pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail ttarquin@newvitaewellness.com
July 9, 2020

Ms. Toby Tarquin-Stackhouse
Administrator
Tri-County Respite, Inc.
219 East Broad Street
Quakertown, Pennsylvania 18951

RE: Tri-County Respite Quakertowne House
License #: 126810

Dear Ms. Tarquin-Stackhouse:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 11, 2019 and February 21, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Claire Mendez

Claire Mendez
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE*
License Number: *12681*
Address: *219 EAST BROAD STREET,, QUAKERTOWN, PA 18951*
County: *BUCKS*
Region: *SOUTHEAST*

Administrator

Name: *Toby Tarquin-Stackhouse*
Phone: *2155382424*
Email: *ttarquin@newvitaewellness.com*

Legal Entity

Name: *TRI-COUNTY RESPITE INC*
Address: *219 EAST BROAD STREET, QUAKERTOWN, PA, 18951*

Certificate(s) of Occupancy

Type: *C-2 LP*
Date: *01/10/1998*
Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *52*
Waking Staff: *39*

Inspection

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

Inspection Dates and Department Representative

12/11/2019 - On-Site: Youn Hie Chung, Sabrina Freeman, Susan Smith

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65*
Residents Served: *52*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *21*
Are 60 Years of Age or Older: *17*
Diagnosed with Mental Illness: *52*
Diagnosed with Intellectual Disability: *9*
Have Mobility Need: *0*
Have Physical Disability: *0*

TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE 12681

15a - Resident Abuse Report

Regulations

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 07/06/2019 at 07:00 PM, resident #1 reported having been hit by another resident. This incident was investigated by the home. However, the home failed to report this allegation of abuse to a local Area Agency on Aging.

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.)

The incident did not meet the definition of abuse as put forth by DHS. The resident reported she was not in emotional distress, pain,fear, injury, unreasonable confiement, mental anguish

The incident was reported because it was a resident to resident issue. To prevent reoccurrence staff were retrained and will be retrained again.

All staff were remediated on abuse and neglect on 8/21/19.

Adminstrator will report in accorance with regulation to enusre compliance.

Legal Entity Representative

Toby Tanyin Stackhouse
Signature

Toby Tanyin Stackhouse -Admin 1/16/20
Printed Name and Title Date

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

The above plan of correction is approved as of 1/16/2020 (Date)

Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented
☐ Not Implemented

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

TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE 12681

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

The file for direct care staff person A, hired on 11/04/2019, does not include a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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.)

Staff person A did produce necessary proof of her educational requirements

New employees will not be permitted into new hire orientation unless they provide the required documents

A temporary indepnedent contractor has been hired to audit all personnel files

Administrator will monitor to ensure compliance

Legal Entity Representative

Signature

Toby Taguin Stackhouse, Admin 1/14/20
Printed Name and Title Date

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Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented

☐ Not Implemented

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

89b - Hot Water Temperature

Regulations

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 12/11/2019 at 03:00 PM, the hot water temperature at the bathroom sink in resident bedroom #109 and #213 was measured 130 degrees Fahrenheit and 131 degrees Fahrenheit, respectively.

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.)

On the day of inspection, 12\11\19 the Director of operations adjsuted the water temperature to a temparture below 131 degrees

Maintenance developed a checklist and will check the water temperatures in 2 random spots in the house each week. This will be documented

The Administrator will review check list to ensure compliance

Legal Entity Representative

Signature

Toby Tarquin Stackhouse, Admin
Printed Name and Title

1/16/20
Date

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

The above plan of correction is approved as of 1/16/2020 (Date)

Plan of correction implementation status as of 3/25/2020 (Date)

☑ Implemented

☐ Not Implemented

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

TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE 12681

103f - Refrigerator/Freezer Temps

Regulations

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 12/11/2019 at 02:20 PM, the temperature in the freezer in the basement was 16 degrees Fahrenheit. The refrigerator in the home's kitchen and the one in the basement used by residents were missing 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.)

On the day of the inspection, 12\11\19, the Director of operations had placed a call to request maintenance to Schulberger's Refrigeration and Air Conditioning for the freezer referred to in this violation.

The freezer was not yet fixed as the time of the physical site portion of the inspection. It was fixed by the end of the day.

Please see attached work order that proves the issue was resolved.

Type text here

Maintenance developed a checklist and will check 1 the temperatures

Administrator will review to ensure compliance

Legal Entity Representative

Signature

Toby Joaquin Stackhouse, Admin 1/16/20

Printed Name and Title Date

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The above plan of correction is approved as of 1/16/2020 (Date)

Plan of correction implementation status as of 12/21/2019 (Date)

☑ Implemented

☐ Not Implemented

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

132h - Designated Meeting Place

Regulations

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill held on 03/13/2019 at 08:30 AM, 41 residents were at the home but only 40 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

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.)

Staff were remediated about fire safety, fire drills and evacuations.

Residents were coached, counseled and educated on fire safety, fire drills and evacuationsType text here

The individual resident was coached, counselded and educated on fire safety, fire drills, and evacuations. He was informed that if he was unwilling or unable to particiate in evacuactions he could be ineligble to reside in a personal care home

Administrator or designee review, monitor and debrief staff and residents on fire safty and the drills to ensure compliance

Legal Entity Representative

Signature

Toby Tangin Stackhouse, Admin 1/16/20
Printed Name and Title Date

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☑ Implemented
☐ Not Implemented

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182c - Medication Administration

Regulations

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
3. Remove the medication from the original container.

Description of Violation

On 08/20/2019 at bedtime, Staff Member B administered the wrong medication to resident #3: Lorazepam instead of Temazepam.

It was previously reported by the home that Staff Member B also administered the wrong medication as follows to Resident #7:

3/29/19 at 6pm - Staff Member administered Zolpidem instead of Lorazepam.

5/15/19 at 6pm - Staff Member administered Ativan instead of Ambien

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.)

Staff member B was removed from the med room

Med techs recieved debriefing from the Director of Wellness on the incident and specifically received coach, counsel and education on sound alike\look alike medications

Med tech meetings are held to review policy and procedure

Administrator will review with Director of Wellness items to review with med techs to ensure med adminstration compliance

Legal Entity Representative

Signature

Toby Targin-Stockhuse, Admin
Printed Name and Title

1/16/20
Date

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☑ Implemented
☐ Not Implemented

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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 #4's Novolog Flexpen does not match his medication administration record (MAR). His MAR reads 16 units in the morning, 13 units at lunch, 16 units at dinner, and 4 units at bedtime while the label says 16 units at breakfast, 11 units at lunch, and 16 units at dinner.

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.)

The label was corrected at time of inspection

Med techs were debriefed on proper medicaion administration, policy and procedure

Med tech meetings are held to review policy and procdure

Adminstrator will review with the Director of Wellness items for reveiw at meetings to ensure compliance

Legal Entity Representative

Signature

Tiffany Stackhouse, Adm 1/16/20

Printed Name and Title Date

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Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented

☐ Not Implemented

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185a - Implement Storage Procedures

Regulations

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

Resident #4 has an order of blood glucose level check three times a day. His glucometer was checked for the readings and the following readings on his glucometer were not recorded on the log:

164 at 07:24 AM on 12/08/2019

200 at 03:50 PM on 12/05/2019

167 at 07:07 AM on 12/04/2019 etc.

Resident #5 has an order of blood glucose level check once a day before breakfast. Her glucometer was checked for daily readings and the following readings on her glucometer were not recorded on the log:

150 on 12/04/2019

156 on 11/30/2019

123 on 11/29/2019

212 on 11/28/2019

146 on 11/27/2019 etc

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.)

This error was fixed day of inspection as it was found by the med tech prior to the inspectors arriving on site.

The Director of Wellness with the med tech chagned the setting in the emar to prompt and ask for the tech to record a value before being allowed to sign for medication

Director of Wellness will assist and review an auditing process for glucometers to ensure compliance

Adminstrator will reivew with the Director of Wellness the finding of audit and will coach, counsel and continue to educate the med techs at meeting to ensure on going compliance and an undertanding of the regulations

Legal Entity Representative

Signature

Toby Taylor Stackhouse, Admin
Printed Name and Title

1/16/20
Date

185a - Implement Storage Procedures *(continued)*

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The above plan of correction is approved as of 1/16/2020 (Date)

Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented

☐ Not Implemented

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187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4 is prescribed Quetiapine Fumarate 300 mg. However, his medication administration record does not indicate the diagnosis for this medication.

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.)

This issue was corrected at the time of inspection

Medd techs were remediated on medication administration and proper procedure, making sure the five rights of medication administrator are done for each and every med pass

Med tech meetings are held to review policy and procedure

The Administratoe will review with the Director of Wellness items for reveiw at meetings to ensure compliance

Legal Entity Representative

Signature

Troy Tarquin Stackhouse, Admin
Printed Name and Title

1/16/20
Date

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Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented
☐ Not Implemented

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TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE 12681

187b - Date/Time of Medication Admin.

Regulations

2600.

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

Description of Violation

On 11/29/2019 at bedtime, resident #6 was not administered his scheduled dose of Temazepam 15 mg, a controlled substance. According to the sign-out sheet for this medication, it was not signed out at bedtime on 11/29/2019 but there was staff initials entered on the MAR.

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.)

The Director of Wellness will enfore a standardized process for siging out controlled substances

Staff were remediated

Med tech meetings are held to review policy and procedure

The Adminstrator will review with Director of Wellness and\or their designee audits of the count and docmentation of controlled substances to ensure compliance

Legal Entity Representative

Signature

[illegible], Admin 1/16/20

Printed Name and Title Date

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Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented

☐ Not Implemented

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

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #3 was administered Lorazepam 1 mg instead of Zolpidem Tartrate 10 mg at bedtime on 08/20/2019. Resident #6 is prescribed Temazepam 15 mg at bedtime. However, he was not administered this med on 11/29/2019.

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.)

Staff were remediated on following the directions of the prescriber and proper medication administration.

Med tech meetings are held to review policy and procedure

Administrator will review with the Director of Wellness items for review at meetings to ensure compliance

Legal Entity Representative

Signature

Toby Tangin Stallone, Admin
Printed Name and Title

1/16/20
Date

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Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented
☐ Not Implemented

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

224a - Preadmission Screen Form

Regulations

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3 was admitted to the home on 11/28/2018; however, the resident's preadmission screening form was completed on 10/13/2017.

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.)

Staff was edcucated on the regulation as it pertains to pre-admission items and the regulatory time frames

The Director of Social Services and or the Supervisor will review preadmission documents to ensure compliance

The Administrator will monitor to ensure compliance

Legal Entity Representative

Signature

[illegible], Adm

Printed Name and Title

1/16/20

Date

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Plan of correction implementation status as of 2/21/2020 (Date)

☑ Implemented

☐ Not Implemented

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

Violation Report

Facility Information

Name: *TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE* **License Number:** *12681*
Address: *219 EAST BROAD STREET,, QUAKERTOWN, PA 18951*
County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: *Toby Tarquin* **Phone:** *2155382424* **Email:** *kpintabone@newvitaewellness.com*

Legal Entity

Name: *TRI-COUNTY RESPITE INC*
Address: *219 EAST BROAD STREET, QUAKERTOWN, PA, 18951*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** **Issued By:**

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *55* **Waking Staff:** *41*

Inspection

Type: *Partial* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *POC Verification*

Inspection Dates and Department Representative

02/21/2020 - On-Site: Denise Gillespie, Christina Eberhart

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served:** *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *20* **Are 60 Years of Age or Older:** *17*
Diagnosed with Mental Illness: *55* **Diagnosed with Intellectual Disability:** *9*
Have Mobility Need: *0* **Have Physical Disability:** *0*

89b - Hot Water Temperature

Regulations

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 2/21/2020 the 3rd Floor Bathroom temperature was checked by Representative at 11:30 A.M. and it was 129.5 degrees F. The Maintenance Worker checked it at 11:35 A.M. and it was 130 degrees F.

On 2/21/2020 the 2nd Floor Bathroom between Resident Bedroom 203 and Resident Bedroom 204 was checked by Representative at 11:40 A.M. and the temperature was 131.4 degrees F. The Maintenance Worker checked it at 11:45 A.M. and it was 133.6 degrees F.

Repeated violation: 12/11/19

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.)

Altemos (heating & A/C) was on site on 2/24/2020, to evaluate the problem; they replaced the automatic feeder for the heater and turned the temperature down on 2 out of 5 water heaters to resolve the issue. The days following, maintenance conducted daily temp checks and concluded that the issue was not resolved because the temperatures continued to exceed 120 degrees. Maintenance turned down the temp on the remaining 3 water heaters, but the issue remained. Director of Operations contacted a plumber who arrived onsite on 3/11/2020. The plumber installed a water temperature control valve on one of the water heaters. The temperatures continued to fluctuate. On 3/14, the plumber was back onsite and determined a water heater needs to be replaced; this is scheduled to occur on 3/17. Maintenance staff will continue daily temp checks until we are certain the issue is resolved. In the meantime, signs have been posted in every bathroom alerting residents to use caution due to high water temperatures. An announcement regarding the water temperature is made during the monthly resident council meetings and staff meetings.

Continued on next page

Legal Entity Representative

3/27: Over the past week, our water temperatures have consistently been within the compliance range (see attached). To ensure stable temperatures, we will continue daily checks for the next week; at that time, we will reduce to once every two weeks and then move to 1x/month. We have posted signs stating that any concerns with the water temperature should immediately be reported to staff.

Legal Entity Representative

Signature

Kate Pintabona, Administrator 3/27/2020

Printed Name and Title Date

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

The above plan of correction is approved as of 3/31/2020 (Date)

Plan of correction implementation status as of 3/31/2020 (Date)

☑ Implemented

☐ Not Implemented

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

TRI-COUNTY RESPITE-QUAKERTOWNE HOUSE

12681

121a - Unobstructed Egress

Regulations

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 12:00 P.M. on 2/21/2020 The Fire Exit Door located between Resident Bedroom 11 and Boiler Room 3 was blocked. The exit had two chairs and caution tape on the wall blocking use of this exit in an emergency.

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.)

This was immediately corrected at the time of inspection by covering the exit sign and posting a sign on the door stating, "this is not an exit." Despite that egress being inaccessible, the ability for our residents to easily exit the building was never compromised as we have 4 other exits on that floor. The egress in question is now fully accessible. Moving forward, anytime an area of the building needs to be blocked off for repairs/upgrades, we will post signs indicating that the egress is inaccessible with clear and descriptive instructions as to all the other alternative exits. When possible, we will post signs at least 24 hours in advance. Maintenance staff will complete daily walk throughs of the building to ensure all objects are removed to provide safe egresses. Director of Operations will conduct weekly walk throughs of the building to monitor compliance.

Legal Entity Representative

Signature

Katie Pritzberg, Administrator
Printed Name and Title

3/16/2020
Date

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The above plan of correction is approved as of 3/31/2020 (Date)

Plan of correction implementation status as of 3/31/2020 (Date)

✓ Implemented
Not Implemented

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

183e - Storing Medications

Regulations

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident # 1 Fluticasone was opened on 1/13/2020. This medication had an expiration date of 2/13/2020. The medication was still being administered 2/13/2020 to 2/21/2020. This medication was present on the medication cart 2/21/2020.

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.)

3/27: Under current circumstances related to covid-19 and the implications it has had on the home and staffing, we would like to amend the plan of corrections submitted on 3/16/2020. Our Director of Wellness provided counseling and re-education on the importance of disposing of all expired routine and PRN medications during their monthly group supervision (see attached). Expiration dates are labeled and highlighted on all medications. An alert will be added to our electronic medication administration record to prompt staff to re-order and dispose of any medication that is approaching the expiration date by Tue, March 31. In addition, med techs will perform monthly medication room audits, which includes the medication carts, to ensure med room compliance.

Legal Entity Representative

Signature

Kate Portabone, Administrator 3/27/2020

Printed Name and Title Date

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The above plan of correction is approved as of 3/31/2020 (Date)

Plan of correction implementation status as of 3/31/2020 (Date)

☑ Implemented

☐ Not Implemented

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