





**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Emailing date: November 25, 2024

[REDACTED]  
Vincentian Home Inc.  
111 Perrymont Road  
Pittsburgh, Pennsylvania 15237

RE: Vincentian Home  
License # 431530

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 16, 2024, and October 17, 2024, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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 from 60 to 90. The expiration date of the license remains unchanged.

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: *VINCENTIAN HOME* License #: *43153* License Expiration: *10/27/2025*  
Address: *111 PERRYMONT ROAD, PITTSBURGH, PA 15237*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *VINCENTIAN HOME INC*  
Address: *111 PERRYMONT ROAD, ATTN MICHELE DOLBY, PITTSBURGH, PA, 15237*  
Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *04/11/1997* Issued By: *Labor and Industry*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *66* Waking Staff: *50*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, New* Exit Conference Date: *10/17/2024*

**Inspection Dates and Department Representative**

10/16/2024 - On-Site: [REDACTED]  
10/17/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *60* Residents Served: *52*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Memory Lane* Capacity: *10* Residents Served: *8*

**Hospice**

Current Residents: *9*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *52*  
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *14* Have Physical Disability: *0*

Inspections / Reviews

10/16/2024 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *10/31/2024*

10/31/2024 - POC Submission

Submitted By [REDACTED]

Date Submitted: *11/13/2024*

Reviewed [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *11/15/2024*

11/18/2024 - Document Submission

Submitted By [REDACTED]

Date Submitted: *11/13/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

20b8 - Quarterly Account

1. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

- 8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home provides financial management services for resident #1. However, the home has not provided the resident a quarterly account of financial transactions on the resident's behalf. The last quarterly account of financial transactions for resident #1 was provided on 6/30/22.

Plan of Correction

Accept (█) - 10/31/2024)

Immediately upon realization that the statements had not been received, the Administrative Assistant printed the statements for 2024 and provided them to resident #1 on 10/17/24. Administrator educated the Administrative Assistant on the regulatory requirement regarding managing resident funds on October 16, 2024 (see attached record of training). Administrative Assistant audited the remaining resident fund accounts on 10/29/24 and ensured statements had been provided to all affected residents. The Administrative Assistant or designee will be responsible for this task moving forward and placed calendar reminders for quarterly statements to be printed and provided to residents and their responsible party in January (Q4), April (Q1), July (Q2) and October (Q3). The Administrator or designee will audit for compliance each quarter utilizing the attached audit report for one year. This audit will began in October of 2024 with the Q3 statements. Records of the audit will be maintained and will be reviewed at the quarterly Quality Assurance meeting beginning with the next one scheduled for January 10, 2025.

Licensee's Proposed Overall Completion Date: 10/30/2024

Implemented (█) - 11/18/2024)

60a - Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident #2's support plan, dated 6/4/24, indicated the resident required extensive supervision in the home, and that the resident is living in a secured unit where the staff is present at all times and monitoring resident's safety. However, on 9/30/24 at 3:32 a.m., there were 8 residents in the SDCU when the fire alarm activated, and only one direct care staff person was documented on the fire drill as participating in the evacuation. There was no staff to supervise the residents who were evacuated while the one staff person was evacuating the other residents.

Plan of Correction

Accept (█) - 10/31/2024)

In the case where there are not already 2 staff assigned to the SDCU, a DCS from another unit will be designated on the nightly schedule to respond to the SDCU in the event of an evacuation in order to assist the Memory Lane staff member with supervising the evacuated residents, this procedure began on 10/28/24. The responding staff member, when needed, will remain in the SDCU until all residents can be safely monitored. The Administrator or designee will audit the fire drill process 6 times/year to ensure that the extra staff person does respond to the unit. The PC Staffing policy was amended to include this new procedure (3.c. on the attached document). All staff have been prompted on 10/31/24 to review this new procedure and record of staff completion will be maintained by the Director,

**60a - Staff/Support Plan (continued)**

*Compliance and Privacy. Any issues with fire drill procedure will be recorded on the Fire Drill record as well as discussed during the monthly Safety Committee meetings (next one scheduled for 11/20/24) and also reviewed during the quarterly Quality Assurance meetings, next one scheduled for 01/10/25.*

**Licensee's Proposed Overall Completion Date: 10/30/2024**

**Implemented [REDACTED] 11/18/2024)**

**91 - Telephone Numbers****3. Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**Description of Violation**

*On 10/16/24 at approximately 2:03 p.m. the emergency telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or near the telephone in resident room #17 belonging to resident #3 and resident #4.*

**Plan of Correction**

**Accept [REDACTED] 10/31/2024)**

*Immediately upon discovery of the missing phone numbers the Administrator placed the phone number list on the table near the residents' landline. An audit was performed on all resident rooms by Administrative Assistant on 10/16/24 to ensure placement in all rooms and common areas. Moving forward, Administrative Assistant or designee will be responsible for auditing the rooms and landlines in common areas on a monthly basis beginning in November of 2024 and for a period of 3 months. The Administrative Assistant and/or designee will also ensure placement of the phone list in a room prior to a new resident moving in on an ongoing basis as part of the move in readiness process. Residents will be reminded to let staff know if they are missing the phone number list during the next Resident Council meeting, scheduled for 11/5/24. Staff will be educated about the importance of this regulatory requirement and where to obtain the phone number list during the staff meeting scheduled for 11/13/24. Records of the audit will be reviewed at the quarterly Quality Assurance meeting and will be maintained. Next QA meeting is scheduled for January 10, 2025.*

**Licensee's Proposed Overall Completion Date: 10/30/2024**

**Implemented [REDACTED] 11/18/2024)**

**92 - Windows****4. 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**

*On 10/16/24 at approximately 4:15 p.m., the left window of resident room #1-166 was missing a window screen.*

*On 10/16/24 at approximately 4:22 p.m., the right window of resident room #1-171 was missing a window screen.*

*On 10/16/24 at approximately 4:24 p.m., the right window of resident room #1-172 was missing a window screen.*

92 - Windows (continued)

**Plan of Correction**

Accept [REDACTED] 10/31/2024)

On 10/17/24 [REDACTED] in Vincentian Home maintenance department replaced the screens in each of the rooms identified. A designee from Vincentian Home maintenance will conduct an audit of the screens in each of the resident rooms in Building 1 once a month for the next 3 months. The next monthly audit will be conducted in November and concluding in January. Records of the audit will be maintained and will be reviewed at the quarterly Quality Assurance meeting (scheduled for 01/10/25) and also at the monthly Safety Committee meeting (scheduled for 11/20/24).

Licensee's Proposed Overall Completion Date: 10/30/2024

Implemented [REDACTED] 11/18/2024)

100a - Exterior - Free of Hazards

**5. Requirements**

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

**Description of Violation**

On 10/16/24 at approximately 9:00 a.m., a pad of the concrete walkway enroute to the home's main entrance from the parking lot was cracked and deteriorated with crumbled rocks and growing moss that was approximately five feet across, six inches at the widest point and approximately one inch deep.

On 10/17/24 at approximately 9:00 a.m., multiple areas in the concrete pads leading to the home's main entry way were cracked, deteriorated with crumbled rocks, and plants and moss were growing in the cracks. The first crack measured approximately one foot long by two-inches wide and was approximately one-inch deep, the second crack measured approximately six-inches long, by two-inches wide and was approximately one-inch deep, and the third crack was approximately two-feet long, two-inches wide and was approximately one-inch deep.

**Plan of Correction**

Accept [REDACTED] 10/31/2024)

The Director, Facilities & Support Services, was contacted by Administrator on 10/16/24 regarding the sidewalk conditions. A contractor came to the facility on 10/22/24 to provide a quote for work needing to be done. Work is scheduled to be completed the second week of November (weather-pending exact date). Moving forward, the Director, Facilities & Support Services, or his designee will audit the exterior grounds of the facility to identify any other issues. The audit will occur once every month over the course of 6 months, beginning in October of 2024 and concluding in March of 2025. Records of the audit will be maintained and findings will be reviewed at the quarterly Quality Assurance meeting (next one scheduled for 01/10/25) as well as at the monthly Safety Committee meeting (next one scheduled for 11/20/24). Staff will also be educated during staff meeting on 11/13/24 regarding the need to report any potential hazards to management.

Licensee's Proposed Overall Completion Date: 10/30/2024

Implemented [REDACTED] 11/18/2024)

132d - Evacuation

**6. Requirements**

132d - Evacuation (continued)

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's fire safety expert indicates there are no fire safe areas in the home's secure dementia care unit (Building #3). However the residents who reside in secure dementia care unit were evacuated to areas within the home for the fire drills as follows:*

- 12/17/22 at 1:20 p.m.
- 1/25/23 at 10:20 a.m.
- 2/27/23 at 7:45 p.m.
- 4/4/23 at 11:05 a.m.
- 5/16/23 at 10:20 a.m.
- 9/29/23 at 5:15 a.m.
- 11/17/23 at 9:10 a.m.
- 12/19/23 at 1:15 p.m.
- 1/8/24 at 1:45 p.m.
- 2/1/24 at 3:30 p.m.
- 3/20/24 at 11:20 p.m.
- 5/28/24 at 1:17 p.m.
- 6/17/24 at 9:10 a.m.
- 7/11/24 at 3:45 p.m.
- 9/30/24 at 3:32 a.m.

**Plan of Correction**

Accept [REDACTED] 10/31/2024)

*Administrator contacted the Fire Safety Expert (McCandless Township) via email on 10/24/24 to address the fire safe area in the SDCU. Fire Safety Expert reviewed floor plan that had previously designated that area as a fire safe egress. Administrator and Assistant Administrator spoke with [REDACTED] via phone call on 10/28/24 to further ensure this would be an acceptable egress. Fire Safety Expert agreed with this and sent over new letters for each of the PC units indicating all fire safe areas within the licensed Personal Care Home (letters are attached, including the letter for the proposed expansion unit). All staff to be educated on all fire safe areas during staff meeting on 11/13/24 - record of this training to be maintained. Administrator or designee will review the Fire Drill record following each drill or alarm activation to ensure that only designated fire safe areas are utilized. If a non-approved area is utilized staff education will occur immediately and a second fire drill will be conducted that month to ensure compliance. This will begin with the November 2024 drill and be ongoing. Any issues/findings will be reviewed in the monthly Safety Committee Meetings, next meeting is scheduled for 11/20/24.*

**Licensee's Proposed Overall Completion Date: 10/30/2024**

**Implemented [REDACTED] 11/18/2024)**

183b - Meds and Syringes Locked

**7. Requirements**

2600.

183b - Meds and Syringes Locked (*continued*)

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

**Description of Violation**

On 10/17/24 at approximately 10:33 a.m. there were two almost full bottles of Nystop Nystatin Topical Powder 100,000 units, that were found unlocked and unattended on the bathroom vanity sink in resident room #7 belonging resident #5 and both bottles were labeled with the resident's name.

REPEAT VIOLATION 11/2/22 et. al.

**Plan of Correction**

Accept [REDACTED] 10/31/2024)

Resident currently has an order for "Unsupervised self-administration" for this medication. LPN Nurse Manager met with resident on 10/23/24 to remind her of the regulatory requirement to have her medications locked away safely. Verified that the resident does have a locking drawer in her dresser and advised that all medications must be kept in that secure area. Beginning the week of 10/28/24, LPN Nurse Manager and/or designee will randomly select 5 resident rooms to audit weekly until all rooms have been audited. Record of audits will be reviewed at quarterly Quality Assurance meetings (next one scheduled for 01/10/25) and will be maintained. All staff will be provided education at our staff meeting scheduled for 11/13/2024. This policy will be reviewed with residents during the next Resident Council meeting which is scheduled for 11/5/24. Record of attendance & training will be maintained.

Licensee's Proposed Overall Completion Date: 10/30/2024

Implemented [REDACTED] - 11/18/2024)

## 184a - Resident's Meds Labeled

**8. Requirements**

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

**Description of Violation**

The pharmacy label for resident #2's Morphine Sulfate 20MG/ML solution prefilled syringe indicated "Take 0.5-1ML (10-20MG) by mouth every 2 hours as needed for pain / shortness of breath." However, resident #2 is prescribed Morphine Sulfate 20MG/ML solution prefilled syringe give 0.5mL (10MG) by mouth every 2 hours as needed for pain or shortness of breath.

**Plan of Correction**

Accept [REDACTED] 10/31/2024)

The hospice company was contacted immediately by LPN Nurse Manager upon discovering this discrepancy to address with their pharmacy. "Directions Changed, Refer to MAR" stickers placed on the remaining syringes at the time of discovery by LPN Nurse Manager on 10/17/24. Education to Med Techs will be addressed during staff meeting scheduled for 11/13/24, covering process for reconciling medication deliveries with physician orders. Record of training will be maintained. Administrator and LPN Nurse Manager will be meeting with Pharmacy Consultant on 10/28/24 to discuss the findings of our inspection and review process for checking all medications sent from all pharmacies & corresponding orders. Monthly cart audits to be completed by Pharmacy Consultant - reports will be reviewed with LPN Nurse Manager and/or designee. This will continue to occur on a monthly basis as per current procedure. Cart audit reports will be maintained and will be reviewed during quarterly Quality Assurance meetings, next one scheduled for 01/10/25.

184a - Resident's Meds Labeled (continued)

Licensee's Proposed Overall Completion Date: 10/30/2024

Implemented [REDACTED] 11/18/2024)

185a - Implement Storage Procedures

9. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 10/14/24 at breakfast time, resident #5's October 2024 medication administration record (MAR) documented a blood glucose reading of 112 mg/dL. However, resident #5's FreeStyle Libre 2 glucometer indicated a blood glucose reading of 119 mg/dL on 10/14/24 at 7:46 a.m.

On 10/15/24 at dinner time, resident #5's October 2024 medication administration record (MAR) documented a blood glucose reading of 171 mg/dL. However, resident #5's FreeStyle Libre 2 glucometer indicated a blood glucose reading of 176 mg/dL on 10/15/24 at 3:40 p.m.

Plan of Correction

Accept [REDACTED] 10/31/2024)

LPN Nurse Manager provided education to staff on shift on 10/17/2024 regarding the importance of accurate transcription of glucometer readings. LPN Nurse Manager completed an audit of all glucometers on 10/18/24 looking back for a period of 2 weeks. LPN Nurse Manager contacted the Diabetic Educator and scheduled a Diabetic Refresher training for 11/8/24 for Med Techs. LPN Nurse Manager spoke with the temporary staffing agency regarding the errors that were made and requested remedial diabetic education for staff involved. LPN Nurse Manager offered to the agency to have their staff attend the Diabetic Refresher training on 11/8/24. A record of all attendees for this training and any training provided by the agency to their employees will be maintained. Moving forward, LPN Nurse Manager or designee will conduct a weekly audit of all glucometer readings to identify trends/patters and needs for further education/remediation. This audit will begin with week of 10/28/24 and will continue for 12 weeks. Records of this audit will be reviewed at the quarterly Quality Assurance meeting, next one scheduled for 01/10/25, and will be maintained.

Licensee's Proposed Overall Completion Date: 10/30/2024

Implemented [REDACTED] 11/18/2024)

190c - Record of Training

10. Requirements

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Direct care staff person B's record of training for both the initial medication administration course, dated 9/22/23, and the medication administration observation, dated 6/6/24, were not signed or dated by direct care staff person B.

Plan of Correction

Accept [REDACTED] 10/31/2024)

Direct care staff person's signature was obtained on both documents on 10/16/2024 by LPN Nurse Manager. Nurse Manager provided education to the Lead Med Tech Trainer regarding completion of required documentation on

**190c - Record of Training (continued)**

10/23/24. Moving forward the Nurse Manager and/or designee will audit 5 Med Tech records per week for entire completion of documentation until all records have been reviewed. This will begin the week of 10/21/24 and will continue for 4 weeks. Beginning after completion of the initial audit, the LPN Nurse Manager and/or designee, will audit 5 Med Tech records per month for 3 additional months beginning in December 2024 and concluding in February 2025. Records of audit will be reviewed at the quarterly Quality Assurance meeting (next one scheduled for 01/10/25) and will be maintained. Record of training with Lead Med Tech Trainer is attached.

Licensee's Proposed Overall Completion Date: 02/28/2025

Implemented [REDACTED] 11/18/2024)