

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

May 7, 2025

[REDACTED]
MOS GRACE MGT LLC
[REDACTED]

RE: GRACE MANOR AT NORTH PARK
9565 BABCOCK BOULEVARD
ALLISON PARK, PA, 15101
LICENSE/COC#: 45085

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/28/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: GRACE MANOR AT NORTH PARK **License #:** 45085 **License Expiration:** 02/03/2026

Address: 9565 BABCOCK BOULEVARD, ALLISON PARK, PA 15101

County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: MOS GRACE MGT LLC

Address: [REDACTED]

Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 11/18/2010 **Issued By:** Township of McCandless

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 74 **Waking Staff:** 56

Inspection Information

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

Reason: Complaint, Incident **Exit Conference Date:** 04/11/2025

Inspection Dates and Department Representative

03/28/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 67 **Residents Served:** 46

Secured Dementia Care Unit

In Home: Yes **Area:** 3rd floor **Capacity:** 25 **Residents Served:** 19

Hospice

Current Residents: 18

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 46

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

Have Mobility Need: 28 **Have Physical Disability:** 1

Inspections / Reviews

03/28/2025 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/24/2025

04/24/2025 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 05/05/2025

Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/30/2025

Inspections / Reviews *(continued)*

04/30/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/05/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/06/2025

04/30/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/05/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/06/2025

05/07/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/05/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

185a - Implement Storage Procedures

1. 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 [REDACTED], resident [REDACTED] was prescribed [REDACTED] tablets-Take 1 tablet by mouth every 12 hours. According to the home's "narcotics delivery acceptance checklist", 30 tablets of resident [REDACTED] [REDACTED] were delivered to the home on [REDACTED] at approximately 4:45pm and were received by direct care staff person A. Direct care staff person A indicated [REDACTED] gave the [REDACTED] tablets to direct care staff person B to place in the medication cart; however, all [REDACTED] [REDACTED] tablets went missing and were unaccounted for in the home.

The home's narcotic policy indicates, "All narcotic medications must be counted daily before and after each shift or whenever a new tech or nurse assumes the cart and keys are exchanged." However, according to the home's "narc count verification signature sheet", narcotics were not counted on numerous occasions, to include the following:

- The 3:00pm shift change on [REDACTED]
- The 11:00pm shift change on [REDACTED]
- The 7:00am shift change on [REDACTED]

REPEAT VIOLATION: [REDACTED]

Plan of Correction

Directed [REDACTED] - 04/30/2025)

Medication was delivered to the facility and was signed in by Staff A and given to Staff B. Staff B didn't put medication in the medication cart upon receiving it from staff A.

Director of wellness identified that the medication was being listed in route on 3/11/2025 and called the pharmacy to verify why. Director of wellness was told it was delivered on 3/8/2025. Director of Wellness notified the Executive Director of the missing medication and an investigation was started. Staff person A and Staff person B was called in to facility to answer for the missing medication. Staff person B said [REDACTED] didn't put the medication away according to policy. Executive Director notified the Police and they arrived at the facility to talk with staff person B regarding the missing medication. Staff person B was terminated at the time of the investigation for not following policies and procedures according to the facility.

Medication was reordered by the Wellness Director and delivered to the facility that evening at no cost to the resident.

Executive Director added addition steps to the medication policy which includes

1. Medication may only be accepted by the med-tech that is on the medication cart at the time of delivery
2. All medication must be put in the medication cart at the time of delivery
3. Pharmacy cart fills may only be done when the med-tech is available. Med techs are not permitted to give medication carts key to anyone (including pharmacy) at anytime.
4. Med-tech and pharmacy must complete a narcotic count at the end of a cart exchange to ensure all narcotics are accounted for and correct.

185a Implement Storage Procedures (continued)

- 5. If medication is available at the time of administration the med tech must review the delivery slips to verify if the medication was delivered
- 6. If medication wasn't delivered they need to notify the doctor to receive a hold order for the medication.

Executive director or designee will review the narcotic count sheet weekly for 3 months then monthly for 5 months to ensure compliance. Documentation of this audit will be kept in the audit binder for review (DIRECTED: The weekly audits shall begin on 5/5/25 and shall include a review of narcotic count sheets and MAR's for all residents prescribed a controlled substance. [REDACTED] 4/30/25).

All narcotics have been reviewed by wellness directors on 3/13/2025 and there was no other concerns or issues identified. Random audits will be performed monthly for 6 months to ensure all narcotics are within compliance by the wellness directors and will be documented and kept in the audit binder for review.

Med techs are educated on the policy by 4/18/2025 (see attached) and are aware of the new responsibilities and procedures. Education was provided by the Assistant Executive Director and will be kept in the education binder for review in accordance with 2600.65i

Proposed Overall Completion Date: 04/29/2025

Directed Completion Date: 05/05/2025

Implemented [REDACTED] - 05/07/2025)

187d - Follow Prescriber's Orders

2. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On [REDACTED], resident [REDACTED] was prescribed [REDACTED] tablets Take 1 tablet by mouth every 12 hours; however, resident [REDACTED] did not receive a dose of the [REDACTED] until 9:00pm on 3/11/25.

REPEAT VIOLATION: [REDACTED], et. al.

Plan of Correction

Directed [REDACTED] 04/30/2025)

Medication was ordered upon admission and received at the facility on 3/8/2025 at 4:45pm and checked in by the floor supervisor and delivered to the Med tech on the medication cart.

The medication was not put into the medication cart according to policy and procedures of the facility.

Staff believed the medication was en route and documented the medication en route. The wellness director noticed on 3/11/2025 medication was still en route so [REDACTED] began the investigation into finding the medication. Physician was notified that the medication was documented en route and not given.

187d - Follow Prescriber's Orders (continued)

3/11/2025 the physician was notified by the Wellness Director the medication was en route from the pharmacy and that the PRN was given and was effective while waiting for the medication. Wellness director let the physician know that [REDACTED] was going to contact the pharmacy and find out why this medication was taking so long to get here. Wellness director let the physician know that the medication was delivered and that it was not stored properly and a medication will be coming in 3/11/2025 in the evening.

Executive Director added addition steps to the medication policy which includes

1. Medication may only be accepted by the med-tech that is on the medication cart at the time of delivery
2. All medication must be put in the medication cart at the time of delivery
3. Pharmacy cart fills may only be done when the med-tech is available. Med techs are not permitted to give medication carts key to anyone (including pharmacy) at anytime.
4. Med-tech and pharmacy must complete a narcotic count at the end of a cart exchange to ensure all narcotics are accounted for and correct.
5. If medication is available at the time of administration the med-tech must review the delivery slips to verify if the medication was delivered
6. If medication wasn't delivered they need to notify the doctor to receive a hold order for the medication.

Assistant Executive Director educated the med-techs on the new policy additions on 4/18/2025 (see attached) and will be kept in the educational binder for review and will be kept in accordance with 2600.65i

Wellness director will print a monthly medication en-route report for review to ensure no medication is being documented en-route without a hold order in place. This report will be printed for 6-months with no errors being documented. First report will be printed 4/20-4/30/2025 to begin the audit. Assistant Executive Director will review the audit monthly to ensure it is completed timely and accurately. Audit will be kept in the audit manual for review.

Wellness director will review medication and MAR documentation for 3 residents per week for 6 weeks starting 5/6/2025 with no errors and then monthly for 6 months with no errors. This documentation will be kept in the audit binder for review.

Proposed Overall Completion Date: 04/29/2025

Directed Completion Date: 05/06/2025

Implemented ([REDACTED] - 05/07/2025)

225c - Additional Assessment

3. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [REDACTED] most recent medical evaluation, dated [REDACTED], includes diagnoses of [REDACTED] and [REDACTED]

225c Additional Assessment (continued)

however, these diagnoses are not indicated on resident [redacted] most recent assessment, dated [redacted].

Plan of Correction

Directed [redacted] - 04/30/2025)

Assistant Executive Director corrected the support plan at the time of inspection (see attached).

Assistant Executive Director was re educated on the importunacy of ensuring all information from the DME is carried over to the Assessment to ensure that staff is given updated and accurate information. This education was given by Executive Director on 4/21/2025 and the assistant Executive Director educated the remaining admission team on this regulation on 4/21/2025. This training will be kept in the education binder for review. (see attached).

Assistant Executive Director audited house wide support plans and DME to ensure all information is accurate on both forms. this audit was done on 4/22/2025 and will be kept in audit book for review.

The Executive Director or Designee will audit 6 residents monthly for 6 months to ensure all DME and assessments are compliant. This audit will begin 5/2025 and all documentation relating to this audit will be kept in the POC binder for review (see attached). (DIRECTED: The monthly audits shall begin on 5/5/25. [redacted] 4/30/25).

Proposed Overall Completion Date: 04/28/2025

Directed Completion Date: 05/05/2025

Implemented [redacted] - 05/07/2025)

227d - Support Plan Medical/Dental

4. Requirements

2600.

227.d. Each home shall document in the resident’s support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident’s physician, physician’s assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident [redacted] was admitted to the home's secured dementia care unit (SDCU) on [redacted] then moved to the personal care section of the home around [redacted] because resident [redacted] was not displaying exit seeking behaviors. Resident [redacted] most recent assessment, dated [redacted] indicates resident [redacted] requires minimal supervision; however, resident [redacted]'s most recent support plan, dated [redacted] indicates "Resident requires 24 hour direct supervision inside the facility in our secured memory care unit".

Plan of Correction

Directed [redacted] - 04/30/2025)

Assistant Executive Director corrected the support plan at the time of inspection (see attached).

Assistant Executive Director was re educated on the importunacy of ensuring all information from the DME is carried over to the Support plan to ensure that staff is given updated and accurate information. This education was given

227d - Support Plan Medical/Dental (continued)

by Executive Director on 4/21/2025 and the assistant Executive Director educated the remaining admission team on this regulation on 4/21/2025. This training will be kept in the education binder for review. (see attached).

Assistant Executive Director audited house wide support plans and DME to ensure all information is accurate on both forms. this audit was done on 4/22/2025 and will be kept in audit book for review.

The Executive Director or Designee will audit 6 residents monthly for 6 months to ensure all support plans are compliant. This audit will begin 5/2025 and all documentation relating to this audit will be kept in the POC binder for review (see attached). (DIRECTED: The monthly audits shall begin on 5/5/25. ■ 4/30/25).

Proposed Overall Completion Date: 04/28/2025

Directed Completion Date: 05/05/2025

Implemented ■ - 05/07/2025)