pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SNH PENN TENANT LLC**
LEGAL ENTITY

To operate **OVERLOOK GREEN**
NAME OF FACILITY OR AGENCY

Located at **5250 MEADOWGREEN DRIVE, PITTSBURGH, PA 15236**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **128** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 23**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 4, 2020** until **March 4, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450571**

Robert E. Robinson
ISSUING OFFICER

Jamie L. Buchenauer
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 6/20

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: September 4, 2020

Ms. Jennifer F. Francis
President & COO
SNH Penn Tenant LLC
255 Washington Street, Ste. 300
Two Newton Place
Newton, Massachusetts 02458

RE: Overlook Green
5250 Meadowgreen Drive
Pittsburgh, Pennsylvania 15236
Certificate #: 450571

Dear Ms. Francis:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on January 22, 2020 and May 21, 2020, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes, and failure to submit an acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (450570) dated January 1, 2020 to January 1, 2021 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on violations and failure to submit an acceptable plan to correct noncompliance items. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from September 4, 2020 to March 4, 2021

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie L. Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

RECEIVED
4/28/2020
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *OVERLOOK GREEN*
Address: *5250 MEADOWGREEN DRIVE, PITTSBURGH, PA 15236*
County: *ALLEGHENY* Region: *WESTERN*
License Number: *45057*

Administrator

Name: *Mary Moran* Phone: *4128818300* Email: *mmoran@5ssl.com*

Legal Entity

Name: *SNH PENN TENANT LLC*
Address: *255 WASHINGTON STREET,SUITE 300, TWO NEWTON PLACE, NEWTON, MA, 2458*

Certificate(s) of Occupancy

Type: *I-2* Date: *03/14/2018* Issued By: *Whithall Boro*

Staffing Hours

Resident Support Staff: Total Daily Staff: *134* Waking Staff: *101*

Inspection

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

Inspection Dates and Department Representative

01/22/2020 - On-Site: Ashley Roser, Joe Eveges, Scott Klein, Shelia Page, Jeanne Parisi

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* Residents Served: *88*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *23* Residents Served: *18*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *1*
Have Mobility Need: *46*
Are 60 Years of Age or Older: *88*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *2*

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:10 a.m., there were 2 unlocked and unattended medication administration record (MAR) books, which contained the January 2020 MAR's for residents #1 and #3's, on top of the medication carts outside of the Florida 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.)

Overlook Green and Five Star Senior Living recognize the importance of regulation 2600.17, Records confidentiality. To ensure that confidentiality is maintained, the Medication Record (MAR) will be locked in the bottom drawer of the medication cart when not in use. The MAR is kept in a zipped binder. The medication passer will be responsible to secure the MAR in the locked drawer when finished with the medication pass. All medication passers/nurses were re-educated on confidentiality of records on 4/22/20. The Director of Resident Care/Designee shall monitor weekly for 4 weeks at that time if there is evidence of non-compliance then further monitoring will be established. Documentation will be presented and reviewed at quarterly QA meetings.
See exhibit A.

Legal Entity Representative

Signature — Mary Moran, Ex Director — 4/28/20
Printed Name and Title — Date

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

The above plan of correction is approved as of 4/29/2020 (Date)

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. Also, the Care Facility Carbon Monoxide Alarms Standard Act requires batteries to be replaced at least annually in all battery-operated carbon monoxide detectors, as well as labeled with the date of battery installation. There are no carbon monoxide detectors located in the basement in close proximity to the 3 gas dryers and 3 gas hot water heaters. Also, the batteries in the carbon monoxide detector located in the dining room are undated, so it is unable to be determined if the batteries have been replaced within the past year.

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.)

Safety is of the utmost importance to Overlook Green and Five Star Senior Living. To comply with regulation 2600.18, carbon monoxide Alarm was installed in the basement on 1/24/20. All batteries in carbon monoxide alarms in the dining room were changed and labeled with date on 1/24/20. All carbon monoxide alarm batteries will be changed biannually ongoing. The Maintenance Director/ Designee will be responsible to monitor and maintain continued compliance through physical plant walk through inspections and tracking monthly with documentation through the TELS computerized building tasks system. Documentation will be presented and reviewed at quarterly QA meetings.
See exhibit C & D.

Legal Entity Representative

Signature | Mary Moran Executive Director | 4/28/20
Printed Name and Title | Date

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

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

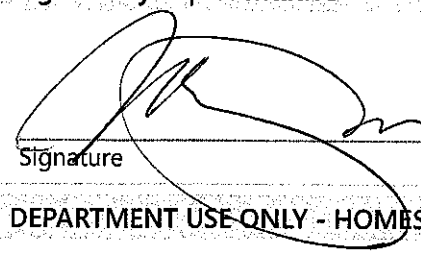
No Pennsylvania criminal background check was completed for direct care staff person B, hired on 10/21/19.

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.)

All employees are background checked as an integral part of the hiring process to obtain a confidential background screening report in accordance with the Older Adult Protective Services Act. Direct care staff member B hired on 10/21/20 had a background screen completed. The Pennsylvania State Police Response for Criminal Record Check was done on 10/21/19 and no record was found. This page was not in the front of the file and was missed and discovered in another section of the employee file. An audit of all employee files will be completed by May 20, 2020 to assure that all records are available and in the correct order. Going forward a new hire checklist will be utilized to assure that all files are complete and in proper order. The Business Office Manage will be responsible to complete the checklist on all new hires. Audit & documentation to be presented at the quarterly QA meeting.
See exhibit D & Y

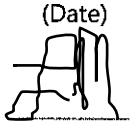
Legal Entity Representative



Signature — MARY MORAN EXECUTIVE DIRECTOR 5/7/20 — Printed Name and Title — Date

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

The above plan of correction is approved as of 5/8/2020 (Date)

The above plan of correction was approved by  (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

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

Direct care staff person B, hired on 10/21/19, does not have 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.)

Direct care staff B has a diploma from Liberia and along with three years transcripts showing Math, English and Science. A waiver was applied for on 1/23/2020 via email. On 2/5/20 response by email from Bureau of Human Services Licensing (BHSL) indicates that no waiver is necessary. Ongoing all out of country diplomas will be sent to BHSL for review and application of waiver. The Executive Director will be responsible to apply for the waiver. All employee files will be audited by the business office manager by May 20, 2020 to assure that all diplomas/waivers are in file. A new hire check off sheet will be completed by Business Office Manager. Audit & documentation to be presented at quarterly QA meeting. The new hire check off sheet shall be implemented immediately upon receipt of the plan of correction. 5/8/2020

See Exhibit E &Y

Legal Entity Representative

Signature Mary Morgan, Executive Director 5/7/20

Printed Name and Title Date

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

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented

☐ Not Implemented

65a - FS Orientation 1st Day

Regulations

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.

Description of Violation

Direct care staff person A, hired on 5/26/19, has not received orientation on any of the topics specified in 2600.65a, to include evacuation procedures and staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

Plan of Correction (POC)

Direct care staff member A was not a new hire, she was a transfer from another Five Star sister community, Mount Vernon of Elizabeth. Her original hire date was 12/24/1991. Records obtained from Mount Vernon of Elizabeth indicate her original training was done verbally then documented on 10/5/1992. Her transfer date to Overlook Green was 5/26/2019. At that time she was oriented to the building by the nursing supervisor to include items in regulation 2600.65a. The documentation was misplaced. The employee will be retrained on the content of regulation 2600.65.b by May 20, 2020. The Business Office Manager/Designee will be responsible to ensure all initial training is completed and filed in the proper location. An audit will be performed of all employee files by May 20, 2020. Biannual audits will be performed by the Business office Manager and Executive Director/Designee to ensure compliance. A new hire checklist will be completed by the BOM. Documentation & audits will be reviewed at QA meeting. See exhibits F & Y. The new hire checklist shall be implemented immediately upon receipt of the plan of correction. 5/8/2020

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN, EXECUTIVE DIRECTOR — Date: 5/7/20

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

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Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented

☐ Not Implemented

65b - Rights/Abuse 40 Hours

Regulations

2600.

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

Direct care staff person A, hired on 5/26/19, has not received orientation on any of the topics specified in 2600.65b, to include resident rights and mandatory reporting of abuse and neglect under the Older Adult Protective Services Act.

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.)

Direct care staff member A was not a new hire, she was a transfer from another Five Star sister community, Mount Vernon of Elizabeth. Her original hire date was 12/24/1991. Records obtained from Mount Vernon of Elizabeth indicate her original training was done verbally then documented on 10/5/1992. Her transfer date to Overlook Green was 5/26/2019. Upon transfer to Overlook Green direct care staff member A was regarded a transferred employee and required to complete the yearly in-service programs as all staff members are required to complete annually. She received Resident Rights , Emergency Medical Plan and Reporting of Incidents on 7/16/19 and Mandatory abuse /neglect per OAPSA on 12/27/19. All employee files will be audited by May 20, 2020 and a new hire check list will be completed by the Business Office Manager. Audit and documentation will be presented at the quarterly Q&A meeting.

See exhibit F & G.

The new hire checklist shall be implemented immediately upon receipt of the plan of correction. 5/8/2020

Legal Entity Representative

Signature — Mary Moran, Executive Director 5/7/20

Printed Name and Title — Date

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

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented

☐ Not Implemented

81b - Resident Personal Equipment

Regulations

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #3's enabler is not securely attached to the resident's bed and moves approximately 2" in both directions.

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.)

Safety is of the utmost importance to Overlook Green and Five Star Senior Living. The enabler was replaced with a sturdier model to comply with regulation 2600.81.b The assigned caregiver will be responsible to check to ensure that enablers are properly secured during the course of their shift and report any excess movement to the Maintenance Director/Designee immediately. Maintenance Director will check monthly to assure that enablers are mechanically secure. Documentation will be presented and reviewed at quarterly QA meetings.
See exhibit H.

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN, EXECUTIVE DIRECTOR — Date: 4/28/20

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 11:29 a.m., there was no sanitary means of hand drying present in the bathroom of bedroom 426.

On 1/22/20 at 7:28 a.m, resident #4's glucometer was used to check the blood glucose level of resident #1.

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.)

It is the goal of Overlook Green and Five Star Senior Living to maintain sanitary conditions at all times and comply with regulation 2600.85.a. Residents are ordered their own individual glucometer upon admission, labeled with resident name and used specifically for each individual resident and replaced as needed. Resident # 4 no longer resides at the home. Physician for Resident #1 was notified on 5/5/20. Resident pictures will now be attached to glucometer case. All nurses/medication passers were retrained on diabetic education including Glucose testing on 4/22/20 by a diabetic educator. The Director of Resident Care/Designee will be responsible to ensure compliance through documented monthly glucometer checks. This documentation will be presented and reviewed at quarterly QA meetings.

See exhibit J. J - 1

Immediately: A designated staff person shall observe each staff responsible for diabetic care perform blood glucose checks to ensure glucometers are not shared among residents. Each staff will be observed once per month. Documentation of the observations shall be maintained by the home for Department review. 5/8/2020

Hand towels and linens are passed every morning to all resident rooms. The towel in room 426 was used and soiled by the resident that morning and had not yet been replaced. Ongoing an extra hand towel will be provided during the pass to assure ample towels are available. The Bridge to Rediscovery Director/Designee will be responsible to oversee this task.

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN/EXECUTIVE DIRECTOR — Date: 5/7/20

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

The above plan of correction is approved as of 5/8/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

Numerous areas of what appears to be rust are present on the exit door next to bedroom 230.

Numerous areas of peeling paint are present on the the exit door next to bedroom 344, as well as the exit door leading from the common living 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.)

To comply with regulation 2600.88.a the doors next to room 230 and 344 were sanded and painted. The Maintenance Director/Designee will assure compliance through monthly rounds of physical site and report any issues to Executive Director immediately. Documentation of compliance will be reviewed at quarterly QA meeting.
See exhibit K.

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN, Executive Director — Date: 4/28/20

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

100a - Exterior - Free of Hazards

Regulations

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The cement pad outside of the exit door next to bedroom 344 is uneven, which poses a tripping hazard.

The asphalt leading from the courtyard is uneven, which poses a tripping hazard.

The asphalt leading from the exit door next to bedroom 230 is uneven, which poses a tripping hazard.

There are metal cords coming from the electrical pole in the ground on the exit route from the door near bedroom 230, which poses a tripping hazard.

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.)

To comply with regulation 2600.100.a on 4/16/20 the ground around cement pad was evened by adding additional soil and planting grass, asphalt near courtyard and exit door B was also evened out to eliminate any tripping hazard. The cords running off of the electrical pole near exit by room 230 was covered with bright green florescent foam per recommendation of survey team. The Maintenance Director/Designee will be mindful of any hazards during the monthly physical plant walk through and immediately report any suspected hazards to Executive Director immediately. Documentation of compliance will be presented and reviewed at quarterly QA meetings.
See exhibit L & M.

Legal Entity Representative

Signature | Printed Name and Title: Executive Director | Date: 4/28/20

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 10:46 a.m. the following unsealed items were present in the home's walk-in freezer:

* 1 veggie burger
* 1 container of Thrive creamy vanilla
* 6 slices of French toast
* A 5 gallon container of ice cream

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.)

Items that were unwrapped in freezer were immediately disposed of. Dietary employees were in-serviced on proper storage procedures on 4/24/20. The Food Service Director/Designee will be responsible to ensure compliance with regulation 2600.103.g through periodic monitoring throughout the day. Executive Director/Designee will complete sanitization checklist weekly. Documentation of compliance will be reviewed at quarterly QA meetings.
See exhibit N & O.

Legal Entity Representative

Signature — Mary Moran, Executive Director — 4/28/20
Printed Name and Title — Date

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

105g - Lint Removal and Duct Cleaning

Regulations

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At 11:25 a.m., there was an approximate ½ inch accumulation of lint in the dryer, located in the secured dementia care unit (SDCU).

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.)

Lint was immediately removed from the dryer, located in the Bridge to Rediscovery. The dryer is shared by visiting families. A sign is visible to remind that lint be cleared after each load. There is also a check list to be completed. All staff utilizing the dryer will be educated by May 20, 2020 the procedure and the importance of removing the lint after each use. The Bridge to Rediscovery Director/Designee will be responsible to ensure compliance with regulation 2600.105.g by viewing the checklist weekly x 4 then monthly. Documentation of compliance will be reviewed at quarterly QA meetings.
See exhibit P.

Legal Entity Representative

Signature | Mary Moran, Executive Director | 5/7/20
Printed Name and Title | Date

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

The above plan of correction is approved as of 5/8/2020 (Date)

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

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

The door near bedroom 437, which is labeled as an exit and serves an egress route, is locked with a keypad locking device and does not allow for immediate egress from the home.

At 11:34 a.m., the exit door next to bedroom 344 was unable to be opened by an agent of the Department. A member of the home's maintenance staff had to use significant force to open the door.

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.)

To comply with regulation 2600.121.a on 4/24/20 the keypad was disarmed to the door near room 437 to allow immediate egress. The threshold of the door next to room 344 has been adjusted to allow ease of movement to open and close. The Maintenance Director/Designee will ensure egress compliance via monthly physical plant walk through and shall report immediately to Executive Director any resistance in completing egress. Documentation will be presented and reviewed at quarterly QA meetings.
See exhibit Q

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN, Executive Director — Date: 4/28/20

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

Plan of correction implementation status as of 6/22/2020 (Date)

☐ Implemented
☒ Not Implemented

125a - Combustible Storage

Regulations

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 10:34 a.m., there were (7) 5 gallon buckets of paint stored next to the gas hot water heater. Also, the home's boiler certificate was taped to the gas hot water heater.

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.)

To comply with regulation 2600.125.a the sign was immediately removed from the water heater and the latex paint was also removed. The area around the boiler (hot water heater) was taped off as a reminder not to store anything near the boiler. The Maintenance Director/Designee will ensure compliance through monthly physical plant walk through. Documentation will be presented and reviewed at quarterly QA meeting.
See exhibit R.

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN/DIRECTOR — Date: 4/28/20

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

The above plan of correction is approved as of 4/29/2020 (Date)

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

133.2 - Exit Signs Direction

Regulations

2600.
133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

The exit sign at the main entrance/exit is not visible in the library, and there is no indication in the library of the line of travel to the front exit. On the day of inspection, the home served 88 residents

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.)

To comply with regulation 2600.133.2 the exit sign at the front door was moved over the front door on 2/13/20 to a height so that it is plainly visible in the library and indicates the line of travel to the front exit. The Maintenance Director checked all exits signs to assure that they are visible and direct to the exits. No other issues noted.
See Exhibit S.

Legal Entity Representative

Signature | MARY MORAN, EXECUTIVE DIRECTOR | Printed Name and Title | 4/28/20 | Date

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

The above plan of correction is approved as of 4/29/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

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 #1's glucometer is not calibrated to the current date and time.

Resident #5 is prescribed Hydroxyzine 25 mg-Take 1 tablet by mouth twice a day as needed; however, this medication was not available in the home.

Resident #7 is prescribed Triamcinolone 0.1%-Apply topically to upper back area twice daily as needed; however, this medication is not available 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.)

All glucometers were calibrated and audited on 4/15/20.0 The Director of Resident Care/Designee will be responsible to assure that this is being done through monthly glucometer checks and sign off. Resident #5 was no longer taking Hydroxyzine and the medication was discontinued per PCP order on 1/28/20. Resident # 7 was no longer using Triamcinolone0.1% and the medication was discontinued on 1/22/20. Medication passers/nurses were re-educated on diabetic education on 4/22/20. All medication staff will be re-educated on the medication administration policy by 5/01/20. Mar audits to be conducted monthly by DRC/ Designee. Monthly Cart Audits will be conducted and documented. Documentation of compliance will be presented at the quarterly QA meetings.
See exhibit T, J & U, V, V-1 ,V-2.

Legal Entity Representative

Mary Moran, Executive Director 5/7/20

Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 5/8/2020 (Date)

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

Plan of correction implementation status as of 6/22/2020 (Date)

☐ Implemented
☒ Not Implemented

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:

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

Description of Violation

Resident #3 is prescribed Humalog-100u/ml-Inject subcutaneously before meals in accordance with the sliding scale; however, the resident's January 2020 MAR does not include the route of administration or the strength of Humalog.

Resident #3 is prescribed Zinc Sulfate-220mg-Take 1 tablet by mouth daily; however, the resident's January 2020 MAR does not include the route of administration.

On 1/21/20 at 5:31 p.m., resident #3's blood glucose level was 353; however, the resident's January 2020 MAR indicates the resident's blood glucose level as 333.

Resident #6 is prescribed Fluxetine-60mg tablet-Take 1 tablet by mouth daily. The home's pharmacy dispensed 40 mg tablets, as well as 20 mg tablets, with a pharmacy labels that indicate, Fluxetine-40 mg tablet-Take (1) 40 mg tablet and (1) 20 mg tablet to equal 60 mgs daily; however, the residents January 2020 MAR indicates Prozac 60 mg-by mouth daily.

187a - Medication Record *(continued)*

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 route of administration for Humalog and Zinc Sulfate for Resident # 3 was corrected @ the pharmacy and on the MAR. The blood sugar reading for Resident #3 was correct at 353 per the glucometer reading but was transcribed incorrectly by the medication tech when documented. The resident did get the correct dose of insulin coverage-this was verified by the med tech. The order for Resident #6 was corrected at pharmacy and on the MAR. A completed MAR audit was conducted on April 16, 2020. All Nurses/Medication Passers were retrained on Diabetic education. All medication staff will be retrained on Medication Administration Policies by 5/12/20. The Director of Resident Care/Designee will conduct monthly MAR audits. Ongoing all new orders will be verified through 24 hour chart check. The Director of Resident Care/Designee will sign off monthly that all orders are correct and match the MAR. Documentation of continued compliance will be presented and reviewed at quarterly QA meetings.

See exhibit J, U , V & V-1

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN, EXECUTIVE DIRECTOR — Date: 5/7/20

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

The above plan of correction is approved as of 5/8/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☐ Implemented

☒ Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #3 is prescribed Humalog-100u/ml-Inject subcutaneously before meals in accordance with the following sliding scale: 70-140=0u; 141-180=1u; 181-220=2u; 221-260=3u; 261-300=4u; 301-340=5u; >340=6u and call doctor.

On 1/21/20 at 5:31 p.m., the resident's blood glucose level was 353; however, the resident was only administered 5 units of insulin. Also, the resident's physician was not notified.

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 physician was notified on 4/16/20. All medication staff attended Diabetic training Review on 4/22/2020 by certified diabetic educator. All medication staff will be re-trained on medication policy by 5/01/20. Glucometers will be audited by Director of Resident Care/Designee monthly. This documentation will be presented and reviewed at quarterly QA meeting.
See exhibit J, U & V-2.

Legal Entity Representative

Signature — Printed Name and Title: [illegible] Director — Date: 4/28/20

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

The above plan of correction is approved as of 4/29/2020 (Date)

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

Plan of correction implementation status as of 6/22/2020 (Date)

☐ Implemented
☒ Not Implemented

233c - Key-Locking Devices

Regulations

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism on the entrance door to the SDCU are not conspicuously posted on or near the door.

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.)

Immediately: A designated staff person shall inspect all doors in the home's SDCU to ensure the directions to operate the locking mechanisms are present in a conspicuous place. 5/8/2020

To meet compliance of regulation 2600.233.c the directions for operating the locking system on the entrance door were reposted in view of the keypad and put into a permanent frame as to keep it from being pulled down. The Bridge to Rediscovery Director/Designee will be responsible to monitor the posting and assure that it remains in view on all exit doors on the unit. See exhibit W.

The doors shall be monitored monthly to ensure the directions to operate the locking mechanisms are present in a conspicuous place. 5/8/2020

Legal Entity Representative

Signature — Printed Name and Title: MARY MORAN, EXECUTIVE DIRECTOR — Date: 7/22

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

The above plan of correction is approved as of 5/8/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented
☐ Not Implemented

234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the SDCU on 4/25/19; however, the resident's initial support plan was not completed until 5/5/19.

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.)

A complete audit of all memory care (BTR) resident files will be performed by May 1, 2020. A resident checklist form was created and put into use for memory care admissions to prevent any future violations of regulation 2600.234.a Director of Resident Care(DRC)/Designee will sign off that all documents are completed within 72 hours of admission to the secured memory care neighborhood. DRC will sign off monthly to ensure all new resident admission paperwork is complete. This documentation will be presented and reviewed for compliance at the quarterly QA meetings.
See exhibit X.

Legal Entity Representative

Signature | MARY MORAN EXECUTIVE DIRECTOR | 4/28/20

Printed Name and Title | Date

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

The above plan of correction is approved as of 4/29/2020 (Date)

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

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented

☐ Not Implemented

252 - Record Content 45057

Regulations

2600.

252. Content of Resident Records - Each resident's record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #1's record does not include a current photograph of the resident that is no more than 2 years old.

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.)

Resident picture was discovered behind physician's prescription page in plastic sleeve. A complete audit of medical records will be completed by 5/01/20 to assure all pictures are visible. The DRC/Designee will be responsible to verify that all documents in the resident files are in logical order and that photos are visible at all times through monthly chart audits x 3 at that time is there is evidence of non-compliance further monitoring will be established. This documentation will be presented and reviewed at the quarterly QA meetings.

Legal Entity Representative

Signature

Mary Murphy Executive Director 4/28/20

Printed Name and Title Date

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

The above plan of correction is approved as of 4/29/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/22/2020 (Date)

☒ Implemented

☐ Not Implemented

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

Facility Information

Name: *OVERLOOK GREEN* **License #**: *45057* **License Expiration Date**:
Address: *5250 MEADOWGREEN DRIVE, PITTSBURGH, PA 15236*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: *Mary Moran* **Phone**: **Email**: *mmoran@5ssl.com*

Legal Entity

Name: *SNH PENN TENANT LLC*
Address: *255 WASHINGTON STREET,SUITE 300, TWO NEWTON PLACE, NEWTON, MA, 2458*
Phone: *4128818300* **Email**: *licensing@5ssl.com*

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/14/2018* **Issued By**: *Whitehall Boro*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *94* **Waking Staff**: *71*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Monitoring* **Exit Conference Date**: *05/21/2020*

Inspection Dates and Department Representative

05/21/2020 - On-Site: Ashley Roser

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Bridge to Rediscovery* **Capacity**: 23 **Residents Served**: *18*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *23* **Have Physical Disability**: *3*

Inspections / Reviews

05/21/2020 - Partial

Lead Inspector: *Ashley Roser* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/05/2020*

Inspections / Reviews *(continued)*

6/10/2020 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/12/2020*

6/10/2020 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/20/2020*

6/22/2020 - Document Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: **Follow-Up Date**:

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.

Description of Violation

On 5/14/20 at approximately 4:00 pm, resident #1's blood sugar reading was 343; however, the resident's May 2020 medication administration record (MAR) indicates the resident's blood sugar reading was 334.

On 5/17/20 at 5:28 am, resident #1's blood sugar reading was 254; however, the resident's May 2020 MAR indicates the resident's blood sugar reading was 247.

Plan of Correction - 06/10/2020 **Accept**

Response to violation 185.a

** Root Cause of violation: failure of medication passer/nurse to accurately transcribe glucometer reading on to the (MAR) Medication Administration Record.*

Detailed action steps to prevent future occurrence:

1. Medication passer/nurse # 1 will have medication passer/nurse # 2 verify glucometer reading matches MAR documentation by reviewing and initialing MAR after each blood sugar check until 100% compliant for 2 months. Re-evaluate as needed.

2. Director of Resident Care/designee will perform monthly MAR audits.

3. All medication staff will be re-educated on Medication Administration Policy by June 20, 2020.

The Director of Resident Care/designee will be responsible to assure compliance is maintained through monthly glucometer/MAR audits.

Documentation will be presented and reviewed at quarterly QA meeting.
**Documentation attached.*
Completion Date: *06/09/2020*

Document Submission - 06/22/2020 **Not Implemented**

Documentation attached

187a - Medication Record

1. **Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.

187a - Medication Record *(continued)*

3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 is prescribed Novolog 100 units/ml-Inject subcutaneously 4 times daily using the following sliding scale: 0-200=0 units; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; >500 call doctor. However, the number of units of insulin that were administered to the resident are not documented on the resident's May 2020 MAR for the following 6:00 am blood sugar readings:
** 5/7/20-blood sugar reading was 225*
** 5/18/20-blood sugar reading was 245*

Resident #3 is prescribed Novolog 100 units/ml-Inject subcutaneously 4 times daily using the following sliding scale: 70-130=4 units; 131-180=6 units; 181-240=8 units; 241-300=10 units; 301-350=12 units; 351-400=14 units; >400=16 units and call doctor.
However, the number of units of insulin that were administered to the resident are not documented on the resident's May 2020 MAR for the following 6:00 am blood sugar readings:
** 5/10/20-blood sugar reading was 219*
** 5/11/20-blood sugar reading was 211*
** 5/18/20-blood sugar reading was 259*
** 5/19/20-blood sugar reading was 217*
** 5/20/20-blood sugar reading was 341*

187a - Medication Record *(continued)*

Plan of Correction - 06/10/2020 **Accept**

Response to Violation 187.a

Insulin administration for resident #3 on 5/10/20, 5/11/20, 5/18/20, 5/19/20, 5/20/20 was verbally verified as administered by nurse on duty for the above dates.

** Root cause of Violation: medication passer/nurse did not document medication administration thus not following policy guidelines.*

Detailed action steps to prevent future occurrence:

1. Director of Resident Care will review Medication Administration policy with said nurse and will provide re-education on policy to all medication staff by June 20, 2020.

2. The Director of Resident Care/designee will perform monthly MAR audits to check for accuracy of documentation.

3. Medication Administration Record will be reviewed by med passer at the completion of every shift until 100% compliant for 2 months. Re-evaluate as needed.

The Director of Resident Care/designee will be responsible to assure compliance is maintained via monthly MAR audits.

Documentation will be presented and reviewed at the quarterly QA meeting.
Documentation attached.

Completion Date: *06/09/2020*

Document Submission - 06/22/2020 **Not Implemented**

Documentation attached

187d - Follow Prescriber's Orders

1. **Requirements**

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

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

Resident #1 is prescribed Humalog 100 units/ml-Inject subcutaneously before meals using the following sliding scale: 70-140=0 units; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; >340=6 units and call doctor.
On 5/14/20 at approximately 4:00 pm, resident #1's blood sugar reading was 343; however, the resident's May 2020 MAR indicates the resident's blood sugar reading was 334 and only 5 units of insulin were administered. Also, the resident's doctor was not notified in accordance with the prescriber's order.

Resident #2 is prescribed Novolog 100 units/ml-Inject subcutaneously 4 times daily using the following sliding scale: 0-200=0 units; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; >500 call doctor. However, on 5/18/20 at 8:00 pm, resident #2's blood sugar level was not checked.

Resident #3 is prescribed Novolog 100 units/ml-Inject subcutaneously 4 times daily using the following sliding scale: 70-130=4 units; 131-180=6 units; 181-240=8 units; 241-300=10 units; 301-350=12 units; 351-400=14 units; >400=16 units and call doctor. However, on 5/2/20 at 6:00 am, resident #3's blood sugar level was not checked.

Plan of Correction - 06/10/2020 **Do Not Accept**

Response to violation 187.d

Physician notified on 5/21/20. Resident/s suffered no ill effects.

** Root cause of violation: medication passer/nurse did not follow policy guidelines.*

Detailed action steps to prevent future occurrence:

1. Medication passer/nurse # 1 will have medication passer/nurse # 2 verify that glucometer reading and documentation match after each blood sugar check until 100% compliant for 2 months. Re-evaluate as needed.

2. The Director of Resident Care/designee will perform monthly MAR audits/glucometer.

3. All medication passers will be re-educated on the medication administration policy by June 20, 2020.

Director of Resident Care will be responsible to maintain compliance via monthly MAR audits and glucometer audit.

Documentation will be presented and reviewed at the quarterly QA meeting.
Documentation attached.

Completion Date: *06/09/2020*

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction - 06/10/2020 **Directed**

Response to violation 187.d

Medication passer failed to notify physician of the high blood sugar.
Physician notified on 5/21/20 by Director of Resident Care when discovered during licensing inspection. Resident suffered no ill effects.

** Root cause of violation: medication passer/nurse did not follow policy guidelines/physicians order.*

Detailed action steps to prevent future occurrence:

1. Medication passer/nurse # 1 will have medication passer/nurse # 2 verify that glucometer reading and documentation match after each blood sugar check until 100% compliant for 2 months. Re-evaluate as needed.

2. The Director of Resident Care/designee will perform monthly MAR audits/glucometer audits.
The audits shall include a review of blood sugar readings to ensure resident physicians are notified of high or low blood sugar readings in accordance with physician orders. LM 6/10/2020

3. All medication staff will be re-educated on the medication administration policy by June 20, 2020.

4. Medication passers/nurses will be in-serviced on regulation #187.d including internal change of practice in notification of physician per order no later than June 20, 2020.

5. Medication passer will immediately notify nurse on duty/Director of Resident Care if further medication direction is indicated by physicians order.

6. Nurse on duty/Director of Resident Care will notify physician and will follow the direction given by physician and document accordingly.

Director of Resident Care/designee will be responsible to maintain compliance via monthly MAR audits and glucometer checks.

Documentation will be presented and reviewed at the quarterly QA meeting.
Documentation attached.

Immediately: Resident #1's physician shall be notified of the resident's blood sugar reading of 343 from 5/14/20 at approximately 4:00 pm. LM 6/10/2020

Completion Date: *06/10/2020*

Document Submission - 06/22/2020 **Not Implemented**