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

June 28, 2023

[redacted]
BCB HOLDINGS FUND
[redacted]

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

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/09/2023 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *VICTORIA MANOR PERSONAL CARE HOME* **Licen e #**: *44642* **Licen e Expiration**: *10/25/2023*

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

Staffing Hours

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

Inspection Information

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

Reason: *Complaint, Fine* **Exit Conference Date**: *05/09/2023*

Inspection Dates and Department Representative

05/09/2023 On Site [redacted], [redacted]

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: *1* **Are 60 Years of Age or Older**: *27*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

05/09/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/27/2023*

06/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/29/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/09/2023*

Inspections / Reviews *(continued)*

06/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/20/2023*

06/28/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

51 - Criminal Background Check

1. 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

No Pennsylvania criminal background check was completed for direct care staff person A, who was hired on [redacted]/22.

REPEAT VIOLATION: 1/11/2023, et. al.; 7/1/2022, et. al.

Plan of Correction ***Directed ([redacted] - 06/12/2023)***

Staff person A was hired on [redacted]/22 and a background check was immediately submitted but was not returned. The owner is the one who does the background checks. The background check for staff A was resubmitted on 5/30/23 and returned. The background check was immediately filed in staff A's employee records chart.
Moving forward a criminal check will be submitted right away and if not returned within 30 days the staff will in fact be suspended until the background check is completed and returned to the home.
Training: The administrator and designee were educated during a meeting including reg 2600 51 that the homes hiring policy or process be in accordance with OAPSA and that the background check is documented on the PA State Police Reques for Criminal Record Check form or the e- patch system on 5/18/23. Documentation is kept of education. A staff records check was started by the administrator or designee on 5/19/23 and will continue to be done monthly to ensure the records are current and do not have any missing documents. Documentation is kept.

DIRECTED: By 6/20/23: The administrator shall review all current staff person records to ensure a Pennsylvania criminal background check was completed for each current staff person. Copies of the completed background checks shall be kept in each staff person's record. [redacted] 6/12/23

DIRECTED: By 6/20/23: The administrator shall develop and implement a new hire checklist to ensure a Pennsylvania criminal background check is completed at time of hire for all newly-hired staff persons in accordance with the Older Adult Protective Services Act. Copies of the completed new hire checklists, as well as copies of the completed background checks, shall be kept in each staff person's record. [redacted] 6/12/23

Directed Completion Date: *06/20/2023*

Implemented ([redacted] - 06/28/2023)

54a - Direct Care Staff

2. 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

No high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry was present for direct care staff person A, who was hired on [redacted]22.

REPEAT VIOLATION: 1/11/2023, et. al.; 7/1/2022, et. al.

54a - Direct Care Staff *(continued)*

Plan of Correction ***Directed (LM - 06/12/2023)***

On 5/9/23 staff A did not have a diploma or GED on file with the home. Staff A was and is aware that the home needs to have a copy. However, staff A could not find [redacted] diploma. Within 48 hours of the receipt of this plan of correction staff A will not perform direct care work until a high school diploma or GED is received. Staff person A will be reassigned to other duties like kitchen and housekeeping duties until the diploma or GED is received.
Training: The administrator and designee were educated during a training on 5/18/23 about reg 2600. 54.a. on quialifications for direct care staff persons. Documentation of the education is kept. A staff records check was started by the administrator on 5/19/23 and will continue to be done monthly to ensure records are current and do not have any missing documents. Documentation is kept.

DIRECTED: By 6/20/23: The administrator shall review all current direct staff person records to ensure qualifications specified in 2600.54a are present in each direct care staff person's record. Copies of qualifications shall be kept in each staff person's record. [redacted] 6/12/23

DIRECTED: By 6/20/23: The administrator shall develop and implement a new hire checklist to ensure copies of qualifications specified in 2600.54a are obtained at time of hire for all newly-hired direct care staff persons. Copies of the completed new hire checklists, as well as copies of the qualifications, shall be kept in each staff person's record. [redacted] 6/12/23

Directed Completion Date: *06/20/2023*

Implemented ([redacted] - 06/28/2023)

81a - Accomodation

3. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home routinely leaves medication carts in the hallway near resident #1's bedroom, which does not allow for resident #1 to safely move throughout the home [redacted]

Plan of Correction ***Accept ([redacted] - 06/12/2023)***

On 5/9/23 med cart B was stationed in hallway B two doors down from resident #1's bedroom. On 5/9/23 the cart was immediately moved further down the hall so it was not in the path of resident #1.
Training: On 5/18/23 all staff were educated on reg 2600. 81.a. that nothing can block the pathway of resident #1. The home's physical site must be designed, arranged, or furnished to meet residents needs. Documentation of education is kept.
On 5/19/23 a daily check was started by the administrator or designee to ensure there is nothing blocking the path of resident #1 in the hallway. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] - 06/20/2023)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

At approximately 9:00 am, a strong odor of urine was present in the hallway outside of bedrooms [redacted] and [redacted], as well as inside bedroom [redacted].

Plan of Correction ***Accept ([redacted] - 06/12/2023)***

On 5/9/23 an order of urine was present in the hallway by room [redacted] and [redacted] also inside of room [redacted]
On 5/10/23 rooms [redacted] and [redacted] were both cleaned using a carpet cleaner.
Training: All staff were educated during a training on 5/18/23 on reg 2600. 85.a. Sanitary conditions must be maintained. Documentation of this education is kept. A daily check was started by the administrator or designee on 5/19/23 to ensure all rooms were odor free. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] 06/20/2023)

88a - Surfaces

5. 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

At approximately 11:00 am, numerous dark and sticky stains were present on the carpeting to the left of resident #1's bed.

Plan of Correction ***Accept ([redacted] - 06/12/2023)***

On 5/9/23 there was a sticky spot on resident #1's bedroom floor. On 5/9/23 the sticky spot was scrubbed and removed.
Training: All staff were educated on reg 2600. 88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean and in good repair and free of hazards. Documentation of this education is kept. A daily resident room check was started by the administrator or designee on 5/19/23 to ensure all rooms were clean and free of spots on the carpet. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] 06/28/2023)

101j3 - Bed/Linens/Pillows/Blankets

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

At approximately 11:00 am, no pillow case was present on resident #1's pillow. Also, numerous dark red/brown stains were present on resident #1's pillow.

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Plan of Correction ***Accept (LM - 06/12/2023)***

On 5/9/23 resident #1's pillow did not have a pillow case and the pillow was stained. On 5/9/23 immediately the administrator removed the stained pillow and replaced it with a new pillow and pillow case.
Training: All staff were educated on 5/18/23 about reg 2600. 101.j. that each resident shall have the following in the bedroom: Pillows, bed linens and blankets that are clean and in good repair. Documentation of this education is kept. On 5/19/23 a daily check was started by the administrator or designee to ensure every resident has a clean pillow with a pillow case. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] - 06/28/2023)

132a - Monthly Fire Drill

7. Requirements

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

Description of Violation

According to staff person B, the home's administrator, the administrator routinely notifies at least one staff person in advance of the monthly fire drills.

REPEAT VIOLATION: 1/11/2023, et. al.; 7/1/2022, et. al.

Plan of Correction ***Accept ([redacted] - 06/12/2023)***

On 5/9/23 the administrator was told no staff is to be notified in advance about a monthly fire drill.
Training: On 5/18/23 all staff were educated on reg 2600. 132.a. unannounced drills ensure that staff and residents will be prepared to evacuate without hesitation in the event of a real fire. Documentation of the education is kept.
During a meeting with [redacted] on 5/24/23 the administrator was educated that one staff who is pulling the fire alarm is aloud to be notified of the drill.
The administrator will check monthly to ensure all fire drills are being done properly and documented properly. The administrator will also interview at least one staff who participated in the fire drill to ensure they were not notified in advance that the fire drill was going to take place. These checks were started on 5/19/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] - 06/28/2023)

132c - Fire Drill Records

8. 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 home's fire drill records do not indicate if the fire drill conducted on 4/20/23 at 10:30 was conducted in the am or pm.

REPEAT VIOLATION: 1/11/2023, et. al.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept ([redacted] - 06/05/2023)***

On 5/9/23 the documentation for the home's fire drill was not documented correctly and did not indicate if the drill was conducted in the am or pm. On 5/9/23 the documentation was immediately corrected.
Training: on 5/18/23 all staff were educated on reg 2600.0 132.c and how to properly document fire drills. The administrator or designee will check monthly to ensure all fire drills are being documented properly. These checks were started on 5/19/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented ([redacted] - 06/28/2023)

132d - Evacuation

9. 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 home does not have documentation from a fire safety expert within the past year indicating a maximum evacuation time to a public thoroughfare that exceeds 2 minutes, 30 seconds. During the following fire drills, the evacuation time to the public thoroughfare exceeded 2 minutes, 30 seconds:

Date and time of fire drill	***Evacuation Time***
2/24/23 at 2:00 pm	*2 minutes, 50 seconds*
3/17/23 at 11:00 am	*4 minutes, 50 seconds*
4/20/23 at 10:30	*5 minutes, 30 seconds*

REPEAT VIOLATION: 1/11/2023, et. al.

Plan of Correction ***Directed ([redacted] - 06/12/2023)***

On 5/9/23 the home did not have the documentation of a supervised timed fire drill. The administrator reached out to the fire chief of North Fayette for the documentation and it was emailed to DHS on 5/11/23. However, the fire drill did not indicate a timed drill. On 6/1/23 the administrator reached out to the fire chief again and was sent a timed fire drill for the fire drill that was done on 3/17/23. Documentation is kept.
Training: On 5/18/23 all staff were educated during a meeting on reg 2600.132.d. a timed 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. Documentation of this education is kept. Moving forward the administrator will check the fire drill log monthly to ensure fire drills are being done and documented correctly. These checks started 5/19/23. Documentation is kept. (DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall review the home's fire drill records monthly to ensure all residents evacuate to a public thoroughfare or to a designated fire-safe area as designated in writing within the past year by a fire safety expert, within the time specified within the past year by the fire safety expert. [redacted] 6/12/23).

Directed Completion Date: *06/20/2023*

Implemented ([redacted] - 06/28/2023)

132i - Testing Fire Alarm

10. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

According to staff person B, the home routinely does not set off the fire alarm during the monthly fire drills.

Plan of Correction ***Accept ([redacted] - 06/12/2023)***

On 5/9/23 the administrator was informed that the home does need to set the fire alarm off and not use a different form of alarm while conducting a fire drill.
Training: On 5/18/23 all staff were educated on reg 2600. 132.i. a fire alarm or smoke detector shall be set off during each fire drill. All staff were educated on how to activate the alarm system for a fire drill. Documentation on this education is kept. The administrator or designee is responsible for initiating the fire drill. The administrator will check monthly to ensure all fire drills are being documented properly. The administrator will check monthly to ensure the fire alarm is active during each fire drill being held. These checks were started on 5/19/23. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] - 06/28/2023)

225a - Assessment 15 Days

11. 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

An assessment has not been completed for resident #1, who was admitted to the home on [redacted]23.

An assessment has not been completed for resident #2, who was admitted to the home on [redacted]23.

An assessment has not been completed for resident #3, who was admitted to the home on [redacted]/23.

An assessment has not been completed for resident #4, who was admitted to the home on [redacted]/23.

REPEAT VIOLATION: 1/11/2023, et. al.; 10/24/2022; 7/1/2022, et. al.

Plan of Correction ***Accept ([redacted] - 06/12/2023)***

On 5/9/23 assessments for resident's #1,#2, #3, #4 were not completed and filed within the 15 day requirement. On 5/12/23 all assessments were completed and properly filed in the resident's charts. By 5/16/23 all resident assessments were checked by the administrator to ensure they were completed and filed in the resident charts.
Training: On 5/18/23 the administrator and designee were trained on reg 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. Documentation of this education is kept. The administrator started a monthly check on 5/19/23 to ensure assessments are completed within a timely manor. On 6/6/23 the administrator has added a new resident admission check list that needs verified twice, once upon admission and again in 30 days to ensure all documents have been

225a - Assessment 15 Days (continued)

received and completed in a timely manor. The administrator has also formed a new document that has completion and due dates for annual assessment updates. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented (- 06/28/2023)

227a Support Plan 30 Days

12. 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

A support plan has not been completed for resident #1, who was admitted to the home on /23.

A support plan has not been completed for resident #2, who was admitted to the home on /23.

A support plan has not been completed for resident #3, who was admitted to the home on /23.

A support plan has not been completed for resident #4, who was admitted to the home on /23.

REPEAT VIOLATION: 10/24/2022; 7/1/2022, et. al.

Plan of Correction ***Accept (- 06/12/2023)***

On 5/9/23 support plans for resident's !1, #2, #3, #4 were not completed and filed within the 30 day requirement. On 5/12/23 all support plans were completed and properly filed in the resident's charts. By 5/16/23 all resident support plans were checked by the administrator to ensure they were completed and filled in the resident charts.
Training: On 5/18/23 the administrator were educated on reg 2600. 227.a. residents shall have a written initial assessment that is documented on the department's assessment form within 15 days of admission. Documentation of this education is kept. On 6/6/23 the administrator has added a new resident admission check list that needs verified twice, once upon admission and again in 30 days to ensure all documents have been received and completed in a timely manor. The administrator has also formed a new document that has completion and due dates for annual

227a - Support Plan 30 Days (continued)

updates. Documentation is kept. The administrator started a monthly check on 5/19/23 to ensure all support plans are completed within a timely manor and properly documented. Documentation is kept.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] - 06/28/2023)