten Signature]
Signature

Janet Torregrosso Administrator
Printed Name and Title
1/13/2020 Date

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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

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. On 10/22/19, the following carbon monoxide detectors were installed within 15 feet of fossil-fuel burning devices or appliances:

*The carbon monoxide detector in the main laundry room was approximately 1'-2' feet from the first gas burning clothes dryer when entering the room.

*The carbon monoxide detector in utility room 3A was installed on the ceiling approximately 3'-4' from 2 gas burning furnaces and 2 gas burning water heaters.

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 1/13/2020 Firefighters Sales & Service and Administrator met to develop plan for re-installation of CO detectors according to DHS regulation. Repairs to be completed by 1/30/2020 (see attached "B")
- CO detectors monitored yearly for proper function by fire fighters sales & service (see attached)
- all monitors are hardwired to our 24/7 monitor system and any malfunctions are called out to proper emergency response team to ensure on-going safety.

Legal Entity Representative

James Tanevino
Signature

James Tanevino Administrator
Printed Name and Title
1/13/2020 Date

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 Not Implemented

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 10/19/19 at approximately 2:00 p.m., staff person A grabbed and pulled resident #1's hair at the nape of her neck causing the resident to yell out in pain after the resident used a racial slur. The staff person then stated, "I am not one of your street bitches" to the resident.

Repeat Violation: 1/8/19, 8/8/18

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 10/22/19 after notification Administrator met c staff and removed from schedule pending investigation.
- DON filed AIT 13 & reportable incident on 10/22/19.
- Both staff were terminated on 10/23/19 and supervisor advised 10/25/19
- Staff training by protective service & Administrator was held on 1/8/20 (see attached training record "A")
- Administrator and/or designee will conduct 2 staff interviews and 2 resident interviews monthly beginning 1/14/20 and continue monthly on-going. Result of interview will be maintained by Administrator and reviewed during Quarterly QM Mtg in April. (see attached "c")

Legal Entity Representative

Within 30 days of receipt of these plans of correction, then monthly thereafter, the administrator will interview 10 residents a month regarding care and treatment by the staff. Documentation of interviews will be kept. *JT* 1/17/20

Janet Torregrossa
Signature

Janet Torregrossa Administrator
Printed Name and Title
1/13/2020 Date

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Fully Implemented
 Not Implemented

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/22/19 at 10:30 a.m., resident #2's private bathroom did not have hand towels, paper towels or other sanitary means for the resident to dry his hands.

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.)

- 10/22/19 Administrator directed Med-techs to restock resident 2's BR with towels.
- Staff education regarding linen replacement conducted by DON and charge nurse on 11/19/19 (see attached training record.)
- All resident rooms were equipped with automatic paper towel dispensers. Work was completed by 11/29/19. (see attached D)
- On 1/10/20 housekeeping checklist developed by Administrator to be completed by housekeepers daily according to cleaning schedule and turned into HSKO Director for review sign off.
- Checklist to be turned into Administrator monthly for retention & review.

Legal Entity Representative

- Daily checklist implementers x 3 months to ensure ongoing compliance begin 1-14-20 then PRN.

James Tanegno
Signature

James Torregrosso Administrator
Printed Name and Title
1/13/2020 Date

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85d - Trash Receptacles

Regulations

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

On 10/22/19 at 2:35 p.m., there was a 1/2 full uncovered trash receptacle in the large shower room across from room #213. The trash receptacle gave off a very strong smell of urine and contained briefs, toilet paper and gloves.

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 10/22/19 after notification Hskp Director emptied trash can and replaced lid.
- Staff training was conducted by Charge Nurse + DON on 12/9/19. (see attached E)
- Administrator developed checklist for housekeepers to complete daily (in conjunction with cleaning schedule) starting 1/14/20 and continue on-going x 3 months *from PRS*
- Hskp Director to collect checklist daily & review for proper completion and sign off.
- Checklist to be turned into Administrator monthly by Hskp Director and results reported at quarterly QM mtg April.

Legal Entity Representative

James Torregrosso
Signature

James Torregrosso Administrator
Printed Name and Title
1/13/2020 Date

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92 - Windows

Regulations

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 10/22/19, multiple windows in the home did not have screens in then to include the following:

- *The window in stairwell A by model room 105
- *Two windows in the 4th floor common area
- *The window in the hallway next to room 326
- *Two windows in the B-side 3rd floor community room.

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 12/18/19 maintenance Director measured all windows & placed order for screens.
- Order picked up on 1/10/2020 and screens inserted by maintenance Director. (see attached F)
- Administrator developed a preventative maintenance checklist on 1/10/20 (see attached).
- Maintenance Director to complete checklist starting wed 1/15/2020 and monthly thereafter.
- Administrator to review with maintenance Director upon completion and sign off. Records to be maintained by Administrator

Legal Entity Representative

James Torregrossa
Signature

James Torregrossa Administrator
1/13/2020 Date

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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 10/22/19 at 11:00 a.m., the water in the urinal in the men's bathroom on the 4th floor continuously ran for approximately 10 minutes after flushing.

On 10/22/19 at 12:30 p.m., the sink in the 3rd common bathroom next to room 313 pulled away from the wall approximately 3/4" to 1" allowing the sink to move up and down loosely. There were also 3 screws loose at the top of the vertical grab bar located next to the toilet which allowed approximately 1/4" of movement when used.

Plan of Correction (POC)

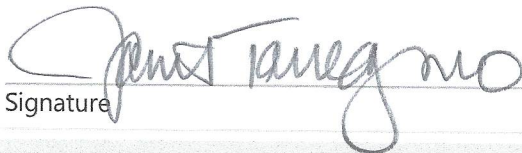
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- On 10/22/19 Maintenance Director turned off H2O to urinal & placed out of order sign. A call was then placed to obtain necessary part for repair.
- Repair was completed by maintenance Director 11/4/19.
- Maintenance Director will complete preventative maintenance checklist monthly beginning 1/15/2020 (see attached 6)
- Administrator will review monthly with Maintenance Director upon completion and sign off. Records to be maintained by Administrator.

See page 9a of 18 1/17/20

(CONTINUED)

Legal Entity Representative



Signature

James Torregrosso Administrator
Printed Name and Title 1/13/2020 Date

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2600.95 (amt from pg 9)

- On 10/23/19. Maintenance Director performed a temporary fix and chocked sink at the wall.
- On 12/18/19 New maintenance Director placed work order for sink repair with vendor Mitchell Plumbing & heating.
- All repairs will be completed by Mitchell plumbing & heating and complete by 1/20/2020. (see attached H)
- Maintenance Director will complete preventative maintenance checklist monthly beginning 1/15/2020
- Administrator will review with maintenance Director upon completion and sign off. Records will be maintained by Administrator and reviewed at quarterly QM mtg.

James Tanegmas

James Torregrossa
Administrator
1/13/2020.

102i - Soap Dispenser

Regulations

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 10/22/19 at 10:45 a.m., there was an unlabeled, used bar of soap on the right side of the sink in the common bathroom next to resident bedroom #423.

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.)

- 10/22/19 Bar of soap removed & discarded by DON.
- On 11/19/19 staff training was conducted by DON & ch. nurse. (see attached)
- Resident & Family notification of proper storage & labeling of personal hygiene products will be completed by 1/31/2020 by DON.
- Housekeeping checklist to be completed daily beginning 1/14/2020 and continue on-going x 3 months then PRN.
- Housekeeping director responsible to collect daily review & sign off.
- Checklist to be turned into Administrator monthly for retention & review results reported quarterly at QM mtg.

Legal Entity Representative

James Torregrosso
Signature

James Torregrosso Administrator
Printed Name and Title
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10/22/2019

103d - Storing Food Off Floor

Regulations

2600.

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

Description of Violation

On 10/22/19 at 12:15 p.m., there were 6 containers including 3 gallons of water each, stored on the floor in the small closet on the 3rd floor, next to bedroom 325.

On 10/22/19 at 2:30 p.m., there were 2 containers including 3 gallons of water each, stored on the floor in the small closet on the 2nd floor.

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 10/23/19 Administrator & Maintenance Director rearranged both closets and stored containers off floor. (see attached photo)
- A meeting with H2O company delivery person & Administrator took place on 11/5/19 to review placement and compliance.
- Delivery person upon delivery ^{monthly} will store H2O off floor. In the event he is unable to do he will seek out Norbert Administrative Assistant to assist with proper placement.
- Activity Director will complete ^{monthly} audit X 3, begin 1/15/2020 and hand in to Administrator for retention & review. (see attached I)

Legal Entity Representative

[Signature]
Signature

Janet Torregrosso Administrator
Printed Name and Title
1/13/2020 Date

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161d - Dietary Needs

Regulations

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #3's medical evaluation, dated 8/30/19, indicated that the resident's meals should be easy to chew with thin lines cut into small pieces or soft meats and no crunchy food. However, on 10/22/19 at 12:15 p.m., resident #3 was served a plate of uncut spaghetti with 2 whole meatballs, a piece of Texas toast, mixed vegetables and a side salad.

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.)

- 10/23/19 DS Director & DON reviewed all resident diet orders to ensure accuracy.
 - A Diet list was printed 10/23/19 and hung in the kitchen for staff review to ensure on-going compliance.
 - DS Director completed staff training on 10/23/19 (see attached training record "5")
 - Charge Nurse will perform monthly review of resident diets for accuracy and make all necessary corrections beginning 1/23/20 upon completion will turn into DON.
 - DON and DS Director to review & sign off monthly.
- Legal Entity Representative - Administrator to maintain records.

James Tanegno
Signature

James Torregrosso Administrator
Printed Name and Title
1/13/2020 Date

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- Not Implemented

183b - Meds and Syringes Locked

Regulations

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 10/22/19 at 2:30 p.m., a 1/2 full 144 count box of individual packets of A & D ointment and a 3/4 full 144 count box of individual packets of triple antibiotic ointment were unlocked, unattended and accessible in the large closet on the 2nd floor.

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.)

- 10/22/19 after notification charge nurse was called to lock cupboard.
- 10/23/19 Don met with Nurse from Anova hospice to educate her on regulation and expectations of Norbert.
- A sign was posted on cupboard door by Administrator on 1/10/2020 to ensure on-going compliance.
- Anova representative + Don + Administrator to meet on 1/7/2020 @ 2pm. Mtg rescheduled for 1/28/2020 to discuss removal of their supplies from cupboard to ensure ongoing compliance.
- Cupboard to be emptied by 2/15/2020.

Legal Entity Representative

James Tomregrosso
Signature

James Tomregrosso Administrator
Printed Name and Title
1/13/2020 Date

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 Not Implemented

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 10/22/19 at 11:20 a.m., resident #4's Mirtazapine 15mg was in the home's medication cart; however, the medication was discontinued on 9/4/19.

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 10/22/19 Medication was removed from cart immediately upon discovery by med-tech.
- A med cart audit was performed on 12-6-19 by our pharmacy and deficiencies were immediately corrected by DON/ADON on 12-6-19.
- A med-tech performed audit on 12-14-19 to ensure on-going compliance and will complete weekly on Thursdays on-going.
- A pharmacy rep will perform Audit of carts every 2nd month of the quarter starting Feb 12, May 13, Aug 12, and Nov 11 2020 to ensure on-going compliance.
- Med tech will audit carts weekly on Thursdays
- Administrator to retain records & review at quarterly QM mtg in April

Legal Entity Representative

James Tanegrosso
Signature

James Tanegrosso Administrator
Printed Name and Title
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10/22/2019

184b - Resident's Meds Labeled

Regulations

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 10/22/19 at approximately 3:45 p.m., resident #5's kitchenette counter and bedside table contained multiple medications that were not labeled with the resident's name to include: 2 tubes of barrier cream, Systane eye drops, 2 bottles of antacid tablets, 8fl oz. of Equate Tussin CF, and a 5fl oz. bottle of Equate Cough DM.

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 10/22/19 DON & resident met to review proper storage & labeling. Medications were stored in lock box and unlabeled medication discarded.
- On 10/23/19 Administrator provided room key to resident reminding him to lock door when room unattended.
- Family & resident notification by DON to be completed by 1/31/2020 to ensure on-going compliance.
- ADON will perform monthly audits of rooms begin 1/14/20 to ensure on-going compliance x 3 months - then quarterly x 2. (See attached K)
- Tool to be reviewed by DONs and signed off, then given to Administrator for retention of record and

Legal Entity Representative

- results at quarterly QM mtg in April.

James Tarregrosso
Signature

James Tarregrosso Administrator
Printed Name and Title 1/13/2020 Date

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Fully Implemented
 Not Implemented

225c - Additional Assessment

Regulations

2600.

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

Description of Violation

Resident #3's most recent assessment, dated 8/30/19, does not include the diagnosis of major neurocognitive disorder as indicated on the resident's 8/30/19 medical evaluation.

Resident #6's most recent assessment, dated 1/2/19, states that the resident is independent with mobility and has a steady gait. However, multiple staff interviews indicated that the resident had an unsteady gait due to dizziness requiring assistance from staff to prevent the resident from falling.

Repeat Violation - 9/13/18

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 10/26/19 DON contacted technical support for computer program to ascertain why DX didn't print but was available when viewing on computer. TS educated DON to ensure on-going compliance.
- On 10/26/19 DX was added to current assessment. (see attached)
- DON and/or ANON to audit RASP and DME monthly. Beginning Jan. 2020 x 6, then quarterly to ensure on-going compliance. (see attached)
- Resident #6 has since passed. However DON/ANON will update RASP as events occur. The above audits will ensure on-going compliance.

Legal Entity Representative

- Results of audits to administrator for retention & review at quarterly @m mta in April

Signature *James Torregrosso*

Printed Name and Title *James Torregrosso Administrator*
Date *1/13/2020*

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 Not Implemented

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Staff person C, participated in the development of resident #5's support plan, dated 10/18/19; however, the staff person did not sign the support plan.

Staff person D, participated in the development of resident #7's support plan, dated 3/3/19; however, the staff person did not sign the support plan.

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.)

- 10/22/19 Staff C reviewed & signed support plan of resident #5. (See attached M.)
- 10/23/19 Staff C reviewed residents # 7 support plan & approved and signed off. Staff D no longer works @ facility.
- A monthly RASP audit is performed by DON and/or ASOJ beginning in Jan 2020 to the quarterly to ensure on-going compliance.
- Results of audit to Administrator for retention & review @ Quarterly QM mtg in April.

Legal Entity Representative


Signature

James Torregrosso Administrator
Printed Name and Title
1/13/2020 Date

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(Date)

Plan of correction implementation status as of

1/17/20
(Date)

The above plan of correction was approved by


(Initials)

- Fully Implemented
- Not Implemented

251b - Record Entries Legible

Regulations

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident #5's record contains a resident intake/discharge form with white-out fluid covering the resident's date of birth and resident #5's date of birth written over it.

Resident #7's record contained a Veteran affairs addendum with white-out fluid in the section for the resident's room rate and the amount of \$3225 written over it.

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 10/25/19 All Administrative staff educated to proper correction method of legal document during exit interview by lead inspector.
- On 1/13/2020 an Administrative staff training regarding new company policy on how to correct error. (see attached N)
- All white out was removed and Administrative Assistant no longer order
- Administrator who did infraction no longer employed here.

[Signature]
Signature

James Torregrosso 1/13/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 1/17/20 Plan of correction implementation status as of 1/17/20
(Date) (Date)

The above plan of correction was approved by [Initials] Fully Implemented
(Initials) Not Implemented