



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: June 26, 2024

[REDACTED]
Norbert Inc.
[REDACTED]

[REDACTED]: Norbert Residential Care Facility
2413 St. Norbert Drive
Pittsburgh, Pennsylvania 15234
License #: 430510

Dear [REDACTED]:

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is an increase of the secured dementia care unit's capacity from 7 to 17. The total maximum capacity of 102 and the expiration date of the license remains unchanged.

Any future requests for changes in capacity should be forwarded to the Department for review and consideration in accordance with the applicable regulations. The revised license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
License

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

Facility Information

Name: *NORBERT RESIDENTIAL CARE FACILITY* License #: *43051* License Expiration: *12/16/2024*
Address: *2413 ST. NORBERT DRIVE, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *NORBERT INC*
Address: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: *72* Waking Staff: *54*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident, New* Exit Conference Date: *04/25/2024*

Inspection Dates and Department Representative

04/25/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *102* Residents Served: *50*

Secured Dementia Care Unit

In Home: *Yes* Area: *3A* Capacity: *7* Residents Served: *4*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *1* Are 60 Years of Age or Older: *49*
Diagnosed with Mental Illness: *5* Diagnosed with Intellectual Disability: *3*
Have Mobility Need: *22* Have Physical Disability: *1*

Inspections / Reviews

04/25/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/19/2024*

Inspections / Reviews *(continued)*

05/20/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/18/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/24/2024

05/29/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/18/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 06/30/2024

06/20/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/18/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED]/24 at approximately 6:30pm, staff person A, who was a medication technician, walked out of the home and abandoned [REDACTED] shift. Staff person B, who was the other medication technician working in the home, texted staff person C, who is the home's Resident Care Coordinator, notifying [REDACTED] that staff person A walked out of the home. Staff person C instructed staff person B to finish staff person A's medication pass to residents; however, staff person B did not administer medications to any of the effected residents. As a result, approximately 26 residents did not receive their medications on the evening of [REDACTED]/24, to include the following residents:

- Resident #1's Aspart Flexpen 100 unit/ml insulin-Inject 4 units subcutaneously at bedtime
- Resident #1's 8:30pm dose of Lantus Solostar 100 unit/ml insulin-Inject 14 units subcutaneously twice daily
- Resident #1's 8:30pm dose of Mycophenolate 500mg tablet-Take 1 tablet by mouth twice daily
- Resident #2's Basaglar Kwikpen 100 unit/ml insulin-Inject 8 units subcutaneously at bedtime
- Resident #2's 8:30pm dose of Brilinta 60mg tablet-Take 1 tablet by mouth 2 times a day
- Resident #2's Oxycodone 5mg tablet-Take 1 tablet by mouth at bedtime
- Resident #3's 4:30pm dose of Gabapentin 100mg capsules-Take 2 capsules by mouth 3 times daily
- Resident #3's 4:30pm and 8:30pm doses of K'Phos Original tablet-Take 1 tablet by mouth before meals and at bedtime
- Resident #3's 4:30pm dose of Morphine Sulfate 15mg tablet-Take 1 tablet my mouth 3 times daily

Plan of Correction

Directed [REDACTED] - 05/29/2024)

- Upon discovery that Staff Person B did not administer the medications as [REDACTED] was instructed to, Staff Person C immediately alerted the Administrator and DON. Staff Person B had not indicated at the time of instruction that [REDACTED] was unable and/or unwilling to complete the medication pass. Staff Person B had previously passed the evening medications by [REDACTED] several times and had no issues. Staff Person A and Staff Person B were terminated the morning of [REDACTED]/24 by the Administrator.
- Upon notification, the Director of Nursing initiated medication error investigation and conducted notifications to responsible parties and physicians regarding failed administration of medications. Responsible parties of residents expressed appreciation of the immediate notification and that no adverse effects had been observed. Vital signs obtained were obtained and staff monitored residents; no adverse outcomes were observed or reported by residents.
- DON conducted staff re-education for all Medication Technicians on regulation 2600.188(b) on 4/16 & 4/17/2024. Documentation of staff education will be kept in accordance with 2600.65(i).
- House Physician did full medical exams on all 26 affected residents on 4/16/24 and indicated that there was no adverse effects on any resident and there was no physical harm cause to any resident.
- DON charted on 4/17/24 that no adverse effects had been observed.
- Administrator was terminated on [REDACTED]/2024.
- All clinical staff were also re-educated by Interim Administrator on communication escalation pathways and receiving confirmation of their escalation on 5/16/2024. Documentation of staff education will be kept in accordance with 2600.65(i).
- Interim Administrator conducted re-education of regulation 2600.42(b) to all staff on 5/16/2024. Interim Administrator also met with all department managers on 5/16/2024 to re-educate that when an escalation occurs, the respective manager must check-in with staff to ensure compliance or escalate to Interim Administrator and/or

42b - Abuse (continued)

designee that a compliance assurance check is needed. Documentation of staff education will be kept in accordance with 2600.65(i).

- Interim administrator and/or designee will interview 5 residents a month beginning 5/21/2024 for four months to ensure compliance with regulation and ensure resident medications are administered as prescribed. Documentation will be kept and reviewed at the monthly QA meeting beginning on 5/29/2024. (DIRECTED: Documentation of the quality management meeting minutes shall be kept. [REDACTED] 5/29/24).
- The community is also scheduling with Protective Services to have an abuse training completed by 6/30/24. Documentation of staff education will be kept in accordance with 2600.65(i).

Proposed Overall Completion Date: 09/30/2024

Directed Completion Date: 06/30/2024

Implemented [REDACTED] - 06/20/2024)

187b - Date/Time of Medication Admin.

2. 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

On [REDACTED]/24 during the 3:00pm through 11:00pm shift, approximately 26 residents did not receive their evening medications; however those resident's April 2024 electronic medication administration records (E-MAR's) were not updated to indicate the residents did not receive their evening medications, to include the April 2024 E-Mar's for the following residents:

- Resident #1's Aspart Flexpen 100 unit/ml insulin-Inject 4 units subcutaneously at bedtime
- Resident #1's 8:30pm dose of Lantus Solostar 100 unit/ml insulin-Inject 14 units subcutaneously twice daily
- Resident #1's 8:30pm dose of Mycophenolate 500mg tablet-Take 1 tablet by mouth twice daily
- Resident #2's Basaglar Kwikpen 100 unit/ml insulin-Inject 8 units subcutaneously at bedtime
- Resident #2's 8:30pm dose of Brilinta 60mg tablet-Take 1 tablet by mouth 2 times a day
- Resident #2's Oxycodone 5mg tablet-Take 1 tablet by mouth at bedtime
- Resident #3's 4:30pm dose of Gabapentin 100mg capsules-Take 2 capsules by mouth 3 times daily
- Resident #3's 4:30pm and 8:30pm doses of K'Phos Original tablet-Take 1 tablet by mouth before meals and at bedtime
- Resident #3's 4:30pm dose of Morphine Sulfate 15mg tablet-Take 1 tablet my mouth 3 times daily

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

Plan of Correction

Directed () - 05/29/2024

- Both Medication Technicians involved on () 4/24 were terminated on ()/24.
- All Medication Technicians employed were re-educated by DON and interim Administrator on Medication Errors 2600.188 on 4/16 & 4/17/24. Documentation of staff education will be kept in accordance with 2600.65(i).
- All Medication Technicians will be re-educated on regulation 2600.187(b) by the Administrator and DON by 5/19/24. Documentation of staff education will be kept in accordance with 2600.65(i).
- DON and/or Interim Administrator and/or designee will audit the MARs for 25% of the patient population weekly for 3 months to ensure compliance beginning May 6, 2024. Documentation will be maintained and reviewed at QA/QI meetings monthly beginning May 29, 2024. (DIRECTED: Documentation of the quality management meeting minutes shall be kept. () 5/29/24).

Proposed Overall Completion Date: 08/31/2024

Directed Completion Date: 06/30/2024

Implemented () - 06/20/2024

187d - Follow Prescriber's Orders

3. Requirements

2600.

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

Description of Violation

On 4/14/24 during the 3:00pm through 11:00pm shift, approximately 26 residents did not receive their evening medications as prescribed, to include the following residents;

- Resident #1's Aspart Flexpen 100 unit/ml insulin-Inject 4 units subcutaneously at bedtime
- Resident #1's 8:30pm dose of Lantus Solostar 100 unit/ml insulin-Inject 14 units subcutaneously twice daily
- Resident #1's 8:30pm dose of Mycophenolate 500mg tablet-Take 1 tablet by mouth twice daily
- Resident #2's Basaglar Kwikpen 100 unit/ml insulin-Inject 8 units subcutaneously at bedtime
- Resident #2's 8:30pm dose of Brilinta 60mg tablet-Take 1 tablet by mouth 2 times a day
- Resident #2's Oxycodone 5mg tablet-Take 1 tablet by mouth at bedtime
- Resident #3's 4:30pm dose of Gabapentin 100mg capsules-Take 2 capsules by mouth 3 times daily
- Resident #3's 4:30pm and 8:30pm doses of K'Phos Original tablet-Take 1 tablet by mouth before meals and at bedtime
- Resident #3's 4:30pm dose of Morphine Sulfate 15mg tablet-Take 1 tablet my mouth 3 times daily

187d - Follow Prescriber's Orders (continued)

Plan of Correction

Directed [REDACTED] - 05/29/2024

- Both Medication Technicians involved on [REDACTED]/24 were terminated on [REDACTED] 24.
- All Medication Technicians employed were re-educated by DON and interim Administrator on Medication Errors 2600.188 on 4/16 & 4/17/24. Documentation of staff education will be kept in accordance with 2600.65(i).
- All Medication Technicians will be re-educated on regulation 2600.187(d) by the Administrator and DON by 5/19/24. Documentation of staff education will be kept in accordance with 2600.65(i).
- DON and/or Interim Administrator and/or designee will audit the MARs for 25% of the patient population beginning May 6, 2024 weekly for 3 months to ensure compliance beginning May 29, 2024. Documentation will be maintained and reviewed at QA/QI meetings monthly beginning May 29, 2024. (DIRECTED: Documentation of the quality management meeting minutes shall be kept. [REDACTED] 5/29/24).

Proposed Overall Completion Date: 08/31/2024

Directed Completion Date: 06/30/2024

Implemented ([REDACTED] - 06/20/2024)