**Department of Human Services**
**Bureau of Human Service Licensing**

October 5, 2020

MARIS GROVE INC
500 MARIS GROVE WAY
GLEN MILLS, PA, 19342

RE: MARIS GROVE
500 MARIS GROVE WAY
1ST AND 3RD FLOORS
GLEN MILLS, PA, 19342
LICENSE/COC#: 13466

Dear Ms. Zdunowski,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/01/2020, 06/05/2020, 06/10/2020, 06/11/2020, 06/12/2020, 06/16/2020, 06/17/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cs: Pennsylvania Bureau of Human Service Licensing

# Department of Human Services
# Bureau of Human Service Licensing
# LICENSE INSPECTION SUMMARY

## Facility Information

**Name**: *MARIS GROVE* **License #**: *13466* **License Expiration Date**:
**Address**: *500 MARIS GROVE WAY, 1ST AND 3RD FLOORS, GLEN MILLS, PA 19342*
**County**: *DELAWARE* **Region**: *SOUTHEAST*

## Administrator

**Name**: *Nicole Zdunowski* **Phone**: *6103874630* **Email**: *Nicole.Zdunowski@erickson.com*

## Legal Entity

**Name**: *MARIS GROVE INC*
**Address**: *500 MARIS GROVE WAY, GLEN MILLS, PA, 19342*
**Phone**: *6103874630* **Email**: *Nicole.Zdunowski@erickson.com*

## Certificate(s) of Occupancy

**Type**: *I-1* **Date**: *06/09/2009* **Issued By**: *Concord Township*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

## Inspection

**Type**: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
**Reason**: *Incident* **Exit Conference Date**: *06/17/2020*

## Inspection Dates and Department Representative

*06/01/2020 - Off-Site: David Carrion*

*06/05/2020 - Off-Site: David Carrion*

*06/10/2020 - Off-Site: David Carrion*

*06/11/2020 - Off-Site: David Carrion*

*06/12/2020 - Off-Site: David Carrion*

*06/16/2020 - Off-Site: David Carrion*

*06/17/2020 - Off-Site: David Carrion*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *66* **Residents Served**: *43*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *13*

### Hospice

**Current Residents**: *3*

**Resident Demographic Data as of Inspection Dates *(continued)***

Number of Residents Who:

**Receive Supplemental Security Income**: *0*
**Are 60 Years of Age or Older**: *43*
**Diagnosed with Mental Illness**: *4*
**Diagnosed with Intellectual Disability**: *0*
**Have Mobility Need**: *13*
**Have Physical Disability**: *0*

## Inspections / Reviews

**06/01/2020 - Partial**

**Lead Inspector**: *David Carrion* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/25/2020*

**7/27/2020 - POC Submission**

**Lead Reviewer**: *Claire Mendez* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/30/2020*

**10/5/2020 - Document Submission**

**Lead Reviewer**: *Claire Mendez* **Follow-Up Type**: *Not Required*

## 42c - Treatment of Residents

1. **Requirements**

2600.

42.c. A resident shall be treated with dignity and respect.

**Description of Violation**

*On May 27th at approximately 1:00 pm, Resident #1's requested lunch as it had not yet been served. The resident first rang the call bell, and then yelled for Staff Member A, who replied "Stop yelling at me" in a loud voice. The resident expressed feeling embarrassed.*

*On a separate occasion, Resident #1 asked for cranberry juice and Staff Member A would not get the juice. The resident described that the Staff Member "was very irate" and was screaming and yelling but the resident could not make out what she was saying. The resident's therapist went to bring the cranberry juice to the resident. The Therapist witnessed the staff person's response to the resident's request for juice and stated that the Staff Person replied to the Resident "I could not get it". "I didn't tell you that you could not have it". The therapist described that "During this altercation, her (the Staff Person's) tone of voice was loud and embarrassing" and the Staff Member "was talking over" the Resident.*

*In another instance, Resident #1 walked into the hallway for exercise. The Staff Member said "You can't come out here. This is my hallway.", and "This is a whole year of this. How's everyone else? I don't have any problem with no one else." The resident went on to describe that he felt intimidated by the Staff Member.*

*Per resident #2's statement, Staff member A's demeanor has changed. The resident does not want Staff Person A to provide care to her because "now she is short with her answers with a tone of voice that I don't appreciate." and that "She used to be pleasant. But lately her attitude and tone of voice has changed for the worse."*

## 42c - Treatment of Residents *(continued)*

**Plan of Correction - 07/27/2020** **Accept**

***#1A***

***Deficiency: 2600.42(c)A resident shall be treated with dignity and respect***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice****? The staff member who had inappropriate interactions with Resident #1 and Resident #2 was immediately suspended in accordance with Erickson policy. Both residents were assured that this staff person would not be providing services to them in the future.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*Residents in the impacted hallway were interviewed regarding their interactions with the staff person in question. No other reports of inappropriate interactions were made by other residents in the community.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*All direct care staff in Personal Care shall receive in-servicing on Resident Rights with a focus on treating residents in the community with dignity and respect. Target date to complete in-servicing for all staff will be September 30, 2020.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*PC Administrator or designee will periodically review Resident Rights during scheduled monthly staff meetings to ensure the topic is being reinforced appropriately. In addition, PC Administrator or designee will regularly check with residents to ensure they are being treated with dignity and respect.*

**Completion Date:** *09/30/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction in-servicing completed. Documents uploaded on 9/30/20.*

## 61 - Substitute Coverage

**1. Requirements**

2600.

61. Substitute Personnel - When regularly scheduled direct care staff persons are absent, the administrator shall arrange for coverage by substitute personnel who meet the direct care staff qualifications and training requirements as specified in § § 2600.54 and § 2600.65 (relating to qualifications for direct care staff persons; and direct care staff person training and orientation).

**Description of Violation**

*On 05/29/20, substitute staff person B, who worked providing direct care services from 7 am to 3 pm, has not successfully pass the Direct Care Certificate Competency Test.*

## 61 - Substitute Coverage *(continued)*

**Plan of Correction - 07/27/2020** **Accept**

***#2B***

***Deficiency: 2600.61. Substitute Personnel-When regularly scheduled direct care staff persons are absent, the administrator shall arrange for coverage by substitute personnel who meet the direct care staff qualifications and training requirements as specified in 2600.54 and 2600.65 (relating to qualifications for direct care staff persons; and direct care staff person training and orientation).***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*Staff person B is no longer employed with Erickson Living communities.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*Any agency staff person who is currently serving Maris Grove Continuing Care has been immediately trained in accordance with 2600.54 and 2600.65 regulations. We are now at 100% compliance with this regulation.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*PC Administrator, in collaboration with Human Resources and the Staff Development Coordinator, will require that any substitute receive appropriate training in line with 2600.54 and 2600.65 regulatory guidelines.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*PC Administrator or designee, Human Resources, and the Staff Development Coordinator will regularly review our training process to ensure that all Maris Grove and agency staff persons receive appropriate training and orientation prior to working in the Personal Care community. An ongoing random monthly audit of employee trainings will be conducted and reported on during the monthly facility QAPI meeting.*

**Completion Date:** *08/31/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction quality assurance documents uploaded on 9/30/20.*

## 65a - FS Orientation 1st Day

1. **Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.

## 65a - FS Orientation 1st Day *(continued)*

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

**Description of Violation**

*Staff person B, whose first day of work was 04/27/20, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.*

## 65a - FS Orientation 1st Day *(continued)*

**Plan of Correction - 07/27/2020** **Accept**

***#3C***

***Deficiency: 2600.65(a) Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:***

***1. Evacuation procedures***

***2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.***

***3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.***

***4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.***

***5. The location and use of fire extinguishers.***

***6. Smoke detectors and fire alarms.***

***7. Telephone use and notification of emergency services.***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*Any agency staff person who is currently serving Maris Grove Continuing Care has been immediately trained in accordance with 2600.65(a) regulation. We are now at 100% compliance with this regulation.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*Any new Maris Grove or agency employee will receive the necessary fire safety trainings as identified in regulation 2600.65(a) prior to or on their first say of employment with the facility.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*The PC Administrator shall work with Human Resources and the Staff Development Coordinator to periodically review the New Employee Orientation program to ensure that all regulatory requirements are maintained.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*An ongoing random audit of employee training records shall be reviewed and reported on during our monthly facility QAPI meeting to ensure ongoing compliance.*

**Completion Date:** *08/31/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction quality assurance documents uploaded on 9/30/20.*

## 65b - Rights/Abuse 40 Hours

**1. Requirements**

2600.

## 65b - Rights/Abuse 40 Hours *(continued)*

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

*Staff person B completed his/her 40th scheduled work hour on 05/12/20. However, this staff person did not complete training in the following topics:*

*1. Resident rights.*

*2. Emergency medical plan.*

*3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*

*4. Reporting of reportable incidents and conditions.*

## 65b - Rights/Abuse 40 Hours *(continued)*

**Plan of Correction - 07/27/2020** **Accept**

***#4D***

***Deficiency: 2600.65b) Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:***

1. ***Resident Rights***
2. ***Emergency medical plan***
3. ***Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. 10225.***
4. ***Reporting of reportable incidents and conditions.***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*Any agency staff person who is currently serving Maris Grove Continuing Care has been trained in accordance with 2600.65(b) regulation. We are now at 100% compliance with this regulation.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*Any new Maris Grove or agency employee will receive the necessary trainings as identified in regulation 2600.65(b) prior to or on their first say of employment with the facility.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*The PC Administrator shall work with Human Resources and the Staff Development Coordinator to periodically review the New Employee Orientation program to ensure that all regulatory requirements are maintained.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*An ongoing random audit of employee training records shall be reviewed and reported on during our monthly facility QAPI meeting to ensure ongoing compliance.*

**Completion Date:** *08/31/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction quality assurance documents uploaded on 9/30/20.*

## 182c - Medication Administration

**1. Requirements**

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

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 subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

## 182c - Medication Administration *(continued)*

**Description of Violation**

*Resident #2 is prescribed Oxycodone 5mg tablet to be administered half of a tablet every 6 hours as needed. On 5/28/2020 at 1:00 pm, there is an entry on the narcotics log with no signature. This administration was not recorded on the eMAR. On 5/29/20, at 9:30 am, the medication was signed out on the narcotics log by staff B. It is logged on the eMAR as being administered at 8:00 am. Resident #2, through interview, stated that she was not administered these medications.*

*Resident #3 is prescribed Tramadol 50 mg once a day at bedtime. On 5/29/20 at 8:00 am, Staff Member B signed out this medication on the narcotics log. Staff B did not document the administration of this medication on the eMAR. Resident #3 stated she did not receive this medication.*

*Resident# 4 is prescribed Tramadol 50mg – 1 tablet by mouth every 8 hours as needed. On 5/29/20 at 8:30 am, Staff Member B signed out this medication on the narcotics log. The eMAR does show this was administered. However, the eMAR also shows that this medication was again administered the same day at 10:43 am. The narcotics log has no entry for this time. Per Resident #4's interview. Resident did not receive Tramadol 50 mg, at 8:30 am or at 10:43 am.*

*Resident #5 is prescribed Lorazepam 0.5mg - Twice per day day at 9 am and 9 pm. Staff Member B signed out this medication on the narcotics log at 1:00 pm on 5/30/20. Staff Member B did not work on 5/30/20. Staff Member B did not document the administration of this medication on the eMAR. On 5/30/20, the eMAR shows that the 9:00 am medication administered by Staff Member C, and it was again administered at 9:00 pm by Staff Member D. Resident #5 does not recall medication as resident cognitive function has declined.*

## 182c - Medication Administration *(continued)*

**Plan of Correction - 07/27/2020** **Accept**

***#5E***

***Deficiency: 2600.182(c). Medication administration includes the following activities, based on the needs of the resident:***

***1. Place the medication in a medication cup or other appropriate container, or in the resident's hand.***

***2. Please the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection(b)(4).***

***3. Complete documentation in accordance with 2600.187 (relating to medication records).***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*RN Wellness Manager and PC Administrator have completed audits of all narcotic administration records. We are now at 100% compliance with this regulation. Staff person B is no longer employed with Erickson Living.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*RN Wellness Manager has completed an audit of all narcotic administration records to identify any other discrepancies. No additional discrepancies identified. The unit nurse or designee shall continue a regular review of narcotic administration records to ensure ongoing compliance.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*All medication technicians shall be in-serviced in a manner consistent with the regulatory requirements of 2600.182(c) and Erickson Policy. The Personal Care Administrator, Wellness Manager, and SDC will complete all medication administration in-servicing by September 30th, 2020.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*An ongoing random monthly audit of narcotic records will be completed and reported on as part of our monthly facility QAPI program to ensure ongoing compliance.*

**Completion Date:** *09/30/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction in-servicing completed. Documents uploaded on 9/30/20.*

## 185a - Implement Storage Procedures

**1. Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

## 185a - Implement Storage Procedures *(continued)*

**Description of Violation**

*According to company policy, "Narcotics/Controlled substances are counted on a regular basis by the off-going nurse/care associate (M) and the on-coming nurse/care associate (M). Where permitted by State or local regulations (in Assisted Living), a licensed nurse and medication technician/registered or certified medication aide may count narcotics/controlled substances. The narcotic keys are passed Nurse/Care Associate (M) to Nurse/Care Associate (M) when the narcotic count is completed. If the count is incorrect, notify the DON or Designee. If the count cannot be reconciled follow the policy for Narcotic Count Discrepancy, the Nurse/Care Associate (M)(s) remain on duty until the count is reconciled or DON or Designee has given permission to leave. At the end of each month, the narcotic count signature sheet goes to the DON / Designee. The DON / Director of Continuing Care may require licensed nurse to complete additional narcotic count records based on incident or narcotic/controlled substance discrepancies within the facility."*

*The narcotic record for the Cardinal unit is missing signatures, for the end of the shift count of narcotics for these dates:*
*May 16, 2020 3pm - 11 pm*
*May 17, 2020 3pm - 11pm*
*May 19, 2020 3pm - 11pm*
*May 28, 2020 7 am - 3 pm*
*May 29, 2020 7 am - 3 pm*
*May 31, 2020 7 am - 3 pm*
.

## 185a - Implement Storage Procedures *(continued)*

**Plan of Correction - 07/27/2020** **Accept**

***#6F***

***Deficiency: 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.***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*RN Wellness Manager and PC Administrator have completed audits of all narcotic administration records to ensure compliance with this regulation. A medication count was completed on each resident to identify any discrepancies. No additional discrepancies noted, we are now at 100% compliance with this regulation. Staff who did not correctly sign out narcotics will receive education and corrective action in accordance with Erickson policy.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*The RN Wellness Manager completed an audit of all narcotic administration records to identify any other discrepancies. No additional discrepancies were identified. The unit nurse or designee will continue a regular review of narcotic administration records to ensure ongoing compliance.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*All medication technicians shall be in-serviced in a manner consistent with the regulatory requirements of 2600.185(a) and Erickson policy. The Personal Care Administrator, Wellness Manager, and SDC will complete all medication administration in-servicing by September 30th, 2020.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*An ongoing random monthly audit of narcotic records will be completed and reported on as part of our monthly facility QAPI program to ensure ongoing compliance.*

**Completion Date:** *09/30/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction in-servicing completed. Documents uploaded on 9/30/20.*

## 190a - Completion Medication Course

**1. Requirements**

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.

## 190a - Completion Medication Course *(continued)*

**Description of Violation**

*According to May 2020 Electronic Medication Administration Record (eMAR), on 05/29/20 at 9:00 am, Staff Person B, who has not successfully completed the Department-approved medications administration course, administered medications to residents of the home.*

**Plan of Correction - 07/27/2020** **Accept**

***#7G***

***Deficiency: 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 and other allergies.***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*Staff person B is no longer employed with Erickson Living.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*Records were reviewed to ensure all direct care staff have completed the performance-based competency test in accordance with 2600.190(a). We are at 100% compliance with this regulation.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*The PC Administrator will work with Human Resources and the Staff Development Coordinator to periodically review the New Employee Orientation program to ensure that all regulatory requirements are maintained.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*An ongoing random audit of employee training records shall be reviewed and reported on during our monthly facility QAPI meeting to ensure ongoing compliance.*

**Completion Date:** *08/31/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction quality assurance documents uploaded on 9/30/20.*

## 251b - Record Entries Legible

1. **Requirements**

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

## 251b - Record Entries Legible *(continued)*

**Description of Violation**

*On line 10 of the Controlled Medication Utilization Record (Narcotics Log) for Resident #5's Lorazepam 0.5 mg tablet, the date was written over. The entry, following an entry dated 5/30/20 at 1300 hours, appears to have been dated 5/29/20 at 9 am, written over as 5/30/20.*

**Plan of Correction - 07/27/2020** **Accept**

***#8H***

***Deficiency: 2600.251(b). The entries in a resident's record must be permanent, legible, dates and signed by the staff person making the entry.***

*Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.*

***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

*PC Administrator and RN Wellness Manager have completed an audit of the Controlled Medication Utilization Record on each resident to identify any additional violations with this policy.*

***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?***

*An initial audit did not identify any additional violations of regulation 2600.251(b). We are now at 100% compliance with this regulation. Continued monitoring will be done to ensure ongoing compliance with this regulation.*

***What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?***

*All medication technicians shall be in-serviced in a manner consistent with the regulatory requirements of 2600.251(b) and Erickson policy. The Personal Care Administrator, Wellness Manager, and SDC will complete all medication administration in-servicing by September 30th, 2020.*

***How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?***

*An ongoing random monthly audit of narcotic records will be completed and reported on as part of our monthly facility QAPI program to ensure ongoing compliance.*

**Completion Date:** *09/30/2020*

**Document Submission - 10/05/2020** **Implemented**

*Plan of correction in-servicing completed. Documents uploaded on 9/30/20.*