pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BCB HOLDINGS FUND**
LEGAL ENTITY

To operate **VICTORIA MANOR PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **100 ROSE COURT, OAKDALE, PA 15071**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **38**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 19, 2023** until **June 19, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **446424**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: DECEMBER 19, 2023

[redacted], Owner
BCB Holdings Fund
[redacted]

RE: Victoria Manor Personal Care Home
100 Rose Court
Oakdale, Pennsylvania 15071
License/COC #: 446424

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 6, 2023, and October 5, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a FOURTH PROVISIONAL license to operate the above facility. A FOURTH 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 FOURTH PROVISIONAL license is enclosed and is valid from December 19, 2023 to June 19, 2024.

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 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
51	II	28	$5	$140	5 calendar days from mailing date of this letter
54(a)	II	28	$5	$140	5 calendar days from mailing date of this letter
65(a)	II	28	$5	$140	5 calendar days from mailing date of this letter
225(a)	II	28	$5	$140	5 calendar days from mailing date of this letter
227(a)	II	28	$5	$140	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.

Your facility's FOURTH PROVISIONAL license will expire on 06/19/2024. Pursuant to 55 Pa. Code § 20.54, a maximum of four consecutive provisional certificates of compliance may be issued to the legal entity for each specific facility or agency (1 Pa. Code. Part II).

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], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

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

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [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:** *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

Type: *C-2 LP* **Date:** *01/02/1996* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *35* **Waking Staff:** *26*

Inspection Information

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

Reason: *Complaint, Provisional* **Exit Conference Date:** *07/06/2023*

Inspection Dates and Department Representative

07/06/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served:** *30*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *30*

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

Have Mobility Need: *5* **Have Physical Disability:** *0*

Inspections / Reviews

07/06/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/04/2023*

Inspections / Reviews *(continued)*

08/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/19/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/17/2023*

08/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/19/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/18/2023*

11/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/19/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

At 4:24pm, the laptops on both of the home's medication carts were unlocked, unattended, and accessible. Agents of the Department were able to access resident medication administration records (MAR's) from the unlocked and accessible laptops.

Plan of Correction ***Accept (- 08/18/2023)***

The med tech that was on shift left the laptops up and open during the inspection on 7/6/23. That staff member was verbally educated on the reg 2600. 17. and given a write up.
Training: All staff will be educated on this regulation during a staff meeting held on 8/11/23. Documentation will be kept in accordance with 2600.65i.
Moving forward the administrator or designee will check each shift to ensure no privacy laws are being broken. These checks will start 8/14/23. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/16/2023*

Implemented (- 11/21/2023)

25b SOPb1 - Rent Rebate: Amount Collected

3. Requirements

2600.
25b.b.1. If the home collects a resident's rent rebate under subsection (a), the resident-home contract is to include the following: The dollar amount or percentage of the rent rebate to be collected.

Description of Violation

Page 5 of resident #2's resident-home contract, dated , indicates the home keeps 50% of rent rebates; however, page 10 of resident #2's resident-home contract indicates the home keeps 0% of rent rebates.

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 page 10 of resident #2's contract was not properly documented. Resident #2's contract was updated by the administrator on 7/6/23. The administrator was educated on this regulation by the auditor on 7/6/23.
(DIRECTED: By 8/22/23: Resident #2 shall initial and date the edit to page 10 of resident #2's resident-home contract. A copy of the updated resident-home contract shall be kept in resident #2's record. 8/18/23).
Training: the administrator and designee will also be educated Documentation kept on this regulation 2600.25b.b.1 during a staff meeting on 8/11/23. The administrator will audit all resident contracts monthly. Documentation will be kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)

DIRECTED: Beginning on 8/25/23: The administrator shall develop and implement a new admission checklist to ensure a resident-home contract is completed in its entirety within 24 hours for all newly-admitted residents. Copies of the completed checklists shall be kept in each newly-admitted resident's record. 8/18/23.

DIRECTED: BY 9/1/23: The administrator shall review all current resident-home contracts to ensure each resident has a complete and accurate resident-home contract present in their record. 8/18/23

25b SOPb1 - Rent Rebate: Amount Collected (continued)

Directed Completion Date: *09/01/2023*

Not Implemented (- 11/21/2023)

51 - Criminal Background Check

4. 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

Staff person A, hired on , does not have a completed Pennsylvania criminal background check.

REPEAT VIOLATION: 5/9/2023; 1/11/2023, et. al.

Plan of Correction ***Directed (- 08/18/2023)***

Staff member #A's criminal background check was submitted on and was completed on and added in the staff file.
Training: all staff were educated on this regulation during a staff meeting documentation is kept. The administrator will continue to check monthly to ensure all new hire criminal background checks are completed in a timely manor, these checks started on 8/14/23. Documentation is kept.

DIRECTED: By 8/25/23: The administrator shall develop and implement a new hire checklist to ensure a Pennsylvania criminal background check is completed for each newly-hired staff person in accordance with the Older Adult Protective Services Act. Copies of the completed new hire checklists shall be kept in each staff person's record. 8/18/23

DIRECTED: By 9/1/23: The administrator shall review each current staff person's record to ensure each staff person has a completed Pennsylvania criminal background check present in their staff record. 8/18/23

Directed Completion Date: *09/01/2023*

Not Implemented (- 11/21/2023)

54a - Direct Care Staff

5. 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 care staff person B, hired on , does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

REPEAT VIOLATION: 5/9/2023; 1/11/2023, et. al.

54a - Direct Care Staff *(continued)*

Plan of Correction ***Directed (- 08/18/2023)***

Staff person B was hired on but could not find high school diploma however, did submit a request for high school graduate transcripts which were received at the home on 7/10/23. Documentation is kept.
Training: all staff were educated on this regulation during a staff meeting on 8/11/23. Documentation is kept
Moving forward the administrator has made a new hire sheet that will need to be reviewed by the administrator or designee 30 days after hire date. Documentation is kept. (DIRECTED: The new hire checklist shall be implemented by 8/25/23 to ensure copies of qualifications specified in 2600.54a are obtained at the time of hire for each newly-hired direct care staff person. Copies of the new hire checklist, as well as copies of the qualifications specified in 2600.54a, shall be kept in each newly-hired direct care staff person's record. 8/18/23).

DIRECTED: By 9/1/23: The administrator shall review each current direct care staff person's record to ensure copies of qualifications specified in 2600.54a are present in each direct care staff person's record. 8/18/23

Directed Completion Date: *09/01/2023*

Not Implemented (- 11/21/2023)

63a - First Aid/CPR Training

6. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 7/4/23 from 3:00pm to 11:00pm, there were no staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR. On this day, there were approximately 30 residents present in the home.

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 the auditor stated on 7/4/23 from 3:00pm to 11:00pm the home did not have a staff person trained in first aid and CPR. I gave them the list of everyone that took the class however i did not have on hand a copy of the card. Greg Davis was trained on 11/8/22 and is not due to renew until 11/2024. Auditors were given this information while in the facility. Documentation is kept.
Moving forward the administrator or designee will continue to schedule as is and monitor the schedule to ensure at least one staff has a current CPR/FA on each shift.

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator shall review the home's schedule daily to ensure at least 1 staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR is present in the home at all times. 8/18/23

DIRECTED: By 8/25/23: The administrator shall create a tracking system which includes the names of all current staff persons who are trained in first aid and certified in obstructed airway techniques and CPR, as well as the date of certification expiration. The tracking system shall be reviewed monthly by the administrator beginning on 9/1/23. 8/18/23

Directed Completion Date: *09/01/2023*

Not Implemented (- 11/21/2023)

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:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person B, whose first day of work was [redacted] did not receive orientation on any of the topics specified in 2600.65a.

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

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

On 7/6/23 training papers were not in staff person #B's file however, [redacted] was given the training papers along with the trainer. It was later found out that [redacted] took them home by accident and forgot to bring them back. Staff B is no longer employed with the home due to non compliance with the homes policies.
Training: All staff will be trained on this regulation during a staff meeting on 8/11/23. Documentation will be kept. (DIRECTED: Documentation of training shall be kept for each staff person in accordance with 2600.65i. [redacted] 8/18/23).
Moving forward the administrator will check each staff file to ensure they are all within regulation. The administrator has added a new hire check list to reference to and will be checked 30 days after each new hire. Documentation will be kept.

DIRECTED: By 8/25/23: The administrator shall develop and implement a new hire checklist to ensure each newly-hired staff person receives training on all topics specified in 2600.65a prior to or during their first work day. Copies of the completed new hire checklists shall be kept in each staff person's record. Documentation of the education shall be kept in each newly-hired staff person's record in accordance with 2600.65i [redacted] 8/18/23

Directed Completion Date: *08/25/2023*

Not Implemented ([redacted] - 11/21/2023)

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d - Initial Direct Care Training *(continued)*

Description of Violation

Direct care staff person C, hired on [redacted], did not successfully complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

On 7/6/23 staff person C did not have a direct care training certificate in [redacted] file which was once there. Staff person C was immediately taken off of direct care responsibility. Staff C no longer works at the home due to non compliance of the homes policies.
Training: all staff will be educated on this regulation during a staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept for each staff person in accordance with 2600.65i. [redacted] 8/18/23).
Moving forward the administrator has since added a new hire check list which needs to be checked within 30 days of hire to ensure all staff have proper documentation in their files. All staff files were checked by 8/14/23 by the administrator. Documentation is kept. (DIRECTED: The new hire checklist shall be implemented by 8/25/23. Copies of the completed new hire checklist shall be kept in each newly-hired staff person's record. Documentation of successful completion of the Department-approved direct care training course shall also be kept in each direct care staff person's record. [redacted] 8/18/23).

Directed Completion Date: *08/25/2023*

Not Implemented ([redacted] - 11/21/2023)

65e - 12 Hours Annual Training

9. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person D, hired on [redacted], only received 3 hours of annual training during the 2022 training year.

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

Staff member D was working part time and was not available during these training hours. Staff D has since been updated on [redacted] annual 12 hour training and reviewed all of the missing 9 hours by 7/20/23. Staff D is current on all training hours for the current year. Documentation is kept.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23.
Moving forward the administrator will keep a templet of all staff and their training hours. Documentation will be kept. The homes quality management meeting was already done earlier in the year. Documentation is kept.

DIRECTED: Beginning on 9/1/23: The administrator shall review the home's staff training plan and completed trainings monthly to ensure each direct care staff person receives at least 12 hours of annual training during each training year. The staff training plan and completed trainings shall also be reviewed during each of the home's quality management reviews in accordance with 2600.26b(3). Documentation of all quality management reviews shall be kept. [redacted] 8/18/23

Directed Completion Date: *09/01/2023*

65e - 12 Hours Annual Training *(continued)*

Not Implemented ([redacted] - 11/21/2023)

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person D, hired on [redacted], did not receive training on any of the topics specified in 2600.65f during the 2022 training year.

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

Staff member D was working part time and was not available during these training hours. Staff D has since been updated on [redacted] annual 12 hour trainings and reviewed the missing hours needed, all hours were updated by 720/23. Documentation is kept.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23.
Moving forward the administrator will keep a templet of all staff and their training hours. Documentation will be kept. Quality management meeting was earlier in the year. Documentation is kept

DIRECTED: By 9/1/23: Staff person D shall receive training on all topics specified in 2600.65f. Documentation of the training shall be kept in accordance with 2600.65i. [redacted] 8/18/23

DIRECTED: Beginning on 9/1/23: The administrator shall review the home's staff training plan and completed trainings monthly to ensure each direct care staff person receives training on all topics specified in 2600.65f during each training year. The staff training plan and completed trainings shall also be reviewed during each of the home's quality management reviews in accordance with 2600.26b(3). Documentation of all quality management reviews shall be kept. [redacted] 8/18/23

Directed Completion Date: *09/01/2023*

Not Implemented ([redacted] - 11/21/2023)

65g - Annual Training Content

11. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65g - Annual Training Content *(continued)*

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
5. Falls and accident prevention.

Description of Violation

Direct care staff person D, hired on [redacted], did not receive training on the following topics during the 2022 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Falls and accident prevention*

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

Staff member D works part time and was not available during these training hours. Staff d has since been updated on all of [redacted] missing annual 12 hours of by 7/20/23. Documentation is kept.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23. Our quality management meet was held earlier in the year.
Moving forward the administrator will keep a templet of all staff and their training hours. Documentation will be kept.

DIRECTED: By 9/1/23: Staff person D shall receive fire safety training completed by a fire safety expert or by a staff person trained by a fire safety expert and training on falls and accident prevention. Documentation of the training shall be kept in accordance with 2600.65i. [redacted] 8/18/23

DIRECTED: Beginning on 9/1/23: The administrator shall review the home's staff training plan and completed trainings monthly to ensure each staff person receives training on all topics specified in 2600.65g during each training year. The staff training plan and completed trainings shall also be reviewed during each of the home's quality management reviews in accordance with 2600.26b(3). Documentation of all quality management reviews shall be kept. [redacted] 8/18/2

Directed Completion Date: *09/01/2023*

Not Implemented ([redacted] - 11/21/2023)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

At 2:07pm, there was a strong odor of urine present in resident #2's shared bedroom.

At 2:07pm, there were feces present on the shower chair and on the floor next to the toilet in resident #2's shared bathroom.

REPEAT VIOLATION: 5/9/2023

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 upon notifying the administrator about the strong odor of urine and feces present on the shower chair in resident # 2's bathroom the administrator immediately had the bathroom cleaned.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23. Documentation will be kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator will check each bathroom daily to ensure they are clean and free of odor starting 8/14/23, staff will also check each shift. Documentation will be kept. (DIRECTED: The administrator daily checks shall include a daily check of the entire home, including bathrooms, to ensure sanitary conditions are maintained. 8/18/23).

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

92 - Windows

13. 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.

Description of Violation

At 2:26pm, no screen was present in resident #3's bedroom window, which was open at the time of inspection.

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 resident #3 removed screen from window. Upon learning the screen was removed the administrator immediately placed the screen back in the window and explained to the resident the screen needs to stay in the window.
Training: all staff will be educated on this regulation during a staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator will check daily to ensure all screens are placed in each window daily. These checks will start with documentation on 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

101j3 - Bed/Linens/Pillows/Blankets

14. 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 2:15pm, no linens were present on resident #2's bed.

REPEAT VIOLATION: 5/9/2023

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

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 during our inspection resident #2's bed was not made. The resident received a shower and bed was stripped to be washed, linen was in the wash, once it was finished bed was made.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward all beds will be checked daily by the administrator or designee to ensure they are made in a timely manor. Theses checks were started on 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

103f - Refrigerator/Freezer Temps

15. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 9:50am, no thermometer was present in the storage room silver refrigerator.

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 during the inspection the of the food room one of the thermometer's was accidently placed in the wrong refrigerator. The designated person doing the walk through with the auditor immediately placed it in the correct refrigerator on 7/6/23.
Training: all staff will be educated on this regulation on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator or designee will check daily to ensure each refrigerator has a working thermometer. These checks will start 8/14/23. Documentation will be kept. (DIRECTED: The daily checks conducted by the administrator shall include a daily check of all refrigerators and freezers to ensure an operable thermometer is present and proper food handling temperatures are maintained in accordance with 2600.103f. 8/18/23)

Directed Completion Date: *08/18/2023*

Not Implemented (- 11/21/2023)

103g - Storing Food

16. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 10:15am, there were 3 open and unsealed bags of potato chips, and 1 open and unsealed bag of stuffing mix in the kitchen cabinets.

REPEAT VIOLATION: 10/24/2022

103g - Storing Food (continued)

Plan of Correction ***Directed (- 08/18/2023)***

The 3 bags of chips and the unsealed bag of potato chips were thrown away immediately.
Training: all staff will be educated on this regulation during a staff meeting on 8/11/23. Documentation will be kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator or designee will check daily to ensure all food stored in the kitchen cabinets and all food storage areas are properly stored and closed or sealed containers. These checks will start 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

132e - Fire Drill Sleeping Hours

17. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home has not conducted a fire drill during sleeping hours within the past 6 months.

Plan of Correction ***Directed (- 08/18/2023)***

The home did not conduct a fire drill during sleeping hours within the past 6 months. The administrator was unaware that there had to be 6 consecutive months in between the sleeping hours fire drills. The administrator thought as long as the facility had 2 in a 12 month time frame we were within regulation. On 8/8/23 a sleeping hours fire drill was conducted at the home by the designee. Documentation is kept. (DIRECTED: Documentation of the 8/8/23 fire drill shall be kept in accordance with 2600.132c. 8/18/23)
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator will check monthly to ensure we are having the proper drills at the proper times. These checks started 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

141a 1-10 Medical Evaluation Information

18. Requirements

2600.

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

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

No medical evaluation was completed for resident #5, who was admitted to the home on [redacted]

Resident #2's medical evaluation, dated [redacted] *does not include resident #2's height, weight, blood pressure, allergies or body positioning/movement needs. These sections of the form are blank. Also, the medication addendum section of resident #2's medical evaluation is blank, and the medication list that is attached to the medical evaluation is dated* [redacted]

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

The medical evaluation was not properly filled out for resident #5 when [redacted] *came to to the home. The medical evaluations were updated on 7/10/23.*

DIRECTED: By 8/25/23: The administrator shall review the records of residents #2 and #5 to ensure each resident has a medical evaluation, completed in its entirety. Copies of the completed medical evaluations shall be kept in resident #2 and #5's records. [redacted] *8/18/23*
Training: all designated staff will be educated on this regulation during a staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. [redacted] *8/18/23)*
Moving forward the administrator will audit all resident medical evaluations and have them completed by 8/25/23. The administrator or designee will then continue to audit 5 medical evaluations per week to ensure they are properly completed and do not have any blank sections. Checks will be done monthly by the administrator or designee. Documentation will be kept.

DIRECTED: By 8/25/23: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety within 60 days prior to admission or within 30 days after admission for each newly-admitted resident. Copies of the completed checklists, as well as copies of the completed medical evaluations, shall be kept in each newly-admitted resident's record. [redacted] *8/18/23*

Directed Completion Date: *08/25/2023*

Not Implemented ([redacted] - 11/21/2023)

141b1 - Annual Medical Evaluation

19. Requirements

2600.

141b1 - Annual Medical Evaluation *(continued)*

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4's most recent medical evaluation, dated [redacted], does not include resident #4's temperature or body positioning/movement needs. These sections of the form are blank.

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

Resident #4's medical evaluation had sections on the form that were blank. The medical evaluation was updated 7/10/23. Documentation is kept.
Training: all designated staff will be educated on this regulation during a staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. [redacted] 8/18/23)
Moving forward has made a new tracking sheet to insure all medical evaluation for new and current residents are completed in a timely manor. The administrator or designee will audit all resident medical evaluations and have them completed by 8/25/23. The administrator or designee will then continue to audit at least 5 medical evaluations per week to ensure they are properly completed and do not have any blank sections. Documentation will be kept. (DIRECTED: The tracking system shall include the most recent dates of all resident medical evaluations, and shall be implemented by 8/25/23. Beginning on 9/1/23, the administrator shall review the tracking system monthly to ensure each resident has a timely medical evaluation, completed in its entirety, at least annually. [redacted] 8/18/23).

Directed Completion Date: *09/01/2023*

Not Implemented ([redacted] - 11/21/2023)

183e - Storing Medications

20. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #3's Toujeo insulin pen was open and undated. According to the manufacturer's instructions, open Toujeo insulin pens must be discarded after 56 days of opening.

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

Resident #3's insulin pen did not have an open date. The pen was immediately thrown away and replaced with a new pen.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. [redacted] 8/18/23)
Moving forward the administrator or designee will check daily to ensure each insulin pen is properly dated. All medications including insulin pens were reviewed to ensure medications are stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturers instructions by the administrator. These checks will start on 8/14/23 by the administrator or designee. Documentation will be kept.

Directed Completion Date: *08/18/2023*

183e - Storing Medications *(continued)*

Implemented (- 11/21/2023)

184a - Resident's Meds Labeled

21. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

No pharmacy label was present on resident #3's Toujeo insulin pen.

Plan of Correction ***Directed (- 08/18/2023)***

Resident #3's insulin pen did not have a label on it, it was in a labeled box that someone had thrown away. The med tech immediately contacted the pharmacy and had the label replaced that same day on 7/6/23.
Training: all staff will be educated on this regulation during our staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator or designated person will check daily to ensure each insulin pen is properly labeled. The administrator or designee will audit all medications monthly. These checks will start on 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

185b - Medication Procedures

22. 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 room.

Description of Violation

The home's medication administration policy states, "off going shift is to count ALL pills, liquids, or any forms narcotic with the oncoming shift. Two signatures are to be on the records after the count is done. If count is off no one (med tech) is to leave the building until the issue is resolved".
On , 2 syringes of Morphine Sulfate-100mg/5ml solution were delivered to the home for resident #4. Resident #4's controlled drug report indicates 2 syringes should be present in the home; however, on 7/6/23, only 1 syringe was present in the home. According to staff persons, they are not routinely counting narcotics stored in the refrigerator in

185b - Medication Procedures (continued)

accordance with the home's medication administration policy.

Plan of Correction ***Directed (- 08/18/2023)***

Resident #4's medication was off count. The med tech that administered the medication did not sign off on it. This staff member is no longer employed at the home.
Training: all staff were educated on this regulation and the homes updated narcotic policy which went into effect 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward a new narcotic sign off sheet has been created along with a new narcotic count policy. The administrator did audit all narcotics on 8/14/23. The administrator or designee will check daily to ensure accurate counts are being done. These checks will start 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

187b - Date/Time of Medication Admin.

23. 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's July 2023 MAR does not include the initials of the staff person who administered resident #1's Divalproex-125mg tablet on 7/2/23 at 2:00pm.

Resident #3's July 2023 MAR does not include the initials of the staff person who administered resident #3's Dicyclomine-10mg capsule on 7/2/23 at 12:00pm.

Resident #3's July 2023 MAR does not include the initials of the staff person who administered resident #3's Gabapentin-300mg capsule on 7/2/23 at 2:00pm.

REPEAT VIOLATION: 10/24/2022

Plan of Correction ***Directed (- 08/18/2023)***

Resident #1 and 3's July MAR did not include the initials of the staff person who administered the medications to these residents on 7/2/23. This staff person is no longer employed at the home.
Training: all staff will be educated on this regulation during a staff meeting on 8/11/23. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator or designee will check each resident MAR daily for one month then weekly to ensure medication is being properly signed off on. These checks will start 8/14/23. Documentation will be kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

225a - Assessment 15 Days

24. 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 #6 was admitted to the home on [redacted]; however, resident #6's assessment was not completed until [redacted]/22.

Resident #6's assessment, dated [redacted], does not include resident #6's supervision needs or medication administration needs. These sections of the assessment are blank.

REPEAT VIOLATION: 5/9/2023; 1/11/2023, et. al.; 10/24/2022

Plan of Correction ***Directed ([redacted] - 08/18/2023)***

On 7/6/23 Resident #6's support plan was not completed until 5 days after it was due, it was also missing the supervision needs and medication administration needs. These updates were made on 7/10/23 by the administrator.
Training: The administrator and designee will be educated on reg 2600. 225.a on 8/11/23 during a mandatory staff meeting for all staff. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. [redacted] 8/18/23)
Moving forward the administrator will audit 15 assessments within 2 weeks and the following 13 assessments the next 2 weeks. (DIRECTED: By 9/18/23: The administrator shall audit all current resident records to ensure each resident has an assessment completed in its entirety within 15 days of admission. Documentation of the audit shall be kept. [redacted] 8/18/23) The administrator or designee will then continue to audit the assessments each week using a new checklist to ensure the support plans are correctly updated with completed and updated with current changes. Documentation is kept. (DIRECTED: The weekly audits shall begin after 9/18/23. [redacted] 8/18/23).
DIRECTED: By 8/25/23: The administrator shall develop and implement a new admission checklist to ensure an assessment is completed in its entirety within 15 days of admission each newly-admitted resident. Copies of the completed checklists, as well as copies of the completed assessments, shall be kept in each newly-admitted resident's record. [redacted] 8/18/2

Directed Completion Date: *09/18/2023*

Not Implemented ([redacted] - 11/21/2023)

227a - Support Plan 30 Days

25. 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

Resident #1's assessment, dated [redacted] indicates resident #1 has minimal problems with long-term memory; however, resident #1's support plan, dated [redacted], indicates "none noted" for the description of service need.

REPEAT VIOLATION: 5/9/2023; 10/24/2022

227a - Support Plan 30 Days *(continued)*

Plan of Correction ***Directed (- 08/18/2023)***

On 7/6/23 resident #1's assessment dated was was not properly documented in the correct place. The administrator updated resident #1' support plan on 8/1/23.
Training: the administrator and designee will be educated on reg 2600. 227.a on 8/11/23 during a staff meeting. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator will audit 15 resident support plans within 2 weeks and the following 13 support plans the next 2 weeks. The administrator or designee will then continue to audit the support plans using an updated spread sheet each week to ensure the support plans are correctly updated with current changes. Documentation is kept. (DIRECTED: By 9/18/23: The administrator shall audit all current resident records to ensure each resident has a support plan completed in its entirety within 30 days of admission. Documentation of the audit shall be kept. 8/18/23)

DIRECTED: By 8/25/23: The administrator shall develop and implement a new admission checklist to ensure a support plan is completed in its entirety within 30 days of admission each newly-admitted resident. Copies of the completed checklists, as well as copies of the completed assessments, shall be kept in each newly-admitted resident's record. 8/18/2

Directed Completion Date: *09/18/2023*

Not Implemented (- 11/21/2023)

251b - Record Entries Legible

26. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on the legally-appointed guardian section, as well as the party responsible for payment section of resident #2's resident-home contract, dated

Plan of Correction ***Directed (- 08/18/2023)***

The administrator was given the wrong information for resident #2 when came to the home, without knowing it was a regulation violation the administrator used correction tape.
Training: all staff was educated on this regulation on 8/11/23 during a staff meeting. Documentation is kept. (DIRECTED: Documentation of training shall be kept in accordance with 2600.65i. 8/18/23)
Moving forward the administrator now knows the records must be permanent. The administrator or designee will audit all contracts monthly, these checks started on 8/14/23. Documentation is kept.

Directed Completion Date: *08/18/2023*

Implemented (- 11/21/2023)

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:** *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:** *31* **Waking Staff:** *23*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *10/05/2023*

Inspection Dates and Department Representative

10/05/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* **Residents Served:** *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older:** *28*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *3* **Have Physical Disability:** *0*

Inspections / Reviews

10/05/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/25/2023*

Inspections / Reviews *(continued)*

10/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/03/2023*

11/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/20/2023*

11/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

Direct care staff person A was hired on [redacted] however, a Pennsylvania criminal background check was not completed until [redacted]

REPEAT VIOLATION: 5/9/2023; 1/11/2023, et. al.

Plan of Correction ***Directed ([redacted] - 11/07/2023)***

Staff member A's background check information was submitted to the owner on [redacted], the administrator did not receive the completed background check until [redacted]
Training: All staff were educated on this reg 51 again during our training held on 10/24/23. Documentation is kept. Moving forward the administrator will continue to try to do a better job with making sure the background checks are completed in on time. The administrator will check weekly starting 11/13/23 until all staff files are completed, once all files are completed the administrator will check monthly to ensure the background checks are being completed , these checks will start 11/8/23. Documentation will be kept. (DIRECTED: By 11/20/23: The administrator shall review all current staff records to ensure each staff person has a Pennsylvania criminal background check completed and that a copy of the background check is present in each staff person's record. [redacted] 11/7/23). The administrator will also keep better communication with the owner, who is the person responsible for submitting the background checks.

DIRECTED: Beginning on 11/13/23: The administrator shall develop and implement a new hire checklist to ensure a Pennsylvania criminal background check is completed within 30 days of hire for all newly-hired staff persons. A copy of the completed checklist shall be kept in each staff person's record. All staff persons responsible for the hiring process shall be educated on the new checklist by 11/13/23. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 11/7/23).

Proposed Overall Completion Date: 11/03/2023

Directed Completion Date: *11/20/2023*

Not Implemented ([redacted] - 11/21/2023)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 9/28/23 from approximately 3:00pm until approximately 7:00am on 9/29/23, there were no staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR.

63a - First Aid/CPR Training *(continued)*

Plan of Correction ***Directed (- 11/07/2023)***

On 9/28/23 there were no staff that was CPR certified working 3pm-7am.
Training: All staff were educated on this reg 63.a during our staff training held on 10/24/23. Documentation kept.
Moving forward The administrator has contacted the CPR trainer and waiting on a response for our next training. All CPR training will be completed by 11/30/23. The administrator will continue to utilize the new staff CPR checklist that was created and will be reviewed weekly by the administrator to ensure all shifts were covered with a CPR certified staff member, these checks will start 11/8/23. Documentation is kept.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall review the home's schedule daily to ensure at least 1 staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR is present in the home at all times. 11/7/23

Proposed Overall Completion Date: 11/03/2023

Directed Completion Date: *11/09/2023*

Not Implemented (- 11/21/2023)

65i - Training Record

3. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Numerous records of training, to include the following, only include the month and year of the trainings and do not include the date the trainings occurred:

- *Personal Care Service Needs of Residents, dated "August 2023"*
- *Safe Management: Combative residents, dated "September 2023"*

Plan of Correction ***Directed (- 11/07/2023)***

All of the homes trainings only have the month and year, the administrator was not aware they had to have the day also since all of the other one's were only dated with month and year. All trainings are self study which is given at
Training: The administrator was educated on regulation 65i RCG book.
Moving forward starting for the month of November 2023 the date will be indicated on the post test, the administrator will have a tracking log for all post test to be completed by staff. Also the administrator will monitor to ensure all staff get at least an 80% or above on all post test. Documentation will be kept. The administrator will check the log monthly, these checks will start 11/8/23. Documentation will be kept.

DIRECTED: Beginning on 11/9/23: The administrator shall review all training records within 48 hours of completion to ensure each record of training includes the staff person trained, date, source, content and length of each course. 11/7/23

Proposed Overall Completion Date: 11/03/2023

Directed Completion Date: *11/09/2023*

65i - Training Record *(continued)*

Not Implemented (- 11/21/2023)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 9:43am, no thermometer was present in freezer #2, located in the food storage room.

Plan of Correction ***Accept (- 11/07/2023)***

No thermometer was present in freezer #2, it was located in another freezer that had two in it. The thermometer was placed back in freezer #2 by staff right away.
Training: Staff meeting held on 10/24/23 went over violation report including detail about how important it is to have thermometer's kept in the refrigerator's and freezer's. We also went over temperatures in regards to food safety. Documentation will be kept.
Moving forward, the administrator or designee will check all refrigerators and freezers twice daily to ensure all refrigerator's and freezer's have a working thermometer in them and correct temperatures, These checks will start 11/8/23. Documentation will be kept.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: *11/03/2023*

Not Implemented (- 11/21/2023)

141b1 - Annual Medical Evaluation

5. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on .

Resident #2's most recent medical evaluation was completed on however, resident #2's previous medical evaluation was completed on .

Plan of Correction ***Directed (- 11/07/2023)***

Resident #1 and #2s most recent medical evaluation were not currently up to dated. Resident #1 sees an outside doctor and the administrator requested the DME at an earlier date. The administrator faxed the resident's doctor for an updated DME on 10/25/23.
(DIRECTED: By 11/20/23: The administrator shall ensure residents #1 and #2 have a new medical evaluation completed at least annually. Copies of the completed medical evaluations shall be kept in residents #1 and #2's

141b1 - Annual Medical Evaluation (continued)

records. [redacted] 11/7/23).
Training: All staff were educated on reg 141.b during a staff training on 10/24/23. Documentation is kept.
Moving forward the administrator will continue to check all medical evaluations dates to ensure they are being completed by the doctor in a timely manor. All medical evaluations will be evaluated and up to date by 10/30/23. After all DME's are checked the administrator will check monthly, these checks will start 11/8/23. Documentation will be kept.

DIRECTED: By 11/12/23: The administrator shall develop and implement a tracking system to ensure each resident has a medical evaluation completed in its entirety at least annually. The tracking system shall be reviewed and updated monthly by the administrator to ensure timely completion of resident medical evaluations in accordance with 2600.141b. Documentation of the tracking system shall be kept. [redacted] 11/7/23

Proposed Overall Completion Date: 11/03/2023

Directed Completion Date: *11/20/2023*

Not Implemented ([redacted] - 11/21/2023)

183d - Prescription Current

6. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

A bottle of Amlodipine-5mg tablets, which belong to resident #3, was present in the home's medication cart; however, resident #3 is not currently prescribed this medication.

Plan of Correction ***Directed ([redacted] - 11/07/2023)***

Resident #3 is a fairly new resident, [redacted] family brought the medication in and one of the med techs just put it in the cart until we could get an order for it.

Training: All staff were educated on reg 183.d during a staff meeting held on 10/24/23. The staff has been educated and documentation is kept.
Moving forward the medication was removed from the medication cart and stored in the administrators office until the family picked it up on 10/5/23. All medication for all residents will be audited by 10/30/23, then cart audits will be done weekly to ensure all medications are correct and there are no medication in the cart that are not on the MAR. (DIRECTED: The weekly medication audits shall begin on 11/15/23, and be completed by the administrator. [redacted] 11/7/23). Documentation will be kept.

Proposed Overall Completion Date: 11/03/2023

Directed Completion Date: *11/15/2023*

Not Implemented ([redacted] - 11/21/2023)

225a - Assessment 15 Days

7. 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 #4's assessment, dated [redacted] does not include resident #4's supervision needs or medication administration needs. These sections of resident #4's assessment are blank.

REPEAT VIOLATION: 5/9/2023; 1/11/2023, et. al.; 10/24/2022

Plan of Correction ***Directed ([redacted] - 11/07/2023)***

Resident #4's support plan for supervision and medication needs was written out but not checked off. The administrator completed a new and complete support plan on 10/10/23. Documentation is kept.
Training: All staff were trained during a staff meeting on completion of support plans on 10/24/23. Documentation will be kept.
Moving forward, the administrator did correct and made a whole new support plan for Resident #4 on 10/10/23. Documentation is kept. The administrator will check weekly all support plans for blank sections starting 10/30/23. (DIRECTED: During the weekly reviews, the administrator shall also ensure resident assessments are current and accurately reflect each resident's care needs. [redacted] 11/7/23). Documentation will be kept.

Proposed Overall Completion Date: 11/03/2023

Directed Completion Date: *11/07/2023*

Not Implemented ([redacted] - 11/21/2023)