



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: August 23, 2017

Ms. Loriann Putzier, President & COO
VS Woods LLC
IntergraCare Corporation
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: The Woods at Cedar Run
824 Lisburn Road
Camp Hill, Pennsylvania 17011
License #: 331320

Dear Ms. Putzier:

As a result of the Department of Human Services' licensing inspection on August 10, 2017 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Brett Swanger".

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report: 33132 - 08/10/2017 - Heemer, Laura
 PCH Name: THE WOODS AT CEDAR RUN

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

2a. DESCRIPTION OF VIOLATION

The home failed to follow the directions of the prescriber on 8-5-2017, when Staff member A administered 85 units of Novalog to Resident 1 instead of 85 units of Lantus, as prescribed.

Resident 1 is prescribed to receive four Glucose 4 mg chewtabs when the resident has a measured blood glucose below 70. The home failed to follow the directions of the prescriber on 8/5/2017 when Staff member B administered 4 Glucose chew tabs to Resident 1, when Resident 1 had a blood glucose measuring 70 and on 8/7/2017 when Staff member C administered 4 Glucose chewtabs to Resident 1 when Resident 1 had a blood glucose measuring 72.

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 Attached

Pages 2A and 2B of 2

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Courtney Bolney

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

Courtney Bolney, Director Date 8/22/17

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

The above plan of correction is approved as of

8/23/17
 (Date)

Plan of correction implementation status as of

8/23/17
 (Date)

The above plan of correction was approved by

CB
 (Initials)

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

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PLAN OF CORRECTION TEMPLATE

Community Name: VS Woods, LLC d/b/a The Woods at Cedar Run

License Number: 331320

Date of Visit: 8/10/17

Date of Submission: 8/22/17

1. **Violation Review: 2600.187(d)** The home shall follow the directions of the prescriber.
2. **Violation Interpretative Statement:** The home failed to follow the directions of the prescriber on 8-5-17, when Staff member A administered 85 units of Novalog to Resident 1 instead of 85 units of Lantus, as prescribed.
Resident 1 is prescribed to receive four glucose 4mg chewtabs when the resident has a measured blood glucose of below 70. The home failed to follow the directions of the prescriber on 8/5/17 when staff member B administered 4 glucose chew tabs to Resident 1, when Resident 1 had a blood glucose measuring 70 and on 8/7/2017 when staff member C administered 4 Glucose chewtabs to Resident 1 when resident 1 had a blood glucose measuring 72.
3. **Review the benefit of the Regulation, per RCG:** Ensures that residents receive medications and treatments as ordered by a physician.
4. **Description of the Repair of the Immediate Problem:** Upon determination of the error, resident 1, resident's(1) designated person, and prescriber were notified of the error. Resident's (1) blood glucose level was monitored through period of efficacy for a short acting insulin. Resident's (1) blood glucose level didn't fall below 70 during this short acting efficacy period. Physician made no new orders. On 8/5/17 staff person administered 4 glucose chew tabs when blood glucose was at 70. On 8/7/17 staff person prepared 4 glucose chews tabs at blood glucose of 72 when resident's designated person asked to have the glucose tabs, and subsequently resident's designated person administered to the resident. Resident's blood glucose levels were reviewed with the physician who made no new orders.

System for separating vials of insulin in medication cart was established on 8/7/17.

Second Signature required was added to Resident 1's insulin orders.

Resident 1 had a nighttime check in added to his evening routine – between 10:30pm and midnight.

5. **Determine / document the Root Cause of the Violation:** Staff person failed to follow physician orders by administering wrong insulin – staff person A was counseled on five rights of

ZB of Z

medication administration on 8/7/17. Staff person B administered 4 glucose tabs on 8/5/17 at blood glucose of 70 versus below 70. Staff person C prepared 4 glucose tabs on 8/7/17 at the persistence of the resident's designated person, the designated person administered the 4 glucose chew tabs.

6. Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice?

Insulin storage within the medication carts have been reviewed and for those residents who require insulin and have more than 1 vial type of insulin their vials will be stored in separate labeled containers within the medication cart and a second person signature required to verify correct insulin will be implemented.

b. Teaching or Training?

1. Staff person's administering medications will be educated on new procedures for those residents who have more than 1 vial type of insulin.

2. Staff person's administering medication will be re-educated on Five rights of medication administration, following physician orders, and diabetic emergency.

c. On-going Monitoring?

1. Senior Living Director will Audit med cart weekly for 4 weeks to assure newly established procedures for insulin storage in the med cart is in compliance.

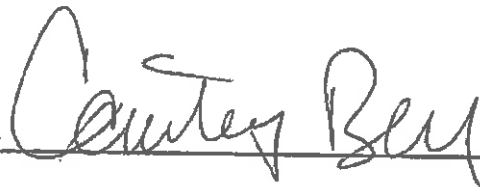
2. Senior Living Director will audit weekly for 4 weeks to assure medication error reports for appropriate follow up actions.

3. Senior Living Director will make recommendations following completion of auditing process on compliance and/or further action steps to achieve ongoing compliance.

Compliance will be reported to the Executive Director.

7. Designated position responsible and specify target date for correction. Executive Director will be responsible for assuring plan of correction is carried out and compliance is achieved by 9-15-17.

Authorized Signature



Date:

