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

January 17, 2023

MOS GRACE MGT LLC

RE: GRACE MANOR AT NORTH PARK
9565 BABCOCK BOULEVARD
ALLISON PARK, PA, 15101
LICENSE/COC#: 45085

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/08/2022, 11/09/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

## Facility Information

**Name**: *GRACE MANOR AT NORTH PARK* **License #**: *45085* **License Expiration**: *02/03/2023*

**Address**: *9565 BABCOCK BOULEVARD, ALLISON PARK, PA 15101*

**County**: *ALLEGHENY* **Region**: *WESTERN*

## Administrator

**Name**: **Phone**: **Email**:

## Legal Entity

**Name**: *MOS GRACE MGT LLC*

**Address**: *118 PARKER ROAD, CHESTER, NJ, 7930*

**Phone**: **Email**:

## Certificate(s) of Occupancy

**Type**: *I-2* **Date**: *11/18/2010* **Issued By**: *Town of McCandless*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *67* **Waking Staff**: *50*

## Inspection Information

**Type**: *Full* **Notice**: *Unannounced* **BHA Docket #**:

**Reason**: *Renewal, Complaint* **Exit Conference Date**: *11/10/2022*

## Inspection Dates and Department Representative

*11/08/2022 - On-Site:*

*11/09/2022 - On-Site:*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *67* **Residents Served**: *42*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Third Floor* **Capacity**: *25* **Residents Served**: *22*

### Hospice

**Current Residents**: *5*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *41*

**Diagnosed with Mental Illness**: *0* **Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *25* **Have Physical Disability**: *0*

# Inspections / Reviews

### 11/08/2022 - Full

**Lead Inspector**: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/09/2022*

### 12/09/2022 - POC Submission

**Submitted By**: **Date Submitted**: *12/29/2022*

**Reviewer**: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2022*

## Inspections / Reviews *(continued)*

### 12/15/2022 - POC Submission

**Submitted By:** [redacted]
**Date Submitted:** *12/29/2022*
**Reviewer:** [redacted]
**Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/15/2023*

### 01/17/2023 - Document Submission

**Submitted By:** [redacted]
**Date Submitted:** *12/29/2022*
**Reviewer:** [redacted]
**Follow-Up Type:** *Not Required*

## 17 - Record Confidentiality

**1. Requirements**

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

**Description of Violation**

*On 11/8/22 at 10:05am, a binder titled, "Emergency Operations Plan" was unlocked, unattended and accessible on the counter in the front lobby. The binder contained the face sheets for numerous residents, which included resident medical information, including resident #1's diagnoses of dementia, HTN, and depression, resident #2's diagnoses of osteoporosis, GERD, and hypothyroidism and resident #3's diagnoses of sleep apnea, asthma, and GERD.*

*On 11/8/22 at 11:05am, a binder containing narcotic logs was unlocked, unattended and accessible on top of the 2nd floor medication cart, which included narcotic logs for numerous residents, to include resident #3's Oxycodone-5mg tablet, resident #4's Oxycodone-5mg tablet and resident #5's Oxycodone-5mg tablet.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*Binders were removed at the time of inspection and put in a confidential place. Staff will be educated on the policy and regulation by 12/30/2022 to prevent this from happening. Documentation of staff education will be kept*

*Assistant Executive Director or designee will complete an audit weekly for 8-weeks and than randomly to ensure compliance. The audits will begin 12/12/2022 and continue according to the schedule.*

*The audit will ensure all information is being kept confidential at all times. Any information being found out and in public view will be removed immediately and staff member will be disciplined as needed.*

*See attached*

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

***Implemented (LM - 01/17/2023)***

## 85a - Sanitary Conditions

**2. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

*On the morning of 11/8/22, there was no soap present at the sink in the 3rd floor common dining room.*

*On the morning of 11/8/22, there were no paper towels, mechanical air blower or other sanitary means of hand drying present at the following sinks:*

- *The 3rd floor common dining room sink*
- *The 3rd floor activities room sink*

## 85a - Sanitary Conditions *(continued)*

**Plan of Correction** ***Directed (LM - 12/15/2022)***

*Soap and paper towels were filled at the time of inspection.*

*All sinks were inspected on 11/10/2022 by the Assistant Executive director and found to have all supplies as needed.*

*All staff will be educated on the policy and regulation by 12/30/2022 to prevent this from happening. All staff will also be educated that all paper towel and soap dispensers must be checked by the shift supervisor at the end of every shift to ensure supplies are there and working properly. Documentation of staff education will be kept. (DIRECTED: The daily checks by the shift supervisor shall begin within 48 hours of receipt of the plan of correction. LM 12/15/22).*

*Assistant Executive Director or designee will complete an audit weekly for 8-weeks and than randomly to ensure compliance beginning 12/12/2022. All soap and paper towel dispensers will be audited to ensure supplies are there and in proper working order.*

*See attached*

**Directed Completion Date:** *12/30/2022*

***Implemented (LM - 01/17/2023)***

## 85d - Trash Receptacles

**3. Requirements**

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 11/8/22 at 11:20am, there was an uncovered and unattended trash can in the home's kitchen, which was approximately 3/4 full of trash.*

**Plan of Correction** ***Directed (LM - 12/15/2022)***

*Lid was put on trash can at the time of inspection.*

*All staff will be educated on the policy and regulation along with education on the requirement to keep the outside receptacles cover closed at all times also by 12/30/2022 to prevent this from happening. Documentation of the staff education shall be kept, (DIRECTED: The education shall also include ensuring trash in kitchens and bathrooms is kept in covered trash receptacles. LM 12/15/22).*

*Assistant Executive Director or designee will complete an audit weekly for 8-weeks starting 12/12/2022 and than randomly to ensure compliance. All garbage cans will be audited to ensure they are covered, clean and in working order house wide. The outside receptible will be included in this audit to ensure the lid is closed at all times.*

*The director of Environmental services or designee will check the outside receptacle daily to ensure lid is closed*

## *85d - Trash Receptacles (continued)*

*when not in use.*

*See attachments*

**Directed Completion Date:** *12/30/2022*

***Implemented (LM - 01/17/2023)***

## 88a - Surfaces

**4. Requirements**

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*On 11/8/22, there was an approximate 14 inch crack along the entire left side of the countertop at the 2nd floor common restroom sink.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*House-wide audit was completed on 11/10/2022 by Assistant Executive Director and all other countertops are in proper condition.*

*Contractor was notified and supplies are ordered and repair will be made by 1/15/2023. Repair was completed on 12/9/2022*

*Assistant Executive Director or designee will complete a house-wide audit weekly for 8-weeks starting 12/12/2022 and than randomly to ensure compliance. All floors, walls, ceiling, windows, doors and other surfaces will be checked to ensure it is in proper working order, no parts are missing or any chips or cracks and free from hazards and in good repair.*

*All staff will be educated on the maintenance request form, maintenance repair protocol and regulation along with education on the requirement to have all floor, walls, ceiling, windows, doors and other surfaces must be clean, in good repair and free of hazards by 12/30/2022 to prevent this from happening. Documentation of the staff education shall be kept,*

*See attached*

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

***Implemented (LM - 01/17/2023)***

## 92 - Windows

**5. Requirements**

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

## 92 - Windows *(continued)*

**Description of Violation**

*On 11/8/22, no screens were present on numerous operable windows in the home, to include the following windows:*

- *Neither window in bedroom #301*
- *The left window in bedroom #302*
- *Neither window in bedroom #307*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*House-wide audit was completed on 11/10/2022 and windows and screens were replaced in room 301 302 307 on 11/10/2022*

*All staff will be educated on the policy and regulations by 12/30/2022 to prevent this from happening again. Documentation will be kept for staff education.*

*Assistant Executive Director or designee will complete a house-wide audit weekly starting 12/12/2022 for 8-weeks and then randomly to ensure compliance. During the audit all windows and doors will be checked to ensure all screens are in place. If any screens are missing than a maintenance request form must be completed so the screen can be replaced.*

*see attached*

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

***Implemented (LM - 01/17/2023)***

## 132d - Evacuation

**6. Requirements**

2600.

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

**Description of Violation**

*According to the documentation from the fire safety expert, dated 1/20/21 and 1/11/22, the maximum evacuation time to the home's fire-safe areas is 8 minutes, 45 seconds; however, the evacuation time for the fire drill conducted on 7/21/22 at 3:15am was completed in 9 minutes, 25 seconds.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*All staff will be educated that all fire drills must be within the allotted time according to the fire expert by 12/30/2022. Documentation will be kept for staff education.*

*Assistant Executive Director or designee will document all fire drills and the Executive director will audit them monthly starting with January 2023 for 12-months to ensure they are within regulations. When auditing Executive Director will be checking that all times are within the time set by fire safety expert, all drills are being spread out between time of day, day of week and location.*

## 132d - Evacuation (continued)

*Assistant Executive Director and/or Executive director will review all fire drill documentation on-going (starting with 1/2023) and sign off that they are all in compliance. If they are not then they will initiate a new drill within that month and will observe the drill to ensure compliance.*

*See attached*

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

***Implemented (LM - 01/17/2023)***

## 141a 1-10 Medical Evaluation Information

**7. 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. 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 #6's medical evaluation, dated [redacted], does not include the resident's temperature. This section of the form is blank.*

**Plan of Correction** ***Directed (LM - 12/15/2022)***

*All DME will be reviewed and signed off by Assistant Executive Director or Executive Director upon admission, significant change and/or annually to ensure compliance. DME needs to be given to the Assistant Executive Director or Executive Director when received to ensure compliance. DME's can not be filed or admission can not be approved without the DME being reviewed first.*

*Assistant Executive director or designee will complete a monthly audit starting 1/2023 on all DME's to ensure they are signed off and completed accurately for 12-months. (DIRECTED: The audit of all current resident records shall be completed by 1/15/23 to ensure each resident has a medical evaluation completed in its entirety within 60 days prior to admission or within 30 days after admission. LM 12/15/22).*

*All staff will be educated that all DME's must be completed fully with no holes and given to Assistant Executive Director or Executive Director for signature of completion when they are received, DME's can not be filed or admission can not be approved without the DME being reviewed first. This will be completed by 12/30/2022. Documentation of the education will be kept.*

## *141a 1-10 Medical Evaluation Information (continued)*

*Nurse Practitioner completed a new DME for resident #6 on [redacted] Resident #6 annual DME was due [redacted]*

*See Attached*

**Directed Completion Date:** *01/15/2023*

***Implemented (LM - 01/17/2023)***

## 185b - Medication Procedures

**8. Requirements**

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

**Description of Violation**

*Resident #6 is prescribed Lorazepam-0.5mg tablet-Take 1 tablet by mouth 3 times daily as needed. On 11/9/22, the home's controlled drug record indicated that resident #6 had 16 Lorazepam tablets present; however, only 14 Lorazepam tablets were present in the home.*

*Resident #6's November 2022 medication administration record (MAR) indicates that 1 Lorazepam tablet was administered to resident #6 on 11/6/22 at 7:49am; however, this administration is not indicated on resident #6's controlled drug record.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*All MAR and controlled drug records were audited at the time of inspection and no other errors were found.*

*All Med-Techs will be re-educated on proper medication documentation and the importance of ensuring all documentation is accurate and according to regulations. This training will be completed by 12/30/2022 and all documentation of the education will be kept.*

*All Med-Techs will be re-educated on the medication error policy and procedure to ensure compliance by 12/30/2022. Any staff with identified errors will be removed from cart and re-training will be completed by the "Train the Trainer" before permitted back on the cart. All staff educational documentation will be kept.*

*Med-tech supervisors will complete a weekly audit X 8-weeks starting 12/20/2022 and then randomly to ensure compliance.*
*When auditing they will be reviewing narcotic log and compare it to the MAR log to ensure all medication was signed off and given as prescribed by the doctor. They will also review the MAR for any holes and ensure all medication is in the cart and available to residents as prescribed. They will also review the MAR for any holes and ensure all medication is in the cart and available to residents as prescribed.*

## *185b - Medication Procedures (continued)*

*See attached*

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

***Implemented (LM - 01/17/2023)***

## 187b - Date/Time of Medication Admin.

**9. 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 #1 is prescribed Hydrocodone/APAP 5-325mg tablet-Take 1 tablet by mouth twice a day as needed. The home's controlled drug record indicates the medication was administered to resident #1 on numerous occasions, to include on 11/1/22 at 10:00pm, 11/3/22 at 8:00pm and on 11/4/22 at 8:00am and 8:00pm; however resident #1's November 2022 MAR does not include the initials of the staff persons who administered these doses to resident #1.*

*REPEAT VIOLATION: 10/12/2021, et. al.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*All MAR and controlled drug records were audited at the time of inspection and no other errors were found.*

*All Med-Techs will be re-educated on proper medication Administration and documentation and the importance of ensuring all documentation is accurate and according to regulations. This training will be completed by 12/30/2022 and all documentation of the education shall be kept.*

*Med-tech supervisors will complete a weekly audit X 8-weeks starting 12/20/2022 and then randomly to ensure compliance. When auditing they will be reviewing all orders to ensure all medication is being given as ordered and being documented on all forms as required.*

*See Attached*

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

***Implemented (LM - 01/17/2023)***

## 187d - Follow Prescriber's Orders

**10. Requirements**

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

**Description of Violation**

*On [redacted] resident #1 was prescribed 2 liters of oxygen via nasal cannula every night during sleep. However, on 11/9/22, resident #1 indicated that [redacted] has not been administered the oxygen for approximately 1 week.*

## 187d - Follow Prescriber's Orders (continued)

*REPEAT VIOLATION: 10/12/2021, et. al.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*All Med-Techs will be re-educated on encouraging the resident to use the oxygen when they reminder at night as prescribed by 12/30/2022. All documentation of education shall be kept.*

*All Med-Techs will be educated on proper ways of documenting if residents refuses the oxygen by 12/30/2022. All documentation of training will be kept.*

*Physician also re-educated the resident that must use the oxygen as stated " doesn't put it on". said will try to use it.*

*Med-Techs will do a every 2-hour check on resident from 9pm-7am to remind resident to use oxygen as prescribed. These checks will go in place on 12/19/2022*

*See Attached*

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

***Implemented (LM - 01/17/2023)***

## 227d - Support Plan Medical/Dental

**11. Requirements**

2600.
227.d. Each home shall document in the resident’s support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident’s physician, physician’s assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

**Description of Violation**

*Resident #1 is prescribed 2 liters of oxygen via nasal cannula every night during sleep; however, resident #1's most recent support plan, dated 9/15/22, does not indicate the use of oxygen, who is responsible for administering the oxygen and how often the oxygen is to be administered.*

*REPEAT VIOLATION: 10/12/2021, et. al.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*Support plan was updated at time of inspection.*

*All staff will be educated on ensuring all RASP’s are documented with any medical, dental, vision, hearing, mental health or other behavioral care services that have been determine a necessity of services.*
*When these services have been ordered they must be documented on the RASP’s by the person receiving the order along with completing the new service ordered log (attached). This training will be completed by 12/30/2022 and all documentation of the education shall be kept.*

## *227d - Support Plan Medical/Dental (continued)*

*A "new service log" (attached) is being put in place 1/2023 to track all new services that are ordered and that these services are put on the RASP's at the time the services begin. The "new service log" will be audited by the Med-Tech Supervisor or designee monthly to ensure all new services have been added and updated properly for 12-months beginning 1/2023 and then randomly to ensure compliance*

*See attached*

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

***Implemented (LM - 01/17/2023)***

## 231c - Preadmission Screening

**12. Requirements**

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

**Description of Violation**

*Resident #7's cognitive preadmission screening, dated [redacted], does not include the resident's diagnoses. This section of the form is blank.*

**Plan of Correction** ***Accept (LM - 12/15/2022)***

*Residents #7 cognitive screening part was updated with an attachment of residents diagnoses on [redacted] and attached to the current prescreen.*

*All staff will be re-educated on ensuring all required information is on all pre-admission screens upon admission by 12/30/2022. All documentation will be kept for staff education*

*All pre-admission screens will be audited upon admission by the Admission Director. When any resident is admitting to the SDCU the prescreen must be signed off on the admission cover sheet by the Assistant Executive Director prior to admission to ensure it is completed correctly and completely. This will begin 1/2023*

*See attached*

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

***Implemented (LM - 01/17/2023)***