



CERTIFIED MAIL - RETURN RECEIPT REQUESTED

MAILING DATE: APRIL 25, 2023

[REDACTED]
BCB Holdings Fund
[REDACTED]

RE: Victoria Manor Personal Care Home
100 Rose Court
Oakdale, Pennsylvania 15071
License/COG #: 446423

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 24, 2022, January 11, 2023, January 18, 2023, January 19, 2023, and January 23, 2023, of the above facility, the citations 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 hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD 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) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from April 25, 2023 to October 25, 2023.

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 (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	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day_	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
5(a)	II	27	\$5	\$135	5 calendar days from mailing date of this letter
51	II	27	\$5	\$135	5 calendar days from mailing date of this letter
54(a)	II	27	\$5	\$135	5 calendar days from mailing date of this letter
82(a)	II	27	\$5	\$135	5 calendar days from mailing date of this letter
132(a)	II	27	\$5	\$135	5 calendar days from mailing date of this letter
225(a)	II	27	\$5	\$135	5 calendar days from mailing date of this letter
227(a)	II	27	\$5	\$135	5 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:

[REDACTED]
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,



Juliet Marsala

Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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: *03/20/2023*
Address: *100 ROSE COURT, OAKDALE, PA 15071*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *BCB HOLDINGS FUND*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/17/1997* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *31* Waking Staff: *23*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Fine* Exit Conference Date: *10/24/2022*

Inspection Dates and Department Representative

10/24/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* Residents Served: *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *1* Are 60 Years of Age or Older: *24*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *6* Have Physical Disability: *0*

Inspections / Reviews

10/24/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/07/2022*

12/08/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2022

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/14/2022

12/20/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/30/2022

03/28/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2022

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 10/24/22, an agent of the Department requested resident #1's record, as well as physician orders for residents #1, #3, #4 and #5; however, the records were locked in the administrator's office and were not accessible to staff person A, who was the home's designee.

REPEAT VIOLATION: 1/25/2022

Plan of Correction

Accept [REDACTED] - 12/15/2022)

On 10/24/2022 records for residents #1, #3, #4, #5 were not available to the agents. The records were locked in the office of the administrator.

2600 5.a The administrator will keep all records in the proper place which are stored in the records room, accessible at all times to agents and all staff. The records were immediately filed in the in the records room upon the administrator's return to the building on 10/31/2022.

Training: All staff were educated 11/30/2022 on proper filing, filing in a timely manor and keeping records available for access at all times to agents. Moving forward all residents records will be stored in the records room ready and available for agents to access at all times. The administrator or designee will review records weekly starting 11/28/22. A new admission check list was added resident records 11/28/22 to ensure all documentation is completed. Audit's were started 11/28/2022. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 12/08/2022

Not Implemented [REDACTED] - 03/28/2023)

16c - Written Incident Report

2. 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 following medications errors were not reported to the Department until 10/24/22:

- *Resident #3 is prescribed Aspirin 81 mg tablet-Take 1 tablet by mouth daily and Vitamin B12 1000mcg tablet-Take 1 tablet by mouth daily; however, these medications were not administered to resident #3 on 9/20/22, because they were not available in the home.*
- *Resident #4 is prescribed Paroxetine HCL 40 mg tablet-Take ½ tablet (20mg) by mouth daily. Staff member A indicated they cut the 40 mg tablet in half; however, the 40 mg tablet is not scored, so it is unable to be determined if resident #4 is receiving the prescribed 20 mg dose on a daily basis.*
- *Resident #4 is prescribed Aripiprazole 30 mg tablet-Take ½ tablet (15mg) by mouth daily. Staff member A*

16c - Written Incident Report (continued)

indicated they cut the 30 mg tablet in half; however, the 30 mg tablet is not scored, so it is unable to be determined if resident #4 is receiving the prescribed 15 mg dose on a daily basis.

- Resident #4 is prescribed Novolog Flexpen 100u/ml-Inject 12 units subcutaneously 3 times daily; however, this medication was not administered to resident #4 on 10/21/22 and 10/22/22 at 12:00 pm.
- Resident #4 is prescribed Gabapentin 300 mg capsule-Take 1 capsule by mouth every 8 hours; however this medication was not administered to resident #4 on 10/21/22 and 10/22/22 at 2:00 pm.
- Resident #4 is prescribed Dicyclomine 10 mg capsule-Take 1 capsule by mouth 4 times daily before meals and at bedtime; however, this medication was not administered to resident #4 on 10/21/22 and 10/22/22 at 12:00 pm.

REPEAT VIOLATION: 3/30/2022

Plan of Correction

Directed ([REDACTED] - 12/15/2022)

Resident #3 was prescribed aspirin 81mg and vitamin B12. On 9/20/22 these medications were not administered due to them not being in the building. The family of resident #3 request that all of his OTC medications be purchased by her at a different pharmacy and was aware of resident being out and did in fact bring them in the evening of 9/20/22.

Resident #4 was prescribed Paroxetine HCL 40mg tablet, take 1/2 tablet 20mg by mouth daily and Aripiprazole 30mg tablet, take 1/2 tablet 15mg by mouth daily. These tablets which were not scored and were cut in half by staff which staff was unable to determine if the resident was receiving the prescribed dose. Staff was unaware they were not permitted to cut a tablet in half without it being scored. upon receiving this information from the auditor the staff A called the pharmacy and ordered the correct dosage with the tablets scored by the pharmacy. These medications were delivered the same day.

apart. Staff A called t [REDACTED] 24/22 to have the times for this medication updated to 8:00 [REDACTED]

We do have a policy which states if the family of the residents would like to use a different pharmacy or gets the OTC medications on their own, after 2 days of the facility not having the medications we are going to order them from our pharmacy. (DIRECTED: By 12/20/22: The administrator shall develop and implement policies and procedures to ensure all resident medications are present in the home and available for administration at all times in accordance with prescribers' orders. Documentation of the policies and procedures shall be kept. All staff persons qualified to administer medications shall be educated on the new policies and procedures by 12/30/22. Documentation of the education shall be kept. [REDACTED] 12/15/22).

DHS was notified of the incident on 10/24/22. All staff were educated 12/2/22 on reporting incidents to the state. On 12/2/2022 the implementation of a plan to notify the administrator or designee immediate when an incident

16c - Written Incident Report (continued)

occurs. The staff were trained about reporting an incident to the Administrator or designee immediately and they were trained how to write a reportable incident and when it has to be reported to ensure that all staff know that an incident has to be reported in 24 hours. A reportable binder was created to guide staff if they have any questions. All staff now know that an incident needs to be reported to the administrator or designee immediately and reported within 24 hours.

All staff were educated 12/2/22 on our policy for not having resident's medication in the building. Staff was also educated 12/2/22 on staff not permitted to cut tablets without a score on the tablet, staff cannot determine if the resident is getting the correct dose of medication. Moving forward there will be a medication audit on each shift completed by the med tech. The administrator or designee will audit daily to ensure these medication audits are being done. These audits will start 12/8/22. Documentation of staff education will be kept.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator/supervisor shall review all internal incidents and conditions daily to ensure all incidents specified in 2600.16a are reported to the Department within 24 hours. [REDACTED] 12/15/22).

Licensee's Proposed Overall Completion Date: 12/30/2022

Implemented [REDACTED] - 03/28/2023)

42u - Right to Remain in Home**3. Requirements**

2600.

42.u. A resident has the right to remain in the home, as long as it is operating with a license, except as specified in § 2600.228 (relating to notification of termination).

Description of Violation

On 9/27/22, the home issued resident #12 a 30-day discharge notice for failure to pay. On 10/13/22, resident #12 was transferred to the hospital via ambulance and returned to the home on the same day. Upon return on 10/13/22, the home refused to accept resident #12 back into the home due to the 30-day notice that was issued to resident #12 on 9/27/22.

Plan of Correction

Directed [REDACTED] - 12/15/2022)

On 9/27/22 resident #12 was hand delivered a 30 day notice by the owner for none payment. A copy a of this notice was immediately filed in [REDACTED] resident chart behind the admission check list on the second page. On 10/13/22 resident #12 developed an all over body rash and was sent to the hospital per the home care nurse. The home did not grant Resident #12 access back into the home.

On 10/14/22 the owner of the home spoke to [REDACTED] at the DHS at 4:00pm concerning not being able to provide the nursing home type of care resident #12 needs which is more than one to two hours of care in a 24 hour time frame. Discussion consisted of [REDACTED] falls, [REDACTED] all over body rash, the RN requesting resident #12 be sent out to be treated.

Moving forward all staff was educated 12/2/22 on reg. 2600.228h grounds for discharge, how to properly serve a resident with a 30 day notice. It is the residents right to reside at the home as long as it is licensed. Documentation of staff education will be kept.

42u - Right to Remain in Home (continued)

DIRECTED: Immediately: Any resident who is transferred to the hospital shall be granted access back into the home, as long as it is operating with a license in accordance with 2600.42u, unless there is documentation in writing from a physician certifying a delay in discharge or transfer of a resident would jeopardize the health, safety or well-being of the resident or others in the home in accordance with 2600.228b. Copies of the physician certifications shall be kept in each resident's record and made available to the Department immediately upon request. If there are valid grounds to discharge a resident in accordance with 2600.228h, a 30-day advance written notice shall be provided to the resident and the resident's designated person in accordance with 2600.228b, and the home shall provide assistance to the resident in relocating the resident to their own home or to another residence that meets the needs of the resident in accordance with 2600.42n and 2600.228a. The home shall not use the hospital as a means to discharge a resident. [REDACTED] 12/20/22

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented [REDACTED] - 03/28/2023

103g - Storing Food**4. Requirements**

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 10:15 am, multiple food items were found open and unsealed in the home's kitchen, to include the following:

- 18 molasses cookies
- A 10 pound bag of Villa Frizzoni spaghetti noodles, approximately 1/5th full

REPEAT VIOLATION: 7/1/2022, et. al.

Plan of Correction

Accept [REDACTED] - 12/15/2022

On 10/24/22 the pack of cookies were open and the bag of spaghetti was not properly sealed. The administrator was told by the prior auditor that the large chip clip was ok to seal the spaghetti bag. Both the pack of cookies and bag of spaghetti were thrown away in front of the auditor. Moving forward the administrator or designee will check daily to make sure all food items stored in the kitchen cabinets are stored and sealed properly. The staff in charge of dietary will check weekly to ensure all food items are being stored properly. These checks were started 12/2/22.

Training: All staff were educated on 12/2/22 by handout on storing food properly. Staff education will be kept.

Licensee's Proposed Overall Completion Date: 12/08/2022

Implemented [REDACTED] - 03/28/2023

183b - Meds and Syringes Locked**5. Requirements**

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

At approximately 9:45 a.m., the medication cart in the east hallway next to the linen closet was unlocked, unattended

183b - Meds and Syringes Locked (continued)

and accessible. The medication cart contained numerous medications for numerous residents, to include the following:

- Resident #6's Carvedilol-3.125mg, Omeprazole-40mg, and Ondansetron-4mg tablet
- Resident #7's Acetaminophen-500mg and Divalproex-250mg
- Resident #8's Gabapentin-300mg

Upon discovery of the unlocked medication cart in the east hallway, staff person A locked the medication cart; however, at 9:51 a.m., the 2nd drawer of the medication cart was still unlocked, unattended and accessible.

Plan of Correction

Accept [REDACTED] - 12/15/2022

On 10/24/22 the agent observed that medication cart A was unlocked, unattended and accessible to residents. The medication cart contained medications for various residents such as resident #6, #7, and #8. The medication cart was found to be broken and did not latch when locked. Staff A immediately called the pharmacy to have the cart repaired. The cart was repaired 10/25/22 and is now working efficiently.

Training: All staff were trained 12/2/22 by handout on how important it is to keep medication locked and properly stored at all times. The administrator or designee will check daily to ensure the medication cart is locked and not broken. These checks started 12/2/22.

Staff education and cart checks will be kept. Documentation for the cart repair will be kept. The administrator has also scheduled a medication administration training refresher course with our med trainer on 12/28/22 for all staff qualified to administer medications. All med techs will take the class. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 12/08/2022

Not Implemented [REDACTED] - 03/28/2023

187b - Date/Time of Medication Admin.**6. Requirements**

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 #4 is prescribed Gabapentin 300 mg capsule-Take 1 capsule by mouth every 8 hours; however, resident #4's October 2022 medication administration record (MAR) does not include the initials of the staff person who administered the medication to resident #4 on 10/11/22 at 6:00 am and 2:00 pm.

Resident #4 is prescribed the following medications; however, resident #4's October 2022 MAR does not include the initials of the staff person who administered the medications to resident #4 on 10/11/22 at 7:00 am:

- Aripiprazole 30 mg tablet-Take ½ tablet (15 mg) by mouth daily
- Aspirin 81 mg tablet-Take 1 tablet by mouth daily
- Brilinta 90 mg tablet-Take 1 tablet by mouth twice a day
- Bumetanide 1mg tablet-Take 1 tablet by mouth once daily
- Cyanocobalamin 1,000 mcg tablet-Take 1 tablet by mouth once daily

Resident #6's October 2022 MAR does not include the initials of the staff persons who administered numerous medications to resident #6 at 7:00 am on 10/1/22 through 10/10/22, 10/12/22, 10/13/22, 10/17/22. and 10/18/22, to include the following medications:

- Biotin 1,000 mcg tablet-Take 1 tablet once daily
- Carvedilol 3.125 mg tablet-Take 1 tablet by mouth twice a day

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

- Omeprazole 40 mg tablet-Take 1 tablet by mouth twice a day
- MAPAP 325 mg tablet-Take 2 tablets by mouth once daily

Resident #6's October 2022 MAR does not include the initials of the staff persons who administered the following medications to resident #6 at 8:00 pm on 10/1/22 through 10/9/22:

- Carvedilol 3.125 mg tablet-Take 1 tablet by mouth twice a day
- Omeprazole 40 mg capsule-Take 1 tablet by mouth twice a day

Resident #6's October 2022 MAR does not include the initials of the staff persons who administered the following medication to resident #6 at 8:00 am on 10/7/22, 10/10/22, 10/17/22 and 10/24/22:

- Furosemide 20 mg tablet-Take 1 tablet by mouth once daily on Monday and Friday

REPEAT VIOLATION: 7/1/2022, et. al.; 3/30/2022

Plan of Correction**Directed** [REDACTED] /15/2022)

The October MAR does not include the initials of staff who administered medication to resident #4 on 10/11/22 at 6:00 am, 7:00 am and 10/11/22 at 2:00 pm.

The October MAR does not include the initials of staff who administered medication to resident #6 on 10/1/22 through 10/10/22, 10/12/22, 10/13/22, 10/17/22, and 10/18/22 at 7:00 am.

The October MAR does not include the initials of staff who administered medication to resident #6 on 10/1/22 through 10/9/22 8:00 pm.

The October MAR does not include the initials of staff who administered medication to resident #6 on 10/7/22, 10/10/22, 10/17/22 and 10/24/22.

All staff who are qualified to administer medications was given a growth and change (re-educating staff) 12/5/22 for not signing off on administered medication. A growth and change is a documented interaction between the administrator and the staff to discuss the incident and talk about what they did wrong and what they will need to do to fix the issues and learn from their errors. (attached). It was given to all staff who have medication issues. The administrator has also scheduled a medication administration training refresher course with our med trainer on 12/28/22 for all staff qualified to administer medications. All med techs will take the class. Documentation will be kept.

All staff had a training 12/2/22 on whenever a medication is not given even if the order states to not give for a specific reason the staff needs to write not given and the reason the medication was not given.

Moving forward a cart audit will be done weekly by the administrator or designee to monitor any holes in the MAR and to ensure med tech's are in fact signing off on medications administered. These checks were started 12/2/22. Education will be kept. (DIRECTED: The weekly administrator cart audit shall include a review of all resident medication administration records to ensure all medications are initialed as administered, at the time of medication administration. The review shall also ensure proper documentation of medication refusals are properly documented on resident medication administration records. Documentation of the weekly audits shall be kept. [REDACTED] 12/15/22).

Licensee's Proposed Overall Completion Date: 12/28/2022

Implemented [REDACTED] - 03/28/2023)

187d - Follow Prescriber's Orders

7. Requirements

2600.

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

Description of Violation

Resident #3 is prescribed Aspirin 81 mg tablet-Take 1 tablet by mouth daily and Vitamin B12 1000mcg tablet-Take 1 tablet by mouth daily; however, these medications were not administered to resident #3 on 9/20/22, because they were not available in the home for administration.

Resident #4 is prescribed Paroxetine HCL 40 mg tablet-Take ½ tablet (20 mg) by mouth daily. Staff member A indicated they cut the 40 mg tablet in half; however, the 40 mg tablet is not scored, so it is unable to be determined if the resident is receiving the prescribed 20 mg dose on a daily basis.

Resident #4 is prescribed Aripiprazole 30 mg tablet-Take ½ tablet (15mg) by mouth daily. Staff member A indicated they cut the 30 mg tablet in half; however, the 30 mg tablet is not scored, so it is unable to be determined if the resident is receiving the prescribed 15 mg dose on a daily basis.

Resident #4 is prescribed Novolog Flexpen 100u/ml-Inject 12 units subcutaneously 3 times daily; however, this medication was not administered to resident #4 on 10/21/22 and 10/22/22 at 12:00 pm.

Resident #4 is prescribed Gabapentin 300 mg capsule-Take 1 capsule by mouth every 8 hours; however this medication was not administered to resident #4 on 10/21/22 and 10/22/22 at 2:00 pm.

Resident #4 is prescribed Dicyclomine 10 mg capsule-Take 1 capsule by mouth 4 times daily before meals and at bedtime; however, this medication was not administered to resident #4 on 10/21/22 and 10/22/22 at 12:00 pm.

Resident #5 is prescribed Levetiracetam 250 mg tablet-Take 1 tablet by mouth every 12 hours; however, this medication was administered to resident #5 at 7:00 am and 8:00 pm daily from 10/1/22 through 10/23/22, which is not 12 hours apart.

REPEAT VIOLATION: 7/1/2022, et. al.; 3/30/2022

Plan of Correction**Directed** [REDACTED] **12/15/2022)**

Resident #3 was prescribed aspirin 81mg and vitamin B12. On 9/20/22 these medications were not administered due to them not being in the building. The family of resident #3 request that all of his OTC medications be purchased by [REDACTED] at a different pharmacy and was aware of resident being out and did in fact bring them in the evening of 9/20/22. Staff will do weekly checks starting 11/28/22 to ensure no resident has less than a weeks supply of medication.

Resident #4 was prescribed Paroxetine HCL 40mg tablet, take 1/2 tablet 20mg by mouth daily and Aripiprazole 30mg tablet, take 1/2 tablet 15mg by mouth daily. These tablets were not scored and were cut in half by staff, which staff was unable to determine if the resident was receiving the prescribed dose. Staff was unaware (but now educated 12/2/22 that they are not permitted to cut a tablet in half without it being scored. Upon receiving this information

187d - Follow Prescriber's Orders (continued)

from the agent staff A called the pharmacy and ordered the correct dosage with the tablets scored by the pharmacy. These medications were delivered the same day on 10/24/22. Documentation is kept.

Resident #5 was prescribed Levetiracetam 250mg tablet, take 1 tablet by mouth every 12 hours the medications were profiled by our pharmacy for 7:00 am and 8:00 pm daily from 10/1/22 through 10/23/22 which was not 12 hours apart. Staff A called the pharmacy immediately on 10/24/22 to have the times for this medication updated to 8:00 am and 8:00 pm the medication administration time was corrected on 10/24/22.

All staff were educated 12/2/22 on our policy for not having resident's medication in the building. Staff was also educated 12/2/22 on staff is not permitted to cut tablets without a score on the tablet, staff cannot determine if the resident is getting the correct dose of medication. These medications were ordered from our pharmacy and delivered the evening of 10/24/22. Moving forward a cart audit will be done weekly by the administrator or designee to ensure OTC medications are in the medication cart starting 11/28/22 to ensure medications are present in the home and to ensure medication matches the mar including medication dosage. (DIRECTED: At least 25% of the residents shall be reviewed during each weekly audit and shall include a full review of resident medications and medication administration documentation to ensure all prescribed medications are present and available for administration and that prescribers' orders are being followed. Documentation of the audits shall be kept. [REDACTED] 12/15/22). If a resident only has one weeks supply of medication the med tech will order it from our pharmacy. The audit will consist of documenting medications are in the cart and also making sure the medications are being ordered within a week of them being completely out. Documentation of this audit will be kept. The administrator has also scheduled a medication administration training refresher course with our med trainer on 12/28/22 for all staff qualified to administer medications. All med techs will take the class. Documentation will be kept.

DIRECTED: By 12/20/22: The administrator shall develop and implement policies and procedures to ensure all resident medications are present in the home and available for administration at all times in accordance with prescribers' orders. Documentation of the policies and procedures shall be kept. All staff persons qualified to administer medications shall be educated on the new policies and procedures by 12/30/22. Documentation of the education shall be kept. [REDACTED] 12/15/22.

Licensee's Proposed Overall Completion Date:12/30/2022

Implemented [REDACTED] - 03/28/2023)

225a - Assessment 15 Days**8. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

No assessment was completed for resident #3, who was admitted to the home on [REDACTED]

No assessment was completed for resident #7, who was admitted to the home on [REDACTED]

No assessment was completed for resident #9, who was admitted to the home on [REDACTED].

225a - Assessment 15 Days (continued)

No assessment was completed for resident #10, who was admitted to the home on [REDACTED]

No assessment was completed for resident #11, who was admitted to the home on [REDACTED]

REPEAT VIOLATION: 7/1/2022, et. al.

Plan of Correction

Directed ([REDACTED] - 12/15/2022)

On 10/24/2022 assessment checklist for residents #3 , #7, #9, #10, #11 were not available to the agents. The records were locked in the office of the administrator

The administrator will keep all records in the proper place in the records room ready and available for agents of the department for access The administrator will keep all records in the proper place which are stored in the records room, accessible at all times to agents and all staff. The assessment checklist were immediately filed in the records room upon the administrator's return to the building on 10/31/2022. The assessments were completed for:

- resident #3 9/28/22
- resident #7 9/20/22
- resident #9 9/20/22
- resident #10 9/23/22
- resident #11 10/8/22

Training: The administrator and designee were educated 11/30/2022 on 2600. 225(a) initial and annual assessment, . Also proper filing and filing in a timely manor. Moving forward the administrator or designee will audit assessments weekly, along with new admission check list to ensure all documentation is completed and in the correct chart and stored in the proper place. Audit's were started 11/28/2022. Documentation is kept.

DIRECTED: Within 10 calendar days of receipt of the plan of correction: The administrator shall review all current resident records to ensure each resident has an assessment completed within 15 days of admission [REDACTED] 12/15/22.

Licensee's Proposed Overall Completion Date: 12/30/2022

Not Implemented ([REDACTED] - 03/28/2023)

227a - Support Plan 30 Days

9. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

No support plan was completed for resident #3, who was admitted to the home on [REDACTED]

No support plan was completed for resident #7, who was admitted to the home on [REDACTED]

No support plan was completed for resident #9, who was admitted to the home on [REDACTED]

227a - Support Plan 30 Days (continued)

No support plan was completed for resident #10, who was admitted to the home on [REDACTED].

REPEAT VIOLATION: 7/1/2022, et. al.

Plan of Correction

Directed ([REDACTED] - 12/15/2022)

On 10/24/2022 support plans for residents #3, #7, #9, #10 were not available to the agents. The records were locked in the office of the administrator. However the support plan for residents were completed.

resident #3 was completed on 9/26/22

resident #7 was completed on 10/7/22

resident #9 was completed on 9/20/22

resident #10 was completed on 9/23/22

The administrator will keep all records in the proper place ready and available for agents of the department for access. The records were immediately filed in the proper place upon the administrator's return to the building on 10/31/2022.

Training: The administrator and designee were educated and trained 11/30/2022 on 2600. 225(a) initial and annual assessment, . Also educated on proper filing and filing in a timely manor. Moving forward the administrator or designee will audit assessments weekly, along with new admission check list to ensure all documentation is completed and in the correct chart and stored in the proper place. Audit's were started 11/28/2022. Documentation is kept. (DIRECTED: The weekly audits shall also include ensuring a support plan is completed for each resident within 30 days of admission. [REDACTED]/15/22).

DIRECTED: Within 10 calendar days of receipt of the plan of correction: The administrator shall review all current resident records to ensure each resident has a support plan completed within 30 days of admission. [REDACTED] 12/15/22.

Licensee's Proposed Overall Completion Date:12/30/2022

Not Implemented [REDACTED] - 03/28/2023)

228h - Grounds Discharge/Transfer

10. Requirements

2600.

228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

1. If a resident is a danger to himself or others.
2. If the legal entity chooses to voluntarily close the home, or a portion of the home.
3. If a home determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the home. If a resident or the resident's designated person disagrees with the home's decision to discharge or transfer, consultation with an appropriate assessment agency or the resident's physician shall be made to determine if the resident needs a higher level of care. A plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/intellectual disability program or drug and alcohol program, for assistance. The administrator shall also contact the Department's personal care home regional office.

228h - Grounds Discharge/Transfer (*continued*)

4. If meeting the resident's needs would require a fundamental alteration in the home's program or building site, or would create an undue financial or programmatic burden on the home.
5. If the resident has failed to pay after reasonable documented efforts by the home to obtain payment.
6. If closure of the home is initiated by the Department.
7. Documented, repeated violation of the home rules.

Description of Violation

On 9/27/22, the home issued resident #12 a 30-day discharge notice for failure to pay. However, there are no documented efforts by the home to obtain payment from resident #12. On 10/13/22, resident #12 was transferred to the hospital via ambulance and returned to the home on the same day. Upon return on 10/13/22, the home refused to accept resident #12 back into the home due to the 30-day notice that was issued to resident #12 on 9/27/22.

Plan of Correction**Directed** [REDACTED] - 12/20/2022)

On 10/24/22 agents from the department of health reviewed the records of resident #12 looking for the 30 notice he received hand delivered by the owner [REDACTED] on 9/27/22. However the notice was overlooked by the agent. Staff called the administrator to give an update on the audit and explained that the agent said the notice was not there. The administrator instructed staff member A to look in the chart on the second page and it was there. The administrator then instructed staff member A to call the agent and let them know the notice was there and overlooked. The agent gave a fax number to staff member A and it was faxed to the agent using fax number 412-565-5633. A copy of the fax receipt is attached serving as documentation that the notice was in fact there it was just overlooked.

Moving forward a resident will not be served a 30 day notice without two documented attempts to obtain payment. When a 30 day notice is served to a resident for nonpayment, the administrator or designee will keep documentation of all invoices not paid. The administrator or designee will check monthly to ensure all payments are being made and making sure documentation is in the resident records for failure to pay. The invoices will serve as documentation that there was at least 2 attempts to obtain payment from the resident. The invoices will be kept in the resident binder in the records room. The administrator and designee were trained 12/2/22 on regulation 2600.22h The home needs 2 documented attempts to obtain payment prior to issuance of a 30 day notices for residents who fail to pay.

DIRECTED: Immediately: Any resident who is transferred to the hospital shall be granted access back into the home, as long as it is operating with a license in accordance with 2600.42u, unless there is documentation in writing from a physician certifying a delay in discharge or transfer of a resident would jeopardize the health, safety or well-being of the resident or others in the home in accordance with 2600.228b. Copies of the physician certifications shall be kept in each resident's record and made available to the Department immediately upon request. If there are valid grounds to discharge a resident in accordance with 2600.228h, a 30-day advance written notice shall be provided to the resident and the resident's designated person in accordance with 2600.228b, and the home shall provide assistance to the resident in relocating the resident to their own home or to another residence that meets the needs of the resident in accordance with 2600.42n and 2600.228a. The written 30-day notice shall include the reason for discharge. The home shall not use the hospital as a means to discharge a resident. [REDACTED] 12/20/22

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented [REDACTED] - 03/28/2023)