



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to CHANDLER HALL HEALTH SERVICES INC  
LEGAL ENTITY

To operate CHANDLER HALL HEALTH SERVICES, INC. - HICKS  
NAME OF FACILITY OR AGENCY

Located at 99 BARCLAY STREET, NEWTOWN, PA 18940  
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

\_\_\_\_\_  
ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

\_\_\_\_\_  
ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

To provide Personal Care Homes  
TYPE OF SERVICES TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 60  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.  
(MAXIMUM CAPACITY)

Restrictions: \_\_\_\_\_

This certificate is granted in accordance with the Public Welfare 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 September 30, 2016 until March 30, 2017,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 129871

Robert E. Robinson  
ISSUING OFFICER

Jay Baulh  
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.



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE:**

SEP 30 2016

Ms. Lynette M. Killen, CEO  
Chandler Hall Health Services Inc  
99 Barclay Street  
Newtown, Pennsylvania 18940

RE: Chandler Hall Health Services, Inc. – Hicks  
License #: 129871

Dear Ms. Killen:

As a result of the Department of Human Services' (Department) licensing inspections on April 13, 2016, April 14, 2016 and July 20, 2016 of the above facility, the violations specified on the enclosed Licensing Inspection Summary were found.

Based on violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes), your current license #129870 dated June 14, 2016 to June 14, 2017 is **REVOKED**. A **FIRST PROVISIONAL** license is being issued based on your plan to correct the violations as specified on the Licensing Inspection Summary. This **FIRST PROVISIONAL** license replaces all previously issued licenses and is effective for six months from the date of issuance. The license dated June 14, 2016 to June 14, 2017 is **NOT** reinstated upon expiration of this **FIRST PROVISIONAL** license. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation.) Your **FIRST PROVISIONAL** license is enclosed.

All violations specified on the Licensing Inspection Summary must be corrected by the dates specified on the Licensing Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

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, Chs. 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:

Kevin Brumbach, Enforcement Manager  
Bureau of Human Services Licensing  
Department of Human Services  
Room 631, Health and Welfare Building  
625 Forster Street  
Harrisburg, Pennsylvania 17120

Ms. Lynette M. Killen

2

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,

A handwritten signature in cursive script, appearing to read "J. Rowe".

Jacqueline L. Rowe  
Director

Enclosures  
License  
Licensing Inspection Summary

**VIOLATION REPORT**  
**PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS		License Number: 12987
Address: 99 BARCLAY STREET, NEWTOWN, PA 18940		County: Bucks
Administrator: Vickie Deller		Region: SOUTHEAST
Legal Entity Name: CHANDLER HALL HEALTH SERVICES INC		
Legal Entity Address: 99 BARCLAY STREET, NEWTOWN, PA 18940		
Certificate(s) of Occupancy C-2 09/29/1986 PA Dept. of L&I		
<b>Staffing Hours</b>		
Resident Support: 0	Total Daily Staff: 59	Working Staff: 44
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Renewal, Incident		
On-Site Inspections Dates and Department Representatives On-Site 04/13/2016: Keppel, Autumn; Kazimer, Lauren 04/14/2016: Keppel, Autumn; Kazimer, Lauren		
Off-Site Inspection Dates and Inspectors, if Applicable 04/18/2016: Keppel, Autumn 04/19/2016: Keppel, Autumn		
<b>Other Details</b>		
Partial or Full Triggers:		Random Indicators:
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 60	Number of Residents who:	Receive Supplemental Security Income: 0
Number of Residents Served: 30	Are 60 Years of Age or Older: 30	Have Mental Illness: 0
Secured Dementia Care Unit in Home: No.	Have an Intellectual Disability: 0	Have a Mobility Need: 29
Area:	Have a Physical Disability: 0	
Secured Dementia Unit Capacity, if Applicable:		
Number of Residents Served in Secured Dementia Care Unit, if applicable:		
Number of Current Hospice Residents: 3		
Number of Hospice Residents in past year: 12		

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
 2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION  
 - On 4/9/16 and 4/10/16, Resident #2's glucometer was used to check Resident #3's blood sugar.  
 - On 4/11/16, Resident #2's glucometer was used to check Resident #4's blood sugar.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 2 of 9 - attached*

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen CEO*      Date *5/6/16*

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of 7/12/16  
 (Date)

The above plan of correction was approved by (Signature)  
 (Initials)

Plan of correction implementation status as of 9/15/16  
 (Date)

Fully Implemented  
 Partially Implemented - Adequate Progress  
 Partially Implemented - Inadequate Progress  
 Not Implemented

Page 2 of 9

**Actions taken to correct Violation**

1. Staff involved in glucometer violations were interviewed beginning April 15-April 21. All staff involved in this violation have received disciplinary counsel.
2. Contact made to the manufacturer of the glucometers to ascertain if errors or missing readings could occur. Findings revealed that missing readings would only occur should the 300 number limit occur and overwriting began.
3. All residents were given new glucometers. All glucometers were labeled with resident name.
4. A review of all Diabetic resident glucometers, residing in all areas of Personal Care at the time of survey was conducted. All glucometer readings were listed by date. A chart was created to compare the glucometer readings and the Blood Sugar Logs for each resident. Hicks did confirm that some glucometer dates/times were off, transcription errors were made, some numbers were transposed, some readings were missing.
5. Audit of glucometers one time per week is ongoing and recorded.
6. Blood tests required for Resident #2, #3 and #4 will be requested and completed by May 31, 2016.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

- A. Audit of glucometer memory comparing to Blood Sugar Log will continue weekly for 3 months. If 100% compliant then audit will change to reduce audit frequency.
- B. Evaluation of findings and action taken if necessary will continue weekly for 3 months. If 100% compliant then audit will change to reduce audit frequency.
- C. Staff reeducation regarding no sharing of glucometers, any problems/errors, must be reported to Resident Care Coordinators/On Call immediately (24/7).
- D. Elimination of 11-7A Blood Sugar check unless ordered by PCP. All AM readings will be done by 7-3 Personal Care LPN or Care Partner.
- E. Staff have received instruction to write glucometer reading into MAR/Blood Sugar Log immediately. Reference glucometer reading to ensure accuracy of transcription.

Compliance Participants- Personal Care Nurse Coordinators(LPN), Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care Administrative Coordinator.

**Supporting Documentation**

Care Partner Communication Form (April 15, 2016)  
Glucometer Blood Sugar Comparison Log

*Shirley M. Sale*  
5/6/16

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
 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.

2a. DESCRIPTION OF VIOLATION  
 According to the home's fire drill record, during the fire drill on 8/31/15, two residents did not evacuate to a public thoroughfare or fire safe area.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 3 of 9 - see attached*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killence*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Lynette M. Killence</i>	Date <i>5/6/16</i>
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**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of 7/12/14  
 (Date)

Plan of correction implementation status as of 7/12/16  
 (Date)

The above plan of correction was approved by (Signature)  
 (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

Page 3 of 9

#### Actions taken to correct Violation

Unannounced fire drills 2600.132(a) are required to ensure that staff and residents will be prepared to evacuate without hesitation. In the event of an unannounced fire drill, Personal Care will develop a Protocol to ensure that any Hospice resident who is actively dying will have: 1.) be placed on the immobility list which is sent to fire department, 2.) location of the residents' room should be on ground level, if not, resident will be offered/moved to ground level, near to exit or fire safe area, 3) Hospice will provide a physician order certifying (in writing) that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill and 4). Personal Care or Hospice will have the Resident POA/Legal Guardian or Health Care Representative provide written informed consent not to evacuate the resident should a fire drill occur.

Staff will simulate the transportation of Hospice residents that are actively dying during fire drills. Documentation of the number of staff needed to simulate the Safely evacuate the residents, starting within 15 days of receipt of this plan of correction. [SW 7.19.16]

#### Compliance Correction

- A. Review of the revision of the Plan of Correction with the Director of Community Services regarding residents who are receiving Hospice care and are actively dying.
- B. Revision of Form - Consent For Non-Participation In Fire Drills/ Sample Hospice Verbal Order
- C. Reviewed revision with Director of Hospice. Review of DHS regulation again with Director of Hospice regarding requirement of a physician order certifying (in writing) that the Hospice resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill. Hospice staff (RN/SW) will assist Personal Care staff to obtain physician order for any Hospice resident actively dying. Hospice and PC staff will collaborate in obtaining written consent from Resident POA/Legal Guardian or Health Care Representative.
- D. Developed a Protocol for Hospice Residents Non-Participation in Fire Drills This Protocol for Hospice Residents who are actively dying is to ensure that all conditions are met for compliance.
- E. Personal Care Social Work/Clinical Staff will be given instruction on new protocol for Hospice Residents who are actively dying. PCA will work with Director of Hospice to inservice Hospice staff on their part in the new protocol. (July 22, 2016)

Compliance Participants- Personal Care Nurse Coordinators(LPN), Personal Care Clinical Liaison(RN), Personal Care Administrator, Personal Care Social Workers, Hospice RN and Hospice Social Worker, PCP/Hospice PCP, Personal Care Administrative Coordinator.

#### Supporting Documentation

Consent For Non Participation in Fire Drills  
Physician Order (Sample)  
Protocol for Hospice Resident Non Participation in Fire Drills

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

- 1. REGULATION 55 Pa. Code §2600**  
 2600.182(c) - Medication administration includes the following activities, based on the needs of the resident:
- (1) Identify the correct resident.
  - (2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
  - (3) Remove the medication from the original container.
  - (4) Crush or split the medication as ordered by the prescriber.
  - (5) Place the medication in a medication cup or other appropriate container, or in the resident's hand.
  - (6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in § 2600.182(b)(4).
  - (7) Complete documentation in accordance with § 2600.187 (relating to medication records).

**2a. DESCRIPTION OF VIOLATION**

- On 4/1/16 at 5PM, the medication administration record (MAR) for Resident #3's Ferrus Sulfate 325mg was not initialed. On 4/1/16 at 5PM and 9PM, the MAR was not initialed for Trazadone 50mg.
- Resident #4 has an order for their blood sugar to be checked three times daily at 7:30AM, 11:30AM, and 4:30PM. Readings in the resident's glucometer do not match what was documented on their MAR as follows:
  - On 4/2/16 at 7:30AM the resident's blood sugar was 154 but 168 was documented
  - On 4/5/16 at 7:30AM the resident's blood sugar was 178 but 113 was documented.
  - On 4/10/16 at 7:30AM the resident's blood sugar was 176 but 170 was documented.
  - On 4/14/16 at 7:30AM the resident's blood sugar was 169 but 164 was documented.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Pages 4 of 9 (Resident #3) attached*  
*See Page 4 of 9 (Resident #4) attached*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen, CEO* Date *5/6/16*

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of 7/12/16  
 (Date)

The above plan of correction was approved by *(Signature)*  
 (Initials)

Plan of correction implementation status as of 7/12/16  
 (Date)

Fully Implemented  
 Partially Implemented - Adequate Progress  
 Partially Implemented - Inadequate Progress  
 Not Implemented

*9/15/16*  
*(Signature)*

Page 4 of 9 (Resident #3)

**Actions taken to correct Violation**

Both staff involved were counseled and reeducated on the following regulations related to medication administration which states:

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

(1) Resident's name. (2) Drug allergies. (3) Name of medication. (4) Strength. (5) Dosage form. (6) Dose. (7) Route of administration. (8) Frequency of administration. (9) Administration times. (10) Duration of therapy, if applicable. (11) Special precautions, if applicable. (12) Diagnosis or purpose for the medication, including pro re nata (PRN). (13) Date and time of medication administration. (14) Name and initials of the staff person administering the medication.

2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

A. Audit of MAR to be conducted by Resident Care Coordinator/designee for 3 months. After 1 month at the time of recaps. At that time evaluation of their compliance to determine further disciplinary action.

B. Recommendation-that nurse review the MARs at the end of Medication Pass or Shift to ensure completion.

C. All staff will be re-trained on the required documentation protocols within 30 days of receipt of this plan of correction.

Compliance Participants- Hicks Personal Care Nurse Coordinator(LPN), Personal Care Clinical Liaison(RN), Personal Care Administrator,

**Supporting Documentation**

Medication Memo (May 2016)

*Lizette M. Kille*  
5/6/16

Page 4 of 9 (Resident #4)

**Actions taken to correct Violation**

1. Staff involved in glucometer violations were interviewed beginning April 15-April 21. All staff involved in this violation have received disciplinary counsel.
2. Contact made to the manufacturer of the glucometers to ascertain if errors or missing readings could occur. Findings revealed that missing readings would only occur should the 300 number limit occur and overwriting began.
3. A review of all Diabetic resident glucometers, residing in all areas of Personal Care at the time of survey was conducted. All glucometer readings were listed by date. A chart was created to compare the glucometer readings and the Blood Sugar Logs for each resident. Hicks did confirm that some glucometer dates/times were off, transcription errors were made, some numbers were transposed, some readings were missing.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

- A. Audit of glucometer memory comparing to Blood Sugar Log will be conducted weekly for 3 months. If 100% compliant then audit will change to reduce audit frequency.
- B. Evaluation of findings and action taken if necessary will be conducted weekly for 3 months. If 100% compliant then audit will change to reduce audit frequency.
- C. Staff reeducation regarding no sharing of glucometers, any problems/errors, must be reported to Resident Care Coordinators/On Call immediately (24/7).
- D. Elimination of 11-7A Blood Sugar check unless ordered by PCP. All AM readings will be done by 7-3 Personal Care LPN or Care Partner.
- E. Staff have received instruction to write glucometer reading into MAR/Blood Sugar Log immediately. Reference glucometer reading to ensure accuracy of transcription.

Compliance Participants- Personal Care Nurse Coordinators(LPN), Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care Administrative Coordinator.

**Supporting Documentation**

Care Partner Communication Form (April 15, 2016)  
Glucometer Blood Sugar Comparison Log

*Lynette M. Kelli*  
5/6/16

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600

2600.183(f) - Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

2a. DESCRIPTION OF VIOLATION

On 3/4/16, Resident #4's Olanzapine 5mg was discontinued. This medication was still in the medication cart on 4/14/16.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

See Page 5 of 9

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Lynette M. Killen COO</i>	Date <i>5/6/16</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/12/16</u> (Date)	Plan of correction implementation status as of <u>7/12/16</u> (Date)
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- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by *(S)*  
 (Initials)

Page 5 of 9

**Actions taken to correct Violation**

On April 14, 2016 medication was pulled from cart by Resident Care Coordinator. RCC contacted family to pick up medication.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

A. Use Discontinued Medication Cart Audit form.

B. Contact to Pharmacy to determine if they can run a "Discontinued Medication Report"

C. Staff instructed that when a resident is transferred, discharged or an order is discontinued, all medications must be removed from the cart immediately. *The nurse liaison will conduct weekly audits of all med carts to ensure all D/C meds are discarded, starting 8/15/16*  
Compliance Participants- Hicks Personal Care Nurses (LPN), Personal Care Clinical Liaison(RN), Resident Care Coordinators.

**Supporting Documentation**

Discontinued Medication Cart Audit Form

*Therese M. Tuller*  
*5/6/16*

Violation Report: 12387 - 04/13/2016 - Keppel, Autumn  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
 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.

2a. DESCRIPTION OF VIOLATION  
 Resident #3 has an order for Antacid Chewable 500mg administer two tabs (1000mg) two times daily as needed. The home has Tums extra strength one tab= 1000mg.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 6 of 9*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Lynette M. Killen CEO</i>	Date <i>5/6/16</i>
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**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of <u>7/12/16</u> (Date)  The above plan of correction was approved by <u>(Signature)</u> (Initials)	Plan of correction implementation status as of <u>7/12/16</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
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Page 6 of 9

**Actions taken to correct Violation**

On April 14, 2016 medication was pulled from cart by Resident Care Coordinator. RCC contacted family to replace incorrect OTC medication with correct strength. Daughter brought in 500mg Antacid tablets and took 1000 mg Antacid tablets home.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

- A. Continue Medication Cart audit.
- B. Staff instructed to double check that families bring in the correct strength of OTC medication/or any medication. Staff are to refuse any OTC medication/or any medication that is not what is ordered by the PCP.
- C. Families will be sent letter defining the importance of providing the correct medication. (June 1, 2016)

**Compliance Participants-** Hicks Personal Care Nurse Coordinator(LPN), Personal Care Clinical Liaison(RN), Personal Care Administrator, Personal Care Administrative Coordinator.

**Supporting Documentation**

Medication Cart Audit Form

*Ryette M. Killian*  
5/6/16

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

- Resident #2 has an order for blood sugar checks four times a day at 7:30AM, 11:30AM, 4:30PM, and 9PM. The resident's glucometer did not contain scheduled accucheck readings for the following prescribed dates and times:

- 4/2/16 at 4:30PM and 9:30PM
- 4/3/16 at 4:30 PM and 9:30 PM
- 4/4/16 at 7:30AM, 11:30AM, and 4:30PM
- 4/5/16 at 7:30AM and 11:30AM
- 4/6/16 at 4:30PM and 9PM
- 4/7/16 at 7:30AM and 9PM

- Resident #2 is on sliding scale insulin as follows: 150-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-460= 12 units, 461-400= 14 units. On 4/6/16 at 4:30PM there was no blood sugar reading in the resident's glucometer. It was documented that their blood sugar was 101 and two units of insulin was given. On 4/6/16 at 9AM there was no blood sugar reading in the resident's glucometer. It was documented that their blood sugar was 157 and two units of insulin was given. On 4/7/16 at 9AM there was no blood sugar reading in the resident's glucometer. It was documented that their blood sugar was 191 and two units of insulin was given. On 4/13/16 at 4:30PM there was no blood sugar reading in the resident's glucometer. It was documented that their blood sugar was 151 and two units of insulin was given. On 4/13 at 9AM there was no blood sugar reading in the resident's glucometer. It was documented that their blood sugar was 171 and no units of insulin was given.

- Resident #3 has an order for blood sugar checks four times a day at 8AM, 12PM, 5PM, and 10PM. The resident's glucometer did not contain scheduled accucheck readings for the following prescribed dates and times:

- 4/1/16 at 10PM
- 4/2/16 at 5PM and 10PM
- 4/3/16 at 5PM and 10PM
- 4/5/16 at 8AM and 12PM
- 4/6/16 at 5PM and 10PM
- 4/7/16 at 5PM and 10PM
- 4/13/16 at 5PM and 10PM

- On 4/6/16 at 5PM there was no blood sugar reading in Resident#3's glucometer. It was documented that their blood sugar was 107 was documented and 2 units of insulin was given.

- Resident #4 is on sliding scale insulin as follows: 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, 401-500= 10 units. On 4/4/16 at 4:30 PM the resident's blood sugar was 210. It was documented that their blood sugar was 118 and so they did not receive any insulin.

- Resident #4 has an order for blood sugar checks three times a day at 7:30AM, 11:30AM, and 4:30PM. The resident's glucometer did not contain scheduled accucheck readings for the following prescribed dates and times:

- 4/1/16 at 7:30AM and 4:30PM
- 4/2/16 at 4:30PM
- 4/3/16 at 4:30PM
- 4/5/16 at 11:30AM
- 4/6/16 at 7:30AM and 4:30PM
- 4/7/16 at 4:30PM
- 4/11/16 at 11:30AM
- 4/13/16 at 4:30PM

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 7 of 9*

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page)

*Lynette M. Killen*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page)

*Lynette M. Killen CEO*

Date

*5/6/16*

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
2600.187(d) - The home shall follow the directions of the prescriber.

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of <u>7/12/16</u> (Date)	Plan of correction implementation status as of <u>9/20/16</u> (Date)
The above plan of correction was approved by <u>(S)</u> (Initials)	<input type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input checked="" type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

*Syretta M. Killen*  
5/6/16

Page 7 of 9

**Actions taken to correct Violation**

1. Staff involved in glucometer violations were interviewed beginning April 15-April 21. All staff involved in this violation have received disciplinary counsel.
2. Contact made to the manufacturer of the glucometers to ascertain if errors or missing readings could occur. Findings revealed that missing readings would only occur should the 300 number limit occur and overwriting began.
3. All residents were given new glucometers. All glucometers were labeled with resident name.
4. A review of all Diabetic resident glucometers, residing in all areas of Personal Care at the time of survey was conducted. All glucometer readings were listed by date. A chart was created to compare the glucometer readings and the Blood Sugar Logs for each resident. Hicks did confirm that some glucometer dates/times were off, transcription errors were made, some numbers were transposed, some readings were missing.
5. Audit of glucometers one time per week is ongoing and recorded.
6. Blood tests required for Resident #2, #3 and #4 will be requested and completed by May 31, 2016.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

- A. Audit of glucometer memory comparing to Blood Sugar Log will continue will be conducted weekly for 3 months. If 100% compliant then audit will change to reduce audit frequency.
- B. Evaluation of findings and action taken if necessary will be conducted weekly for 3 months. If 100% compliant then audit will change to reduce audit frequency.
- C. Staff reeducation regarding no sharing of glucometers, any problems/errors, must be reported to Resident Care Coordinators/On Call immediately (24/7).
- D. Elimination of 11-7A Blood Sugar check unless ordered by PCP. All AM readings will be done by 7-3 Personal Care LPN or Care Partner.
- E. Staff have received instruction to write glucometer reading into MAR/Blood Sugar Log immediately. Reference glucometer reading to ensure accuracy of transcription.

Compliance Participants- Personal Care Nurse Coordinators(LPN), Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care Administrative Coordinator.

**Supporting Documentation**

Care Partner Communication Form (April 15, 2016)  
Glucometer Blood Sugar Comparison Log

*Robert M. Keller*  
5/6/16

Violation Report: 12987 - 04/13/2016 - Keppel, Autumn  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
 2600.190(a) - A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

2a. DESCRIPTION OF VIOLATION  
 Staff Member A was certified in medication administration in March of 2014. Their annual practicum was not completed until 5/17/15.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Page 9 of 9

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Lynette M. Killen CEO*      Date *5/18/16*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 7/12/16  
 (Date)

The above plan of correction was approved by (Signature)  
 (Initials)

Plan of correction implementation status as of 7/20/16  
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

*9/15/16*

Page 9 of 9

**Actions taken to correct Violation**

Review of Medication Pass observation files were conducted to ensure that no one else was missed.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

Medication Administration Trainer created spreadsheet of each trained employee, and shared spreadsheet with Personal Care Administrative Coordinator. In collaboration, quarterly MAR reviews and annual Medication Pass Observations will be tracked through an Outlook Calendar as well as communication with employees to ensure timeliness of each employee's compliance.

**Compliance Participants-** Resident Care Coordinator(LPN)/Medication Administration Trainer, Personal Care Administrative Coordinator.

**Supporting Documentation**

Med Pass Spreadsheet (April 25, 2016)

*Robert M. Yallie*  
5/6/16

**VIOLATION REPORT**  
**PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS		License Number: 12987
Address: 99 BARCLAY STREET, NEWTOWN, PA 18940		County: Bucks
Administrator: Vickie Deller		Region: SOUTHEAST
Legal Entity Name: CHANDLER HALL HEALTH SERVICES INC		
Legal Entity Address: 99 BARCLAY STREET, NEWTOWN, PA 18940		
Certificate(s) of Occupancy C-2 LP 09/29/1986 Commonwealth of PA L&I		
<b>Staffing Hours</b>		
Resident Support: 0	Total Daily Staff: 57	Working Staff: 43
Type of Inspection: Interim - POC	BHA Docket Number:	Notice: Unannounced
Reason(s) for inspection(s) Interim		
On-Site Inspections Dates and Department Representatives On-Site 07/20/2016: Gray, Dean		
Off-Site Inspection Dates and Inspectors, If Applicable		
Other Details		
Partial or Full Triggers:		Random Indicators:
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 60 Number of Residents Served: 32 Secured Dementia Care Unit In Home: No Area: Secured Dementia Unit Capacity, If Applicable: Number of Residents Served in Secured Dementia Care Unit, if applicable: Number of Current Hospice Residents: 2 Number of Hospice Residents in past year: 12	<b>Number of Residents who:</b> Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 32 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 25 Have a Physical Disability: 0	

Violation Report: 12987 - 07/20/2016 - Gray, Dean  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
 2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION

- On 7/7/16, blood glucose testing were performed at 7:58 AM, 12:09 PM, 5:07 PM, 9:45 PM and on 7/8/16 at 7:48 AM. The readings were documented on the home's blood sugar logs for resident #1.
- On 7/9/16, blood glucose testing was performed at 6:58 AM matched the readings for Resident #2. The readings were documented on the home's blood sugar logs for resident #2. The form stated "used backup".
- On 7/18/16, at 5:37 PM, an unidentified resident's blood glucose testing was completed. The reading was not recorded.
- On 7/20/16, at 8:38 AM, a blood glucose testing was completed on resident #3. The readings were documented on the home's blood sugar logs for resident #3.

*listed above*

All of the glucose testings were performed utilizing the home's "back-up" glucometer. The home reported keeping a "back-up" glucometer for use when experiencing problems with a resident's glucometer or with new arrivals.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 2 of 6 Attachment*

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette Killian*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Lynette Killian, CEO*      Date *8/31/2016*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <i>8/31/16</i> (Date)	Plan of correction implementation status as of <i>9/15/16</i> (Date)
The above plan of correction was approved by <i>[Signature]</i> (Initials)	<input type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input checked="" type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Page 2 of 6 Page 1

Action taken to correct Violation:

1. Personal Care changed policy for recording blood glucose readings. Readings will only be documented on the Medication Administration Record effective August 1, 2016
2. "Back Up Glucometer" was removed and disposed of July 20, 2016. (NOTE: Back up glucometer was never to be used repeatedly on more than one resident. It was available should a glucometer be needed (outside of business hours) if a glucometer did not work or was unavailable. Glucometer was to be labeled and become the glucometer for that resident. Back Up should have been called "Replacement")
3. Review of all glucometers-labeling/operation/setup(time/date accuracy) (July 21, 2016)
4. All resident glucometers moved to where the resident's medications are located in medication cart.
5. Review of all glucometer readings between July 1 and July 23, 2016. (July 23, 2016) Immediate intervention/action taken with staff- counselings/disciplinary measures. Some glucometers needed recalibration of time and date.
6. Investigation of use of the "back up glucometer".(What residents may have been affected/what staff used the back up glucometer/reason why it was used)

Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)

Compliance Correction

- A. All residents confirmed/issued new or had existing, working glucometer. A supply of new glucometers are available for use to any new admission or a resident who does not have a working glucometer. New glucometers are available in Hicks Residence/Resident Nurse Coordinator office(24/7)/or Central Supply during business hours.(July 21, 2016)
- B. All Personal Care Nurses, Medication/Diabetic Certified Care Partners all given/reviewed and signed for: 1. Communication regarding Glucometers, Blood Glucose Log and 2. DHS Director correspondence dated March 17, 2015. (August 4, 2016)
- C. All staff involved in the use of this "backup glucometer" received disciplinary actions and have participated in a MANDATORY REMEDIATION Training specifically designed around the issues of our violations. (August 30, 2016).
- D. Blood tests conducted on identified resident(s) involved in this violation - tested for HIV, HepB and HepC with negative findings.

*Regnette Hiller*  
8-31-2016

Hicks Residence Chandler Hall  
Interim POC July 20, 2016

License #129870

August 30, 2016

Page 2 of 6 Page 2

**Compliance Participants**

Personal Care Nurses/Medication/Diabetic Certified Care Partners, Personal Care Nurse Coordinators(LPN),  
Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care  
Administrative Coordinator.

**Supporting Documentation**

Care Partner Communication Form  
PA Department of Human Services Letter March 17, 2015

*Lyette Hill*  
8/31/2016

Violation Report: 12987 - 07/20/2016 - Gray, Dean  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600

- 2600.182(c) - Medication administration includes the following activities, based on the needs of the resident:
- (1) Identify the correct resident.
  - (2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
  - (3) Remove the medication from the original container.
  - (4) Crush or split the medication as ordered by the prescriber.
  - (5) Place the medication in a medication cup or other appropriate container, or in the resident's hand.
  - (6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in § 2600.182(b)(4).
  - (7) Complete documentation in accordance with § 2600.187 (relating to medication records).

2a. DESCRIPTION OF VIOLATION

On 07/09/16, 07/10/16, 07/17/16, 07/18/16, Resident #2's 6:30 AM glucose readings were not documented on the medication administration record (MAR). On 07/08/16, Resident #2's 9:00 PM glucose reading was initiated but no reading was documented on MAR.

On 07/05/16 at 11:30 AM and on 07/08/16, 07/16/16, 07/17/16 and 07/18/16 at 8:00 AM, Resident #4's glucose readings were initiated but no readings were documented on MAR. On 07/10/16 at 11:30 AM, no readings were documented in the MAR.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 3 of 6 Attachment*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>Lynette Killen</i>
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Lynette Killen, CEO</i>	<i>8/31/2016</i>

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u><i>8/31/16</i></u> (Date)	Plan of correction implementation status as of <u><i>9/15/16</i></u> (Date)
The above plan of correction was approved by <u><i>[Signature]</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input checked="" type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Page 3 of 6

Action taken to correct Violation:

1. Personal Care eliminated and will no longer use the Blood Glucose Log. (August 1, 2016)
2. All staff involved received disciplinary actions and have participated in a MANDATORY REMEDIATION Training specifically designed around the issues of our violations identified July 20, 2016. (August 30, 2016)

Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)

Compliance Correction

A. During 7-3 and 3-11 shift change, all MARS reflecting Insulin orders of Diabetic residents will be reviewed to ensure that all required information is complete. (September 1, 2016)

B. Form created to sign off on MAR check at shift change

C. Blood Sugar readings will only be documented on the Medication Administration Record. (August 1, 2016)

*All staff will be trained on the documentation protocols within 30 days of receipt of this plan of correction. @ 9/16/16*

D. Administrator/Designee will randomly check shift change to observe MAR checks/monitor form completion. *at least once weekly starting within 30 days of receipt of this plan of correction.*

*@ 9/15/16*

Compliance Participants

Personal Care Nurses/Medication/Diabetic Certified Care Partners, Personal Care Nurse Coordinators(LPN), Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care Administrative Coordinator.

Supporting Documentation

See Diabetic Education Remediation Training Outline  
MAR Review- Shift Change

*Lynette Miller  
8/31/2016*

Violation Report: 12987 - 07/20/2016 - Gray, Dean .  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600.  
 2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #1 is prescribed sliding scale insulin as follows; 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-460 = 12 units, 461-500 = 14 units. ~~On 7/15/16, a glucose reading of 166 is documented with 0 units of Novolog 100 ml administered on the MAR.~~ On 7/15/16, a glucose reading of 166 is documented with 0 units of Novolog 100 ml administered on the MAR.

Resident #4 is prescribed sliding scale insulin as follows; 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-450 = 10 units. Notify MD/NP if less than 70 or greater than 400. On 7/11/16, a glucose reading of 247 and 4 units of Novolog 100 ml administered is documented on the MAR.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct (a violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

*See Page 5 of 6 Attachment*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette Kellen*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Lynette Kellen</i>	Date <i>8/31/2016</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/31/16  
 (Date)

Plan of correction implementation status as of 9/15/16  
 (Date)

The above plan of correction was approved by *[Signature]*  
 (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented --Inadequate Progress
- Not Implemented

Page 5 of 6

Action taken to correct Violation:

1. Investigation of errors and inaccuracies with staff involved.
2. All staff involved counseled and received disciplinary actions and have participated in a MANDATORY REMEDIATION Training specifically designed around the issues of our violations identified July 20, 2016. (August 30, 2016)

Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)

Compliance Correction

- A. During 7-3 and 3-11 shift change, all MARS reflecting Insulin orders of Diabetic residents will be reviewed to ensure that all required information is complete and that the correct insulin dose was administered. (September 1, 2016), *daily by nurse manager or designee.*
- B. Form created to sign off on MAR check at shift change - *documentation will be maintained for the Department's review.*
- C. Administrator/Designee will randomly check shift change to observe MAR checks/monitor form completion, *at least weekly, starting within 30 days of receipt of this plan of correction. Documentation of the MAR review will be maintained for the Department's review upon request.*

Compliance Participants

Personal Care Nurses/Medication/Diabetic Certified Care Partners, Personal Care Nurse Coordinators(LPN), Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care Administrative Coordinator.

Supporting Documentation

MAR Review- Shift Change

*Suzette Kellen*  
*8/31/2016*

Violation Report: 12987 - 07/20/2016 - Gray, Dean  
 PCH Name: CHANDLER HALL HEALTH SERVICES INC HICKS

1. REGULATION 55 Pa.Code §2600  
 2600.190(a) - A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

2a. DESCRIPTION OF VIOLATION  
 On 6/1/16, 6/15/16, 6/19/16 through 6/24/16, 6/26/16, 7/2/16, 7/11/16 and 7/12/16, staff person A, administered medications to residents of the home. Staff person A was certified in medication administration March of 2014. Their annual practicum was not completed until 5/17/15.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

*See Page 6 of 6 Attachment*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Lynette Killen*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Lynette Killen* Date *8/3/2016*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <i>8/31/16</i> (Date)	Plan of correction implementation status as of <i>9/15/16</i> (Date)
The above plan of correction was approved by <i>[Signature]</i> (Initials)	<input type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input checked="" type="checkbox"/> Not Implemented

Page 6 of 6

**Actions taken to correct Violation**

1. Review of staff person record revealed that staff person was still not current with annual requirements(observation/MAR review). (July 20, 2016)
2. Identified staff person immediately suspended from being scheduled to pass medication. (July 20, 2016)
4. Medication Administration Trainer responsible for tracking requirement compliance was counseled for not ensuring that staff met compliance requirements and for not following the original plan of correction submitted May 6, 2016.

**Step by Step Plan of Correction for Compliance (Change Made/Person Responsible for change/when change will be implemented/training)**

**Compliance Correction**

- A. Administrator and Personal Care Administrative Coordinator reviewed all staff training documents, *quarterly.*
- B. Created a grid to track current standing of staff for compliance and projections of compliance requirements by month.
- C. Two (2) additional nurses have been trained to observe and monitor medication administration compliance requirements(observations and MAR reviews).
- D. Assignments of staff due for observation/MAR review will be created by the Personal Care Administrative Coordinator and given to the Trainers at the beginning of each month. PC Administrative Coordinator will ensure compliance at the end of each month.
- E. Administrator will be given a report monthly to validate and ensure staff compliance.

*F. Staff A will complete the entire med administration course prior to giving medications, starting within 30 days of receipt of this plan of correction.*

Compliance Participants- Personal Care Nurses/Medication/Diabetic Certified Care Partners, Personal Care Nurse Coordinators(LPN), Personal Care Medication Trainer, Personal Care Clinical Liaison(RN), Personal Care Nurses(LPN 11-7), Personal Care Administrator, Personal Care Administrative Coordinator.

**Supporting Documentation**

See Outline of Diabetic Education Remediation Training  
Medication Training Compliance Tracking Grid

*Lizette Fuller*  
*8/31/2016*