

Department of Human Services
Bureau of Human Service Licensing

May 23, 2022

[REDACTED]
BCB HOLDINGS FUND
[REDACTED]
[REDACTED]

RE: VICTORIA MANOR PERSONAL CARE
HOME
100 ROSE COURT
OAKDALE, PA, 15071
LICENSE/COC#: 44642

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 03/30/2022 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Larry Mazza

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *VICTORIA MANOR PERSONAL CARE HOME* License #: *44642* License Expiration: *09/29/2022*
Address: *100 ROSE COURT, OAKDALE, PA 15071*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7246938336* Email: [REDACTED]

Legal Entity

Name: *BCB HOLDINGS FUND*
Address: *3925 PALISADES DRIVE, WEIRTON, WV, 26062*
Phone: *7246938325* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/17/1977* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *25* Waking Staff: *19*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *03/30/2022*

Inspection Dates and Department Representative

03/30/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* Residents Served: *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *23*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *2* Have Physical Disability: *0*

Inspections / Reviews

03/30/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/13/2022*

Inspections / Reviews (*continued*)

05/16/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *05/20/2022*

05/23/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *06/23/2022*

141a - Medical Evaluation

1. Requirements

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.

Description of Violation

Resident #1's medical evaluation, dated [REDACTED] indicates, "see attached" in the medication addendum section; however, nothing is attached to the resident's medical evaluation. Resident #1 is prescribed multiple medications, to include Atorvastatin 80-mg tablets and Eliquis-5 mg tablets.

Plan of Correction

Directed

A new DME was completed and signed along with a medication list on [REDACTED] by the doctors(attached). The old DME we received the medication list but it was not signed off on.

All residents DME's will be audited by June 7th and anyone one that does not have a DME with a med list signed off on with the same date as the DME will have a new DME completed. The doctor comes to the building Every Tuesday and will see any resident that does not have one that is correct.

A new admission checklist was created (will be attached) to ensure a medical evaluation is completed for each residents 60 days prior to admission or within 30 days after admission. And that the medication list is completed. This will be completed by the Administrator or designee upon admission of each residents. (DIRECTED: A copy of the new admission checklist shall be kept in each resident's record. LM 5/23/22).

Completion Date: 06/07/2022

183e - Storing Medications

1. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #1's bottles of Novolog 100u/ml and Lantus 100 u/ml were open and undated in the home. According to the manufacturer's instructions for the medications, they are to be discarded 28 days after opening.

Plan of Correction

Accept

The insulin bottle was not dated this was a Med tech oversight. A new Lantus and Novolog ordered and a date was put on the bottles. The insulin bottle was dated for 3/30/22.

A training with all Med techs was on 5/9/22.

Moving forward a cart audit will be completed twice a week and signed off by the Med tech and the Administrator or designee will do a med cart audit to ensure all Medications are stored correctly. The cart audits began on 5/17/22 by the med tech. The Med techs will be doing full audits making sure the MAR matches the Medication in the Cart, that everything is in the cart and if a medication had 7 days of a medication it will be ordered, that everything is signed and dated, and that the MAR is signed off properly.

The documentation of the training on 5/9/22 will be kept in the training binder. This training went over all the errors on the POC and glucometer issues, signatures on MAR's.

Completion Date: 05/17/2022

185a - Implement Storage Procedures

1. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed blood sugar checks 3 times daily. On 3/20/22 at approximately 5:00 PM, resident #1's blood sugar was 345; however, was documented on resident #1's March 2022 medication administration record (MAR) at 357.

Plan of Correction**Directed**

There was an error when documenting the blood sugar. This was corrected by the Med tech immediately.

There was a training on 5/9/22 with all Med techs and we will be doing a training with the Person in charge of our Medication training [REDACTED] is an outside resource. This will be set up in the next 30 days.

And moving forward the administrator or designee will check off daily that all glucometers match documentations. This will be signed off by the Administrator or designee. (DIRECTED: The administrator/designee checks shall begin within 72 hours of receipt of the plan of correction. LM 5/23/22).

The documentation of the training on 5/9/22 will be kept in the training binder. This training went over all the errors on the POC and glucometer issues.

The documentation of the training by the training coordinator scheduled for June 1st 2022 will also be kept in the training binder with each staff signing off.

This training will include a medication refresher that highlights the key teaching points in medication training. The trainer will give us a copy to keep in our binder of all talking points. Example glucometers, signing off on MAR's, medication administration signing off on medications when given and documentation of resident medication when a resident is not present in the home. This is the [REDACTED] who trains our staff in medication administration. [REDACTED] sent [REDACTED] a copy of the POC to ensure [REDACTED] hits on all the issues and errors. Along with all important medication administration issues.

Completion Date: 06/01/2022

187a - Medication Record**1. Requirements**

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

187a - Medication Record (continued)

Description of Violation

Resident #1 is prescribed Nitroglycerine 0.4 mg-Place 1 tablet under tongue as directed as needed for chest pain; however, this medication is not present on resident #1's March 2022 MAR.

Resident #1 is prescribed Novolog 100 u/ml-Inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units. Resident # 1's March 2022 MAR does not include the amount of insulin administered to the resident on numerous occasions, to include the following:

- At 8:00 AM on 3/7/22, 3/8/22, 3/15/22 and 3/20/22 through 3/22/22

Resident #1 is prescribed Novolog 100 u/ml – Inject 10 units subcutaneously 3 times daily before meals; however, the amount of insulin that was administered was incorrectly documented on resident #1's March 2022 MAR on numerous occasions, to include the following:

<u>Date & Time</u>	<u>Dosage recorded (in units)</u>
• 3/2/22 at 5:00 PM	4
• 3/7/22 at 8:00 AM	3
• 3/7/22 at 12:00 PM	3
• 3/12/22 at 5:00 PM	3
• 3/13/22 at 5:00 PM	4
• 3/21/22 at 12:00 PM	4

Resident #1 is prescribed Novolog 100 u/ml-Inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units; however, the amount of insulin that was administered was incorrectly documented on resident #1's March 2022 MAR on numerous occasions, to include the following:

<u>Date & Time</u>	<u>Blood sugar reading</u>	<u>Dosage administered (in units)</u>	<u>Dosage recorded (in units)</u>
• 3/2/22 at 5:00 PM	287	4	10
• 3/12/22 at 5:00 PM	188	3	10
• 3/13/22 at 5:00 PM	243	4	10
• 3/21/22 at 12:00 PM	286	4	10

Plan of Correction**Accept**

The doctor was immediately notified to look at all the orders and correct the Verbiage to ensure the pharmacy is writing it correctly on the MAR and that the MAR and the script is the same. All orders were written and correct by both the MD and the pharmacy. The resident has agreed to use the homes doctors to make this medication orders easier and more clear. Instead of an outside DR. who doesn't understand Personal Care Home.

The residents Nitroglycerin was added to the MAR on 4/4/22.

All Med tech staff were all giving a medication training on 5/9/22. And a training is being scheduled for the [REDACTED] who does our Medication Administration training out side of the home. This will be done in next few weeks. The documentation of the training on 5/9/22 will be kept in the training binder. This training went over all the errors on the POC and glucometer issues. The documentation of the training by the training coordinator scheduled for June 1st 2022 will also be kept in the training binder with each staff signing off. This training will include a medication refresher that highlights the key teaching points in medication training. The trainer will give us a copy to keep in

187a - Medication Record (continued)

our binder of all talking points. Example glucometers, signing off on MAR's, medication administration. This is the [redacted] who trains our staff in medication administration. [redacted] sent [redacted] a copy of the POC to ensure [redacted] hits on all the issues and errors.

Moving forward a cart audit will be completed twice a week and signed off by the Med tech and the Administrator or designee will do a med cart audit to ensure the MAR and medications are following the Doctors orders. The new doctors will check weekly to ensure that all orders are correct on the MAR

An initial cart audit was completed on 4/10/22 to ensure all prescribed medication are present on the MAR. The physician check all residents 1's meds on 4/1 to ensure all orders were correct and everything was ordered.

A full cart audit of all residents will be completed twice a week. This started on 5/17/22 by med techs.

The Administrator or designee will do a cart audit twice a week and will audit a minimum of 5 residents an audit.

The audit will include that the MAR and Medication in the cart match and that the staff have signed off on all medications. documentation will be kept on each audit. This audit will start on 5/20.22.

Completion Date: 05/20/2022

16c - Written Incident Report

1. Requirements

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

The home did not report the following medication errors involving resident #1 to the Department:

Resident #1 is prescribed Novolog 100 u/ml-Inject 10 units subcutaneously 3 times daily before meals. From 3/22/22 at 12:00 PM through 3/23/22 at 12:00 PM, no insulin was administered to resident #1, because insulin syringes were unavailable.

Resident #1 is prescribed Novolog 100 u/ml-Inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units. From 3/22/22 at 12:00 PM through 3/23/22 at 12:00 PM, no insulin was administered to resident #1, because insulin syringes were unavailable. Resident #1 should have been administered Novolog on the following dates/times in accordance with resident #1's sliding scale:

Date and Time	Blood sugar reading	Units required
3/22/22 12:00 PM	350	6
3/22/22 5:00 PM	322	6
3/23/22 8:00 AM	333	6
3/23/22 12:00 PM	320	6

Resident #1 is prescribed Lantus 100 units/ml – Inject 48 units subcutaneously twice daily. On 3/22/22 at 8:00 PM and on 3/23/22 at 8:00 AM, no insulin was administered to resident #1, because insulin syringes were unavailable.

16c - Written Incident Report (continued)

Resident #1 is prescribed Novolog 100 u/ml-inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units. According to resident #1's March 2022 MAR, resident #1's blood sugar was 357 on 3/20/22 at 5:00 PM, and 8 units of insulin were administered. However, according to resident #1's glucometer, the resident's blood sugar was 345 on 3/20/22 at 5:00 PM, and 6 units of insulin should have been administered.

REPEAT VIOLATION: 9/9/2021

Plan of Correction**Directed**

The new administrator is still learning all the regulations and did not realize this had to be sent to the state. The New administrator will have a training in the next 30 days with the Medication Trainer to ensure she understands all the Medication regulations and [REDACTED] will study the RCG to ensure [REDACTED] understands all reportable issues. (DIRECTED: Documentation of the education shall be kept. LM 5/23/22)

And the administrator or designee will ensure all incident reports are checked weekly to ensure that no incident goes unreported.

The cited incidents for resident # 1 all four incidents were written up and sent to the state on 5/17/2022. (will be attached).

The staff all received a training on 5/18/22 on reportable incidents. What they are and how to fill them out. The training was signed off by the staff and will be kept in the training binder. (will be attached).

Moving forward the administrator or designee will do cart audits twice a week auditing a minimum of 5 residents and sign off that there are no errors and if there is an error it will be reported. This will start on 5/20/22. Staff were trained in the training about med errors and what is to be reported to the state and how to fill out and fax a reportable incident. If there is a med error it will be reported to the administrator immediately. (check list will be kept to ensure there are no med errors and if there is a med error it will be immediately reported. Once the administrator is notified that there is a medication error it will be reported to the state within 24 hours.

DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall review all internal incidents and conditions daily to ensure all incidents and conditions specified in 2600.16a are reported to the Department within 24 hours. LM 5/23/22

Completion Date: 05/20/2022

187b - Date/Time of Medication Admin.**1. Requirements**

2600.

187b - Date/Time of Medication Admin. (continued)

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

Description of Violation

Resident #1 is prescribed Novolog 100 u/ml-Inject 10 units subcutaneously 3 times daily before meals, as well as Novolog 100 u/ml-inject subcutaneously 3 times daily before meals in accordance with sliding scale.

On 3/21/22 at 5:00 PM, resident #1 was not in the facility; however, resident #1's March 2022 MAR indicates the resident's blood sugar was 286 and that 4 units of Novolog was administered to the resident, as well as the 10 units of Novolog.

Resident #1 is prescribed Amlodipine 10 mg tablet-Take 1 tablet by mouth daily; however, resident #1's March 2022 MAR does not include the initials of the staff person who administered the Amlodipine on 3/7/22 at 8:00 AM.

Resident #1 is prescribed Hydroxyzine HCL 50 mg tablet-Take 1 tablet by mouth 3 times daily; however, resident #1's March 2022 MAR does not include the initials of the staff person who administered the Hydroxyzine on 3/4/22 and 3/18/22 at 2:00 PM.

Resident #1 is prescribed Lisinopril 20 mg tablet-Take 1 tablet by mouth daily; however, resident #1's March 2022 MAR does not include the initials of the staff person who administered the Lisinopril on 3/7/22 at 8:00 AM.

Resident #1 is prescribed Metformin ER 500 mg tablet-Take 3 tablets by mouth twice daily; however, resident #1's March 2022 MAR does not include the initials of the staff person who administered the Metformin on 3/7/22 at 8:00 AM.

Resident #1 is prescribed Mupirocin 2% Ointment-Apply topically to bilateral heels 3 times daily; however, resident #1's March 2022 MAR does not include the initials of the staff person who administered the Mupirocin on 3/4/22 and 3/18/22 at 2:00 PM.

Resident #1 is prescribed Novolog 100 u/ml-Inject 10 units subcutaneously 3 times daily before meals; however, resident #1's March 2022 MAR does not include the initials of the staff person who administered the Novolog on 3/8/22 and 3/15/22 at 8:00 AM.

Resident #1 is prescribed Novolog 100 u/ml-Inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units; however, resident # 1's March 2022 MAR does not include the initials of the staff person who administered the Novolog on 3/7/22, 3/8/22 and 3/15/22 at 8:00 AM.

REPEAT VIOLATION: 4/16/2021

187b - Date/Time of Medication Admin. (continued)

Plan of Correction**Accept**

Med pass was not signed off on. That staff member is no longer on the Med cart.

All Med tech staff were all giving a medication training on 5/9/22. And a training is being scheduled for [REDACTED] who does our Medication Administration training out side of the home. This will be done in next few weeks. The documentation of the training on 5/9/22 will be kept in the training binder. This training went over all the errors on the POC and glucometer issues. The documentation of the training by the training coordinator scheduled for June 1st 2022 will also be kept in the training binder with each staff signing off.

This training will include a medication refresher that highlights the key teaching points in medication training. The trainer will give us a copy to keep in our binder of all talking points. Example glucometers, signing off on MAR's, medication administration, signing off on medications when given and documentation of resident medication when a resident is not present in the home. . This is the [REDACTED] who trains our staff in medication administration. [REDACTED] sent [REDACTED] copy of the POC to ensure [REDACTED] hits on all the issues and errors

Moving forward a cart audit will be completed twice a week and signed off by the Med tech and the Administrator or designee will do a med cart audit to ensure the MAR and medications are following the Doctors orders and everything medication is initialed. The new doctors will check weekly to ensure that all orders are correct on the MAR. A full cart audit was completed on 4/10/22 after the state left to ensure everything was corrected and the doctor went over all residents and the errors to correct the issues from POC. This was completed On 4/1/22. A full cart audit of all residents will be completed twice a week. This started on 5/17/22 by med techs.

The Administrator or designee will do a cart audit twice a week and will audit a minimum of 5 residents an audit. The audit will include that the MAR and Medication in the cart match and that the staff have signed off on all medications. documentation will be kept on each audit. This audit will start on 5/20.22.

Completion Date: 05/20/2022

187d - Follow Prescriber's Orders

1. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed Novolog 100 u/ml-Inject 10 units subcutaneously 3 times daily before meals. From 3/22/22 at 12:00 PM through 3/23/22 at 12:00 PM, no insulin was administered to resident #1, because insulin syringes were unavailable.

Resident #1 is prescribed Novolog 100 u/ml-Inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units. From 3/22/22 at 12:00 PM through 3/23/22 at 12:00 PM, no insulin was administered to resident #1, because insulin syringes were unavailable. Resident #1 should have been administered Novolog on the following dates/times in accordance with resident #1's sliding scale:

<u>Date and Time</u>	<u>Blood sugar reading</u>	<u>Units required</u>
• 3/22/22 12:00 PM	350	6
• 3/22/22 5:00 PM	322	6
• 3/23/22 8:00 AM	333	6
• 3/23/22 12:00 PM	320	6

187d - Follow Prescriber's Orders (continued)

Resident #1 is prescribed Lantus 100 units/ml – Inject 48 units subcutaneously twice daily. On 3/22/22 at 8:00 PM and on 3/23/22 at 8:00 AM, no insulin was administered to resident #1, because insulin syringes were unavailable.

Resident #1 is prescribed Novolog 100 u/ml-inject subcutaneously 3 times daily before meals in accordance with the following sliding scale: 140-180=2 units; 181-240=3 units; 241-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units. According to resident #1's March 2022 MAR, resident #1's blood sugar was 357 on 3/20/22 at 5:00 PM, and 8 units of insulin were administered. However, according to resident #1's glucometer, the resident's blood sugar was 345 on 3/20/22 at 5:00 PM, and 6 units of insulin should have been administered.

REPEAT VIOLATION: 1/25/2021

Plan of Correction**Accept**

We had no syringes we ordered them two weeks prior to [REDACTED] running out. We offered to go out and buy them but [REDACTED] said [REDACTED] was not paying for them. The resident was told on [REDACTED] that if we do not have the proper medications in the building we will use our pharmacy regardless if [REDACTED] has to pay or not. We sent [REDACTED] to the E.R so that he could get proper treatment.

Our doctor was immediately notified to look at all the orders and correct the Verbiage to ensure the pharmacy is writing it correctly on the MAR and that the MAR and the script is the same. All orders were written and correct by both the MD and the pharmacy. The resident has agreed to use the homes doctors to make this medication orders easier and more clear. Instead of an outside DR. who doesn't understand Personal Care Home.

All Med tech staff were all giving a medication training on 5/9/22. And a training is being scheduled for [REDACTED] who does our Medication Administration training out side of the home. This will be done in next few weeks. The documentation of the training on 5/9/22 will be kept in the training binder. This training went over all the errors on the POC and glucometer issues. The documentation of the training by the training coordinator scheduled for June 1st 2022 will also be kept in the training binder with each staff signing off. This training will include a medication refresher that highlights the key teaching points in medication training. The trainer will give us a copy to keep in our binder of all talking points. Example glucometers, signing off on MAR's, medication administration signing off on medications when given and documentation of resident medication when a resident is not present in the home. This is [REDACTED] who trains our staff in medication administration. [REDACTED] sent [REDACTED] a copy of the POC to ensure [REDACTED] hits on all the issues and errors.

Moving forward a cart audit will be completed twice a week and signed off by the Med tech and the Administrator or designee will do a med cart audit to ensure the MAR and medications are following the Doctors orders and everything is in the cart even if the resident gets the medication from a different pharmacy. The new doctors will check weekly to ensure that all orders are correct on the MAR and everything that is needed is in the cart. All residents will be reviewed by the Med tech audit and documentation will be kept. This will start on 5/17/22.

The Administrator or designee will do 2 audits a week and audit a minimum of 5 residents checking MAR and medications match the doctors orders and that all medications have been signed off properly. This will start on 5/20/22.

187d - Follow Prescriber's Orders (continued)

During the medication Audits that happen at minimum 4 times a week between administrator or designee and med techs all medications supplies will be check and ordered a minimum of 7 days in advance to ensure we always have medications in the building. And during the contract signing all residents will be told that if they do not have medications in the building if they use their own pharmacy it will be ordered by our pharmacy at their personal charge.

Completion Date: 05/20/2022