



August 26, 2019

Ms. Stacey Meyer
Assistant Secretary
Brookdale Senior Living Communities, Inc.
7151 Saltsburg Road
Pittsburgh, Pennsylvania 15235

RE: Brookdale Penn Hills
Certificate #: 431590

Dear Ms. Meyer:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 31, 2019, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock".

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

8/7/19

Violation Report

Facility Information

Name: *BROOKDALE PENN HILLS*
 Address: *7151 SALTSBURG ROAD, PITTSBURGH, PA 15235*
 County: *ALLEGHENY* Region: *WESTERN*

License Number: *43159*

Administrator

Name: *Judy Carrabbia* Phone: *4127983400* Email: *jcarrabbia@brookdale.com*

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*
 Address: *7151 SALTSBURG ROAD, PITTSBURGH, PA, 15235*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/22/1997* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *15* Waking Staff: *11*

Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
 Reason: *Renewal*

Inspection Dates and Department Representative

05/31/2019 - On-Site: Karen Georgoulis, Desmond Grace

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* Residents Served: *15*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>14</i>
Diagnosed with Mental Illness: <i>0</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>0</i>	Have Physical Disability: <i>2</i>

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 5/30/19, staff member A prepared and served breakfast and lunch to the residents. Direct care staffs A does not have a ServeSafe certification. Allegheny County requires any person who works in a facility where food preparation and handling take place to obtain a ServSafe certification. Currently there are no staff persons ServeSafe certified working in the home.

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 2A of 14

(See attached)

Legal Entity Representative

Judith Carrabba
Signature

Judith Carrabba ED 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600 .18

Immediately-Staff member A, who was new to the position, was scheduled for ServeSafe class on July 13, 2019. This class has been rescheduled for October 14, 2019 and staff person A is enrolled to attend.

June 4, 2019-Another staff person was trained in Safeserve so there is a certified person currently working in the home.

August 2, 2019-District Director of Clinical Services retrained Staff Person A and Executive Director on the community policy regarding the ServeSafe Certification requirement.

The Lead Cook will verify and schedule any newly hired staff whose job it is to prepare and serve food to attend ServeSafe training certification.

Evidence- SafeServe Certificate, training attendance sheet

Completed: October 14, 2019

Judith Cavalleri

Judith Carrabbia, ED 8/6/19

8/7/19

gr

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Direct care staff person B, hired 4/18/16, did not receive annual training in emergency preparedness during the 2018 training year (1/1/18 to 12/31/18).

Repeat violation: 5-17-18

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 3A pf 14

(See attached)

Legal Entity Representative

Judith Carrabba
Signature

Judith Carrabba, ED *8/6/19*
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600.65 (g)

August 2, 2019- District Director of Clinical Services retrained the Executive Director and Health and Wellness Coordinator on the community policy regarding annual training requirements.

August 6, 2019- Staff Person B received training on Emergency Preparedness for 2019.

Staff training records will be audited on a quarterly basis and documented on a tracking form by the Health and Wellness Coordinator or designee for completion of required training topics for that quarter. The Health and Wellness Director will review the results of the audits to verify compliance and to determine if any further action is warranted.

Evidence: Annual PA Training Schedule, Training attendance sheet, tracking form

Completion Date: August 2, 2019

Judith Carrobbio - Judith Carrobbio, ED 8/6/19

8/7/19 *gr*

82c - Locking Poisonous Materials

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 5/31/19 at approximately 9:55 a.m. the following poisonous materials with a manufactures label indicating contact poison control center if swallowed was unlocked, unattended, and accessible, to include:

- * A 1-quart spray bottle of Dyna Foaming Decabonant Oven Grill Cleaner, ¾'s full.
- * A 1-quart spray bottle of Misty Deep Cleansing Hard Tile Cleaner approximately 9/10th full.

Residents #1, #2 and #3 have been assessed as not capable of recognizing and using poisonous materials safely.

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 4A of 14

(See attached)

Legal Entity Representative

Judith Carrabbia
Signature

Judith Carrabbia, ED 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600.82.c

Immediately- The oven cleaner and Misty Deep Cleaner were discarded.

June 3, 2019- A locked cabinet was designated in the kitchen area for chemicals and poisonous materials to be stored.

August 9, 2019- The Lead Cook and appropriate kitchen staff were retrained on the community policy regarding storage of poisonous materials by the Executive Director.

The Maintenance Technician or designee will add checking for secured poisonous materials to his audit tool for community rounds weekly for 1 month then monthly thereafter.

The Executive Director will review the results of this audit to verify if any further action is warranted.

Evidence- Daily Walk Through Rounding sheet, training attendance sheet

Completed: 08/09/2019

Judith Cavabbi Sudits Cavabbi, E.D. 8/6/19

8/7/19 *gr*

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/31/19 at 11:20 a.m., there were no paper towels, mechanical air blower, or other means of hand drying in the private bathroom of bedroom #14.

On 5/31/19 at 11:20 a.m., there were no paper towels, mechanical air blower, or other means of hand drying in the private bathroom of bedroom #17.

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 5A of 14

(See attached)

Legal Entity Representative

Judith Carrabba
Signature

Judith Carrabba, EP
Printed Name and Title

8/6/19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600.85.a

Immediately-Paper towels were replaced in room #14 and #17 bathrooms at time of inspection.

August 9, 2019- Executive Director retrained the Maintenance Technician on the community policy regarding maintaining sanitary conditions.

The Maintenance Technician or designee will add checking for bathroom towels to his audit tool for community rounds weekly for 1 month then monthly thereafter.

The Executive Director will review the results of this audit to verify no further action is warranted.

Evidence- Daily Walk Through Rounding sheet, training attendance sheet

Completed: 08/09/2019

Judith Carabbi

Judith Carabbi, ED 8/6/19

8/7/19 *gr*

85d - Trash Receptacles

Regulations

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/31/19 at 11:25 a.m., a trash can in the common bathroom in the second dining room hallway, was half filled with trash and the lid was open. the trash can lid is battery operated and was not functioning.

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.)

2600.85d

Trash can was replaced. During daily walk through of community ED/ designee will audit for compliance weekly for 1 month then monthly thereafter.

Completed: 07/30/2019

Legal Entity Representative

Judith Cavalli
Signature

Judith Carrabba ED
Printed Name and Title

8/6/19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

92 - Windows

Regulations

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 5/31/19, there is a 6" by 2" linear tear located in lower right corner of the screen in the open window of the Discovery Room.

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 7A of 14

(See attached)

Legal Entity Representative

Judith Carrabba
Signature

Judith Carrabba ED, 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600.92

Immediately- The Discovery Room window was closed and a new screen was ordered by the Executive Director.

June 3, 2019- Maintenance Technician assessed all of the window screens in the community for tears or damage. There were no other torn screens noted.

June 3, 2019- The torn window screen was replaced in the Discovery Room by the Maintenance Technician.

August 9, 2019- Executive Director retrained the Maintenance Technician on the community policy regarding windows and screens being in good working order.

The Maintenance Technician or designee added checking windows screens to his audit tool for community rounds weekly for 1 month then monthly thereafter.

The Executive Director will review the results of this audit to verify no further action is warranted.

Evidence- Daily Walk Through Rounds sheet, training attendance sheet, picture of new window screen

Completed: 08/09/2019

Judith Cavablis Judith Carrabba, E D 8/6/19

8/7/19 *gr*

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 5/31/19 at 11:30 a.m., the bedside lamp in the bedroom of resident #1 was placed approximately 3.5' to 4' from resident's bed. Resident #1 is unable to reach the lamp from his/her bedside.

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 8A of 14

(See attached)

Legal Entity Representative

Judith Carrabba
Signature

Judith Carrabba, ED 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600.101.j

Immediately- The bedside lamp was relocated closer to the bed so the resident could reach the lamp.

June 7, 2019- Tap Lights have been placed on the headboards of all beds to ensure a light source is within reach for each resident.

August 9, 2019- Executive Direct retrained the Maintenance Technician and appropriate staff on the community policy regarding bedside lamps being in good working condition as well as within reach of bedside.

The Maintenance Technician or designee added checking bedside lights to his audit tool for community rounds weekly for 1 month then monthly thereafter. Direct care staff were also retrained to notify maintenance if bedside lights are not close to the bed or not functioning properly.

The Executive Director will review the results of this audit to verify if any further action is warranted.

Evidence- Walk Through Rounds sheet, training attendance sheet, picture of new Tap Lights

Completed: 08/09/2019

Judith Cavalli

Judith Carrabba, ED 8/6/19

8/7/19

gr

132g - Fire Drills Days/Times

Regulations

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home's sleeping hour fire drills conducted from 5/18/18 to 5/31/19 were routinely held between the hours of 6:00 a.m. to 7:00 a.m., to include:

6/29/18 at 6:19 a.m.

9/29/18 at 6:45 a.m.

12/21/18 at 6:46 a.m.

2/23/19 at 6:22 a.m.

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 9A of 14

(See attached)

Legal Entity Representative

Judith Carrabbio
Signature

Judith Carrabbio, E.D. 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19 (Date)

Plan of correction implementation status as of 8/7/19 (Date)

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

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

Regulation 2600.132.g

Immediately- The Executive Director established a new schedule for fire drills for the next 6 months of 2019 which included the time of the day, day of the week as well as the date.

August 9, 2019- Executive Director retrained the Maintenance Technician on the community policy regarding fire drill scheduling at different times and days of the week.

The Executive Director will review the fire drill records to verify if any further action is warranted.

Evidence- training attendance sheet, copy of the fire drill schedule for the remainder of 2019

Completed: 8/09/2019

Judith Canale *Sudy Carrabba, ED 8/6/19*

8/7/19

g

141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation for resident #1, dated 10/14/18, does not include resident's height, body positioning/movement, if the resident is safe around poisons, the special health and dietary needs. These sections are blank. The Special Health Needs does not address needing finger foods or food cut up and plate positioning to eat independently.

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 11A of 14

(See attached)

Legal Entity Representative

Judith Carabalia
Signature

Judith Carabalia, ED 8/6/19
Printed Name and Title Date

1

141a 1-10 Medical Evaluation Information *(continued)*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Regulation 2600.141.a

Immediately- The Health and Wellness Director had the Medical Evaluation updated to include the missing information.

Immediately- The Health and Wellness Director audited all current Medical Evaluations for completion. All were found to be completed according to community policy.

August 2, 2019- The Executive Director retrained the appropriate clinical staff on the community policy regarding complete information on the Medical Evaluation from the prescribing physician.

The Resident Care Coordinator and or designee will review all new Medical Evaluations upon receipt to ensure completion according to community policy. This review will be noted by signing their initials after review of each of 2 staff in the corner prior to filing the form in the medical record.

The Health and Wellness Director will review the Medical Evaluations for 2 months to verify if any further action is warranted.

Evidence: training attendance sheet, Medical Evaluation for Resident #1 with the completed information

Completed: 8/02/2019

Judith Cavabbi

Sudith Carrobbia, ED 8/6/19

8/7/19 gr

141b1 - Annual Medical Evaluation

Regulations

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent medical evaluation, completed 12/14/18, is missing the special health and dietary needs. The section was blank.

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.)

Regulation 2600.141a

Immediately- The Health and Wellness Director updated the Medical Evaluation by hand writing regular diet on the form prior to exit. The resident does not have a special diet order, therefore it was left blank. There was no special diet order to add to form.

Immediately: All staff persons involved in the medical evaluation process shall be educated on proper documentation of medical evaluations. Documentation of education shall be kept. 8/7/19 *gr*

Legal Entity Representative

Judith Corrao
Signature

Judith Corrao, ED 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

171b5 - First Aid Kit

Regulations

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 5/31/19 at 11:15 a.m., the first aid kit in the home's 2016 Ford Transit Van does not include eye coverings or a thermometer.

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.)

Regulation 2600.96a

Transportation person/designee will check that all required items for the first aid kit in the van are available at all times by utilizing a tracker form.

Evidence: Training Attendance Sheet, Tracker form.

Completed: 8/1/2019

Immediately: The missing items cited in the violation shall be placed in the first aid kit. 8/7/19

g

Legal Entity Representative

Judith Carrobbio
Signature

Judith Carrobbio, E.D. 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

184a - Labeling OTC/CAM

Regulations

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 #3's Losartan Potassium 25 mg tablet - take one tablet every day. However, the physician order indicates Losartan Potassium 25 mg tablet, take 12.5 mg tablet one time a day (8:00 a.m.).

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 14A of 14

Legal Entity Representative

Judith Carrobbia
Signature

Judith Carrobbia, EP, 8/6/19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19
(Date)

Plan of correction implementation status as of 8/7/19
(Date)

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

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

Immediately- The Health and Wellness Director contacted the prescribing physician to clarify the medication order. Medical Technicians were administering half of a tablet thus no medication occurred. A change of dosage order sticker was placed on the medication to clarify the dosage.

June 3, 2019- The Executive Director retrained the appropriate clinical staff on the community policy regarding use of the dosage change order stickers.

The Health and Wellness Director or designee will review new orders when there is a change in dose and check the medication label for updates. The Health and Wellness Director will verify if any further action is warranted.

Evidence: Staff training log

Completed: 06/03/2019

Judith Cavabli
Judith Carrabbi, ED 8/6/19

8/7/19 *J*