CERTIFIED MAIL - RETURN RECEIPT REQUESTED

MAILING DATE: APRIL 25, 2023

BCB Holdings Fund

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

Dear

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.

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17105 | 717.783.3670 | F 717.783.5662 | www.dhs.pa.gov

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day_	Mandated Correction Date (to avoid Fine)
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:

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:

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

Legal Entity

Name: *BCB HOLDINGS FUND*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/17/1977* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal, Complaint, Monitoring* **Exit Conference Date**: *01/23/2023*

Inspection Dates and Department Representative

01/11/2023 - On-Site:
01/18/2023 - On-Site:
01/19/2023 - On-Site:
01/23/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served**: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *25*
Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

01/11/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/17/2023*

03/06/2023 - POC Submission

Submitted By: [redacted] [redacted] **Submitted**: *03/16/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/10/2023*

03/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/16/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/16/2023*

03/28/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/16/2023*

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 1/18/23 at 10:30 a.m., 1:15 p.m., and 5:20 p.m. and again on 1/19/23 at 9:45 a.m. and 3:10 p.m., agents of the Department requested financial records for residents #1 and #2, however, they were never provided. Staff person A, the administrator, indicated [redacted] had yet to receive them from staff person B, the owner.

Repeat violation 1/25/22

Plan of Correction ***Directed ([redacted] - 03/14/2023)***

On 1/18/23 and 1/19/23 the administrator did not have the correct financial records for resident #1 and resident #2. Staff person A, the administrator contacted staff person B, the owner and is waiting for the correct documents.

Training: On 1/26/23 all staff were educated during a QA meeting on reg 2600 5.a on 1/26/23. The administrator or designee will check monthly to ensure proper financial records are being kept in the resident records in the records room at all times so agents have immediate access at all time upon request. These checks started 2/13/23. Documentation is kept.

DIRECTED: Within 5 days of receipt of the plan of correction - The administrator will obtain the financial records for residents #1 and #2, and forward them to BHSL, to the attention of [redacted]. [redacted] 3/14/23

Licensee's Proposed Overall Completion Date: *03/07/2023*

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

25c1 - Personal Needs Allowance

2. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

1. Each resident shall retain, at a minimum, the current personal needs allowance as the resident's own funds for personal expenditure. A contract to the contrary is not valid. A personal needs allowance is the amount that a resident shall be permitted to keep for his personal use.

Description of Violation

Resident #1's contract, dated 9/9/22, does not indicate the amount the amount of the personal needs allowance (PNA) the resident is allocated for [redacted] personal use. "N/A" is written in the area indicating the amount resident #1 will retain. The resident is an SSI recipient and should be receiving $85.00 per month for the PNA.

Resident #2's contract, dated 9/12/22, does not indicate the amount the amount of the personal needs allowance (PNA) the resident is allocated for [redacted] personal use. "N/A" is written in the area indicating the amount resident #2 will retain. The resident is an SSI recipient and should be receiving $85.00 per month for the PNA.

Plan of Correction ***Accept [redacted] - 03/06/2023)***

Resident #1 and resident #2's contract was updated on 2/7/23.
Training: Both of the resident's contracts were updated on 2/7/23. All staff were educated on this regulation during a QA meeting on 1/26/23. Moving forward the administrator or designee will check resident records monthly to ensure all records are complete and correct. These checks were started on 2/13/23. Documentation is kept.

25c1 - Personal Needs Allowance *(continued)*

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (- 03/28/2023)

27a - SSI Benefits

3. Requirements

2600.
27.a. If a home agrees to admit a resident eligible for SSI benefits, the home's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

Description of Violation

Resident #2 receives SSI. Resident #2's contract indicates the monthly charge is $1215.30; however, $1195.30 is the maximum amount of rent that can be charged to a SSI recipient.

Plan of Correction ***Accept - 03/06/2023)***

Resident #2's contract was updated along with financial records on 2/7/23.
Training: all staff were educated during a QA meeting on 1/26/23 on this regulation.
Moving forward the administrator or designee will check monthly to ensure all resident's who receive SSI are getting the correct monthly personal needs allowance. These checks stated 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (- 03/28/2023)

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 1/11/23, the lock on the door of bedroom 18 could not be latched, and stayed open approximately 8"-10", therefore, privacy is not provided for the resident.

Plan of Correction ***Accept - 03/06/2023)***

On 1/12/23 room #18 door latch was broken, the administrator contacted the maintenance man and the door was fixed on 1/19/23.
Training: During a QA meeting on 1/26/23 all staff were educated on doing room checks and told to report anything broken to the administrator right away so broken things can be repaired in a timely manor. Moving forward the administrator or designee will conduct weekly maintenance checks to ensure all rooms and doors are in working order. These checks were started on 2/16/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/16/2023*

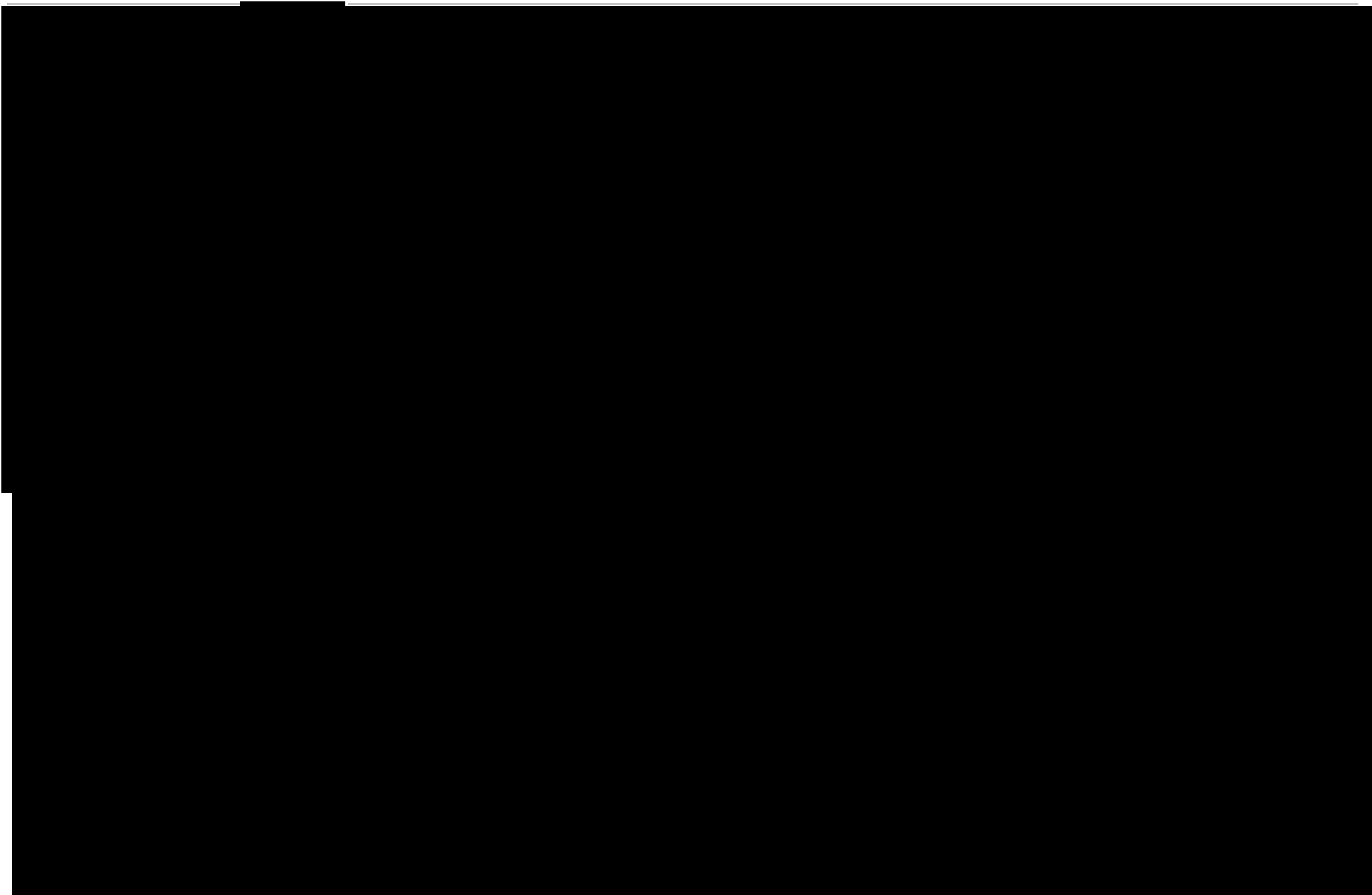
Not Implemented 03/28/2023)

51 - Criminal Background Check

5. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation



54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct are staff person C, hired , has performed direct care services and does not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Repeat violation: 7/1/22 *et al*

Plan of Correction ***Directed 03/14/2023)***

Staff person C, is currently in high school and have not received diploma yet.
On 2/2/23 the administrator received a letter from the school stating staff person C will graduate 6/2/23, staff C will not give direct care to residents until the administrator receives her diploma. Moving forward all direct care staff will have a HS diploma on record upon hire and while working with residents.

54a - Direct Care Staff (continued)

Training: The administrator and designee were educated during a QA meeting on 2/13/23. A staff records check was started on 2/13/23 and will continue to be done monthly to ensure the records are current and do not have any missing documents. Documentation is kept.

DIRECTED: Within 48 hours of receipt of this plan of correction: Staff person C will not perform direct care work until a HS Diploma is received in June 2023. Staff person A will be reassigned to other duties like kitchen and housekeeping duties until that time. or suspended. ■ 3/14/23

DIRECTED: Within 24 hours of receipt of this plan of correction: No direct care staff will hired without documentation of a HS Diploma, GED Diploma or listing on the the Certified Nursing Assistant registry. ■ 3/14/23

Licensee's Proposed Overall Completion Date: *03/07/2023*

Not Implemented ■ 03/28/2023)

65a - FS Orientation 1st Day

7. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person D, hired ■, has not received orientation in any of the required topics in accordance with 2600.65a.

Repeat violation: 7/1/22 et al

Plan of Correction ***Accept (■ - 03/06/2023)***

Staff D was missing the first day orientation of ■ training packet. First day orientation was completed on 1/23/23 and filed in ■ staff records file. All staff were educated during our QA meeting on 1/26/23. Moving forward the administrator or designee will conduct monthly checks to ensure all staff records are complete.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented ■ 03/28/2023)

82a - Poisonous Materials

8. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 1/11/23, there was no manufacturer's product label on the clear plastic spray bottle on the baker’s rack in the supply room. The bottle contained a clear liquid and was marked “bleach & water”.

Repeat violation: 7/1/22 et al

82a - Poisonous Materials *(continued)*

Plan of Correction ***Accept ███ 03/14/2023)***

On 1/11/23 the bottle with a mixture of bleach and water was labeled bleach and water but did not have an original bleach warning on it. Upon notification of this the administrator immediately placed the original bleach label with the warning on the spray bottle.
Training: 1/26/23 all staff was educated during a QA meeting about this regulation. Moving forward the home will only use spray bottles that come from the manufacturer and will no longer mix chemicals. The administrator or designee will check weekly to ensure there are no spray bottles that have been mixed with chemicals. These checks started on 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *03/10/2023*

Not Implemented ███ - 03/28/2023)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 1/11/23, multiple poisons were unlocked and accessible on the baker's rack in the supply room, including the following:
- A can of ant & roach killer, with a manufacturer's label indicating "If inhaled: Remove victim to fresh air. If not breathing, give artificial respiration preferably mouth to mouth. Get medical attention"
- Two 1-gallon jugs of Biocide 100, with a manufacturer's label indicating "If swallowed: Call a poison control center or doctor immediately for treatment advice."
- A container of Round-Up Extended Control Weed & Grass Killer, with a manufacturer's label indicating "In eyes: Call a poison control center or doctor for treatment advice."
- A can of paint, with a manufacturer's label indicating "If swallowed, call a poison control center, hospital emergency room, or physician immediately."

On 1/11/23, a 1-gallon jug of bleach, with a manufacturer's label indicating " Call a poison control center or doctor for treatment advice." was on the bathroom floor in bedroom 17.

Not all residents of the home, including resident #2, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Directed ███ - 03/14/2023)***

On 1/11/23 the door to the utility room was not locked. When notified of this the administrator immediately closed and locked the door. Also during the inspection there was a bottle of bleach left in bathroom 17 by the cleaner.

Training: all staff were educated on this regulation during a QA meeting on 1/26/23. Moving forward the administrator or designee will check each shift to ensure the utility room door is closed and locked. The administrator or designee will also check each shift to ensure there are no chemicals left in residents rooms or bathrooms. The checks for ensuring the utility room door is kept locked at all times started on 2/13/23. The checks for chemicals left in residents rooms and bathrooms started 3/10/23. Documentation is kept.

82c - Locking Poisonous Materials (continued)

DIRECTED: Within 24 hours of receipt of the plan of correction- The bleach in bathroom 17 will be removed and stored in a locked area.

Licensee's Proposed Overall Completion Date: *03/10/2023*

Not Implemented ███ 03/28/2023)

85a - Sanitary Conditions

10. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/11/23, there was approximately 3" of what appeared to be pink mold on the shower stall floor and bottom of the shower stall walls and a dark brownish/gray dirt with black raised specks covering approximately 15" at the bottom of all 3 sides of the shower stall walls in bedroom 17's bathroom.

On 1/11/23 at 4:25 p.m., as residents were gathering in the dining room for dinner, a male resident took out a cordless shaver and began shaving his head & beard at the table. The resident continued to shave despite objections from other residents sitting at the dining table.

Plan of Correction ***Accept ███ - 03/14/2023)***

On 1/11/23 during the inspection it was discovered a shower in room 17 was dirty. Upon notifying the administrator it was cleaned immediately. Also during the inspection close to dinner time a male resident was observed using a cordless razor shaving at the dining room table, upon seeing this behavior the resident was immediately redirected back to ███ room and was assisted with finishing ███ shave. The staff explained to the resident that it is unsanitary to shave at the table.
Training: During a QA meeting on 1/26/23 all staff were educated on this regulation. Moving forward the administrator or designee will check weekly to ensure all bathroom showers are cleaned and in good working order. They will also make sure residents are shaving in the bathroom area's. These checks started on 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *03/07/2023*

Implemented (███ - 03/28/2023)

85e - Trash Outside Home

11. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/18/23, there was a large black trash bag on the ground next to the dumpster.

Plan of Correction ***Accept ███ - 03/06/2023)***

On 1/18/23 someone sat a trash bag on the ground next to the dumpster the administrator removed the bag before the agents left that day.

85e - Trash Outside Home (continued)

Training: On 1/26/23 all staff were educated on regulation 2600. 85 e. Moving forward the administrator or designee will check daily to ensure there are no trash bags or debris on the ground or by the dumpster. These checks were started on 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (█ - 03/28/2023)

101j7 - Lighting/Operable Lamp

12. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 1/11/23, bed #1 in bedroom 6 did not have a source of lighting that could be turned on/off from bedside.

On 1/11/23, bed #2 in bedroom 6 did not have a source of lighting that could be turned on/off from bedside. as the tap light in was inoperable.

On 1/11/23, bed #1 in bedroom 10 did not have a source of light that could be turned on/off from bedside.

Repeat violation: 7/1/22 et al

Plan of Correction ***Accept (█ - 03/06/2023)***

On 1/11/23 during the inspection in room #6 it was found that there was not a lamp beside bed #1 and a tap light that was not working properly. Also in room #10 there was not a lamp next to bed #1. The lamps were put next to all beds that did not have lamps next to them before the agents left the home.
Training: on 1/26/23 all staff were educated on this regulation during a QA meeting. Moving forward the administrator or designee will check weekly to ensure all residents have a working lamp next to each bed. These checks started 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (█ - 03/28/2023)

101o - Walls, Floors, Ceilings

13. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 1/11/23, there was a carpet stain, approximately 3"x4" on top of a larger dark brown stain approximately 20" x 15" to the left of bed #1 in bedroom 10.

101o - Walls, Floors, Ceilings *(continued)*

Plan of Correction ***Accept (JW - 03/06/2023)***

On 1/11/23 during the inspection in room #10 there was a stain found on the carpet next to bed #1. The carpet was cleaned before the agents left the home.
Training: all staff were educated on this regulation during a QA meeting on 1/26/23. Moving forward the administrator will do daily checks of all rooms to ensure the carpets are clean and free of stains. These checks were started on 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented - 03/28/2023)

103i - Outdated Food

14. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 1/11/23, two undated, extra-large plastic bags of chicken pieces in the chest freezer located in the pantry.

Plan of Correction ***Accept - 03/06/2023)***

On 1/11/23 during inspection there were two bags of chicken that were in the original packaging but was not dated. The administrator placed a date on both bags of chicken immediately.
Training: all staff were educated on 1/26/23 during a QA meeting on this regulation. Moving forward the administrator or designee will check weekly to ensure all foods have a label and date. These checks were started 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (- 03/28/2023)

132a - Monthly Fire Drill

16. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

There was no fire drill conducted during the month of September 2022.

Repeat violation: 7/1/22 et al

Plan of Correction ***Accept 03/06/2023)***

The home did not conduct a fire drill during the month of September 2022.
Training: all staff were educated on this regulation on 1/26/23 during a QA meeting. Moving forward the administrator or designee will check monthly to ensure all fire drills are being done and documented correctly. These checks were started 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Not Implemented - 03/28/2023)

132c - Fire Drill Records

17. Requirements

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 does not indicate the number of residents in the home at the time of each drill, "Yes" was indicated on that line on the form.

The fire drill record for the drills conducted on 12/18/22 and 1/18/23 at 10 does not indicate a.m. or p.m. or the actual amount of time to evacuate in minutes and seconds.

The fire drill record for the drills conducted on the following dates do not indicate the time the drills were held:

- 10/18/22, 7:00 a.m. – 3:00 p.m. shift
- 10/18/22, 3:00 p.m. – 11:00 p.m. shift
- 10/18/22, 11:00 p.m. - 3:00 p.m. shift

132c - Fire Drill Records (continued)

- 11/18/22, 7:00 a.m. – 3:00 p.m. shift
- 11/18/22, 3:00 p.m. – 11:00 p.m. shift
- 11/18/22, 11:00 p.m. - 3:00 p.m. shift
- 12/18/22, 7:00 a.m. – 3:00 p.m. shift
- 12/18/22, 3:00 p.m. – 11:00 p.m. shift
- 1/18/23, 7:00 a.m. – 3:00 p.m. shift
- 1/18/23, 3:00 p.m. – 11:00 p.m. shift

The fire drill log does not indicate the actual amount of time to evacuate in minutes and seconds for the following fire drills:

DATE	TIME	SHIFT	EVACUATION TIME
10/18/22	10 a.m.	7:00 a.m. – 3:00 p.m.	15
10/18/22	------	3:00 p.m. – 11:00 p.m.	8
10/18/22	------	11:00 p.m. – 7:00 a.m.	10
11/18/22	------	7:00 a.m. – 3:00 p.m.	15
11/18/22	------	3:00 p.m. – 11:00 p.m.	8
11/18/22	------	------	10
12/18/22	------	7:00 a.m. – 3:00 p.m.	15
12/18/22	------	3:00 p.m. – 11:00 p.m.	8
12/18/22	------	11:00 p.m. – 7:00 a.m.	10
1/18/23	------	7:00 a.m. – 3:00 p.m.	15
1/18/23	------	3:00 p.m. – 11:00 p.m.	8
1/18/23	------	11:00 p.m. – 7:00 a.m.	10

Plan of Correction ***Accept - 03/06/2023)***

Fire drills were not documented correctly.
Training: on 1/26/23 during a QA meeting all staff were educated on how to properly document fire drills. Moving forward the administrator or designee will check monthly to ensure proper documentation is properly made. These checks were started on 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Not Implemented - 03/28/2023)

132d - Evacuation

18. 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

The below fire drills exceeded 2 minutes and 30 seconds for evacuation time.

SHIFT DATE TIME EVACUATION TIME

132d - Evacuation (continued)

7:00 a.m. – 3:00 p.m.	10/18/22	10 a.m.	15
3:00 p.m. – 11:00 p.m.	10/18/22	-----	8
11:00 p.m. – 7:00 a.m.	10/18/22	-----	10
7:00 a.m. – 3:00 p.m.	11/18/22	-----	15
3:00 p.m. – 11:00 p.m.	11/18/22	-----	8
Blank	11/18/22	-----	10
7:00 a.m. – 3:00 p.m.	12/18/22	-----	15
3:00 p.m. – 11:00 p.m.	12/18/22	-----	8
11:00 p.m. – 7:00 a.m.	12/18/22	-----	10
7:00 a.m. – 3:00 p.m.	1/18/23	-----	15
3:00 p.m. – 11:00 p.m.	1/18/23	-----	8
11:00 p.m. – 7:00 a.m.	1/18/23	-----	10

The home does not have a designated evacuation time specified in writing within the past year from a fire safety expert.

Plan of Correction ***Directed (/14/2023)***

The home does not have proper fire drill documentation. The home is currently waiting to schedule a timed fire drill with the North Fayette Fire Chief.
Training: all staff were educated on 1/26/23 during a QA meeting about proper fire drill documentation. The administrator contacted fire chief of North Fayette to observe a timed fire drill and waiting on a response from . The administrator will check monthly to ensure all fire drills are being done and checking for proper documentation is being made. These checks started on 2/13/23. Documentation is kept.

DIRECTED: The administrator will monitor all fire drills and the fire drill record to ensure a fire drill is conducted at least once a month, all residents are evacuated to a public thoroughfare, or to a fire-safe area in 2 minutes 30 seconds or under, or in accordance with a time designated in writing, by a fire safety expert within the past year, if this is obtained. The administrator will ensure fire drills are documented for each fire drill on a record which includes all information required by 2600.132c.

Directed Completion Date: *03/10/2023*

Not Implemented - 03/28/2023)

Violation withdrawn 3/28/23

162c - Menus Posted

20. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 1/11/23, the posted menus were dated 1/2/23-18/23 and 1/9/23 – 1/15/23. The menu for the upcoming week was not posted.

Plan of Correction ***Accept - 03/06/2023)***

The new menu is usually completed on Wednesday when the food order is submitted. The menu was completed before the agent left the building.
Training: The administrator will now complete the menu each Friday before the new menu is scheduled. All staff were educated on 1/26/23 during a QA meeting. The administrator will check weekly to ensure there are always two menu's posted, a current week and the next week. These checks were started 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented - 03/28/2023)

183b - Meds and Syringes Locked

21. 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

On 1/11/23, in bedroom 15, there was a bottle of Hydroxychloroquine on a table and a tube of Calmoseptine on the bathroom sink, both belonging to resident #3, unlocked and accessible.

Plan of Correction ***Accept - 03/06/2023)***

On 1/11/23 the agent found two prescription medications in room 15 that belonged to resident #3, after further investigation into this the administrator was told that the of resident #3 gave them to The medications were immediately removed from the room.

183b - Meds and Syringes Locked (continued)

Training: all staff were educated on this regulation during a QA meeting on 1/26/23. Moving forward the administrator or designee will check daily to ensure there is no medications in a resident room. These checks were started 2/13/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

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

187a - Medication Record

22. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

The January 2023 medication administration record (MAR) for resident #4 does not include a diagnosis or purpose for Metoprolol Tartrate 25mg.

Repeat violation: 7/1/22 et al and 3/30/22 et al

Plan of Correction ***Accept [redacted] - 03/06/2023)***

Upon notification of this violation the administrator while the agent was still in the home called the doctor and received a proper diagnosis for the resident and presented this documentation to the agent showing that it was on the MAR.
Training: all staff were educated on this regulation during a QA meeting on 1/26/23. Moving forward a cart audit will be done weekly by the administrator or the designee to ensure all medications match the MAR along with a proper diagnosis. These checks were started on 2/8/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented [redacted] - 03/28/2023)

225a - Assessment 15 Days

23. 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

Resident #2 was admitted [redacted] however, the assessment was not completed until 10/7/22.

Repeat violation: 7/1/22 et al

Plan of Correction ***Accept ([redacted]/06/2023)***

Reg 2600 225.a Assessment was not completed within the 15 day requirement for resident #2.
On 2/10/23 administrator checked all assessments to ensure they were completed.
Training: on 2/10/23 the administrator and designee were trained on reg 2600 225.a Initial and Annual Assessments. Moving forward the administrator or designee will start auditing each resident's records to ensure assessments are

225a - Assessment 15 Days (continued)

completed within a timely manor. These checks were started on 2/10/23.

Licensee's Proposed Overall Completion Date: *02/16/2023*

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

252 - Record Content

24. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
 23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

Resident #5 ceased to breathe in the home on [redacted]; however, on 1/19/23, the home does not have a copy of the resident's death certificate.

Plan of Correction ***Accept [redacted]/06/2023)***

At the time the agents where in the home i had not received resident #5's death certificate. However i did receive the certificate on 2/7/23.
Training: On 1/26/23 all staff were educated on this regulation during a QA meeting. Moving forward the administrator or designee will check monthly to ensure all death certificates are received. These checks were started on 2/7/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented [redacted] - 03/28/2023)