Department of Human Services
Bureau of Human Service Licensing

June 16, 2021

[redacted]
REASTHEAVEN 2 LLC
166 NORTH GALATIN AVENUE
UNIONTOWN, PA 15401

RE: REASTHEAVEN 2
166 NORTH GALATIN AVENUE
UNIONTOWN, PA, 15401
LICENSE/COC#: 44778

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 04/06/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *REASTHEAVEN 2* **License #:** *44778* **License Expiration Date:** *07/15/2021*
Address: *166 NORTH GALATIN AVENUE, UNIONTOWN, PA 15401*
County: *FAYETTE* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *7244399411* **Email:** [redacted]

Legal Entity

Name: *REASTHEAVEN 2 LLC*
Address: *166 NORTH GALATIN AVENUE, UNIONTOWN, PA, 15401*
Phone: *7244399411* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date:** *05/11/1981* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *22* **Waking Staff:** *17*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *05/17/2021*

Inspection Dates and Department Representative

04/06/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* **Residents Served:** *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *22* **Are 60 Years of Age or Older:** *14*
Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability:** *4*
Have Mobility Need: *0* **Have Physical Disability:** *0*

Inspections / Reviews

04/06/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/27/2021*

Inspections / Reviews *(continued)*

6/7/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/14/2021*

6/16/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/26/2021*

17 - Record Confidentiality

1. Requirements

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 Repeat Violation

The privacy coding document, which contained the names of resident #1 and resident #2, was attached to the licensing inspection summary, dated 10/10/18, and was posted on the kitchen bulletin board.

Repeat Violation: 11/06/2019

Plan of Correction **Accept**

Administrator removed immediately. While checking for mandatory postings a staff member noticed the violation report was missing. That staff member copied one from the file and did not realize there was a privacy coding document. Staff will alert administrator when documents are missing. Administrator will replace missing documents personally. Administrator will educate staff regarding resident records and confidentiality on 5/25/2021. Daily monitoring will be done and documentation will be kept.

Completion Date: *05/25/2021*

18 - Compliance With Laws

1. Requirements

2600.

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

18 - Compliance With Laws *(continued)*

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, indicates a carbon monoxide alarm battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.
The carbon monoxide detector in the basement was beeping, indicating a low battery, and the battery was labeled with an installation date of 6/6/19.

The carbon monoxide detector next to bedroom #7 was beeping, indicating a low battery; however, it was not labeled with the date of the last battery installation.

34 Pa. Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations, indicates if a home has a boiler it must have a valid "Certificate of Boiler or Pressure Vessel Operation" issued by the PA Department of Labor and Industry. Upon expiration of the certificate, boilers must be inspected and if they pass inspection, they will be issued a new certificate.
The home's boiler certificate expired 3/3/19.

Plan of Correction **Accept**

All carbon monoxide detectors were checked. New batteries were placed in all of them and new dates labeling when batteries were changed on 05/21/2021. All batteries will be changed yearly and new dates placed on the detectors. Staff will check weekly to ensure batteries are not low. Administrator will ensure batteries are changed yearly or sooner in all devices. Staff education will take place on 05/25/2021. The boiler certificate was renewed on 5/28/2019 and again on 4/27/2021. Pictures attached

Completion Date: *05/25/2021*

81b - Resident Personal Equipment

1. Requirements

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

The enabler bars at the upper left and upper right side of resident #3's bed were uncovered and contained four 4 1/2" X 21" vertical openings, posing entrapment hazards.

81b - Resident Personal Equipment *(continued)*

Plan of Correction **Accept**

Resident #3's family purchased the bed new for [redacted] Maintenance assembled the bed with all parts and was not aware that the bed rails were unnecessary. Maintenance removed the bed rails immediately at the time of inspection. Administrator will check any new furniture immediately for any hazards. Administrator/ supervisor will check existing furniture for hazards weekly. The home will evaluate any resident who possibly needs bedrails or other personal assist equipment in the future. Prior to using bedrails or personal equipment the home will speak to the doctor for alternate solutions and call DHS for assistance. Weekly monitoring will be done and documentation will be kept. Staff will receive education on resident personal equipment on 05/25/2021.

Completion Date: *06/15/2021*

85a - Sanitary Conditions

1. **Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

There were no paper towels, mechanical air blower, individual cloth towels or other sanitary means of hand drying in the 1st floor common bathroom by the kitchen.

There were no paper towels, mechanical air blower, individual cloth towels or other sanitary means of hand drying in the 1st floor common bathroom by the dining room.

A brown liquid covered the inside freezer door of the white refrigerator/freezer in the kitchen.

Multiple crumbs and food particles covered the utensils and the bottom of the silverware drawer in the kitchen.

Plan of Correction **Accept**

Paper towels were replaced in the bathrooms immediately. Administrator held a resident meeting about removal of paper towels and to alert staff if they get low between shifts. Each shift checks for paper towels and hand soap among other supplies within an hour of arrival. Administrator will check multiple times and shifts throughout the week and make staff accountable for missing supplies. Documentation of checks will be kept.
The drip of ice cream that was on the shelf was immediately cleaned up upon discovery. Fridges and freezers are cleaned every Saturday. Administrator and supervisor will also check daily to ensure no spillage has occurred. Any spillage will be cleaned daily.
Crumbs were cleaned out of the silverware drawer immediately. Drawers were currently being cleaned weekly. Midnight shift will check kitchen drawers nightly to ensure no crumbs have fallen into the silverware drawer. Administrator/supervisor will check weekly to ensure the drawers are crumb free and documentation will be kept. Staff will be educated on 05/25/2021.

Completion Date: *05/25/2021*

85b - Infestation

1. **Requirements**

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

85b - Infestation *(continued)*

Description of Violation

There were 3 live bedbugs in the seam and approximately 30 brownish-red bed bug casting stains on the side of resident #4's bedspring cover.

There were 2 live bedbugs and approximately 20 brownish-red bed bug casting stains on resident #5's mattress cover.

There was 1 dead bed bug and approximately 20 brownish-red bed bug casting stains on resident #6's pillow.

There was 1 live bedbug on the floor next to resident #7's bed and 2 dead bed bugs in the crease of her mattress cover.

Plan of Correction **Accept**

The facility has exterminators (PMSI) coming monthly to keep the home bug free. Upon discovery of the live bed bugs PMSI set up a 4 week extermination for bed bugs. Staff did extra cleaning to ensure no dead bodies are to be found. Administrator/supervisor and staff will monitor once per shift for one month and daily thereafter. Resident interviews will be done daily to determine if residents have seen any bugs, have any bites, and have any questions or concerns. Any evidence of bedbugs will be immediately reported to the administrator and immediate action will be taken to resolve the situation and eliminate any infestation. Documentation will be kept. Staff education on identifying and reporting issues will take place on 05/25/2021

Completion Date: *06/15/2021*

86b - Bathroom

1. **Requirements**

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The 2nd floor common bathroom does not have an operable window or ventilation fan.

Plan of Correction **Accept**

The second floor common bathroom window was painted and shut before it was dry. Maintenance loosened the window so that it is easily operational. Fuse was replaced for vent to work properly. Administrator/ supervisor and staff will check daily and documentation will be kept. Staff education will be completed on 05/25/2021

Completion Date: *05/25/2021*

89a - Water Pressure

1. **Requirements**

2600.

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

The shower head in the common bathroom next to bedroom #6 did not have sufficient water pressure to meet the bathing needs of the home. The shower head produced only a trickle of water when the hot and cold taps were opened.

89a - Water Pressure *(continued)*

Plan of Correction **Accept**

The shower head was cleaned and replaced at the time of inspection. Maintenance stated there was calcium deposits in the shower head. Maintenance checked all of the other shower heads and sinks to ensure they were working properly with good pressure. Administrator/supervisor and staff will check weekly to ensure pressure is still good in all water outlets. Documentation will be kept. Staff education will take place on 05/25/2021

Completion Date: *05/25/2021*

93a - Handrails

1. **Requirements**

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

The front porch wooden handrail was unsecure and moved approximately 2" left and right.

Plan of Correction **Accept**

The new railing did have a "wiggle" at the very bottom of the railing at the time of inspection. Maintenance tightened the railing at the time of inspection and checked all other railing for any loose railings. Supervisor/ Administrator and staff will check daily for any loose railings/handrails. Documentation will be kept. staff education will be done on 05/25/2021

Completion Date: *05/25/2021*

94b - Non-Skid Surface

1. **Requirements**

2600.

94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

The ramp leading from the side of the front porch to the lawn did not have a non-skid coating.

The ramp leading from the rear of the home to the parking area did not have a non-skid coating.

Plan of Correction **Accept**

Both ramps were painted with non slip coating but continues to need repainted yearly. Maintenance did re-coat both ramps at the time of inspection. Maintenance also did the other ramps at the same time. The ramps and porch floors were scheduled to be painted once the rain and snow stopped for the season. Administrator/ supervisor will check daily to ensure the paint is still fully covering the ramps. Weather permitting, maintenance will paint within 24 hours of report. Staff education will take place on 05/25/21

Completion Date: *05/25/2021*

95 - Furniture and Equipment

1. **Requirements**

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

95 - Furniture and Equipment *(continued)*

Description of Violation

There was no light bulb in bedroom #3's ceiling fan light socket, posing an electrical hazard.

The glass dome cover was missing from the ceiling light fixture in bedroom #7.

Plan of Correction **Accept**

Light bulb in bedroom #3's ceiling light was replaced immediately. All other light fixtures were checked for missing bulbs as well. The replacement glass dome on the ceiling light in room #7 is scheduled to be delivered on 05/26/2021. All other light fixtures were checked for missing covers. Staff will check all light fixtures for bulbs and covers daily. Administrator will check weekly and documentation will be kept. Satff education will be on 05/25/2021.

Completion Date: *05/25/2021*

100a - Exterior - Free of Hazards

1. **Requirements**

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 left panel of the exterior Blico door was unsecure, and depressed approximately 2" lower than the right panel when the bottom edge was stepped on, posing a trip/fall hazard.

Plan of Correction **Accept**

The Blico door was fixed at the time of inspection. A metal latch was tightened which stopped the left panel from depressing at all. Inspector at the site did re check the door upon tightening and approved of repair. Maintenance also checked all other doors for any repair needs, Administrator/supervisor will check all doors daily to ensure no repair is needed. Documentation will be kept. Staff will receive on education on 06/22/2021.

Completion Date: *06/15/2021*

101j1 - Mattress Fire Retardant

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

There was a 3" tear in resident #6's mattress.

Plan of Correction **Accept**

Resident #6's mattress was changed at the time of inspection. Administrator checked all other mattresses and ensured there was no damage. All mattresses that needed replaced were replaced. Administrator does keep brand new mattresses on site for quick replacement when needed. Staff will check all mattresses daily and documentation kept. Administrator/supervisor will check weekly to ensure no rips or tears or any damage has occurred. Staff education will take place on 05/25/2021

Completion Date: *05/25/2021*

101j3 - Bed/Linens/Pillows/Blankets

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

There was an approximate 24" x 12" stain in the center of resident #4's bedsheet.

There were multiple crumbs/particles and loose tobacco particles on resident #5's bed.

There were multiple crumbs/particles and loose tobacco particles on resident #6's bed.

Plan of Correction **Accept**

All beds were changed and cleaned immediately. Midnight shift pulls and makes all beds. Residents do take snacks and personal belongings into their beds. Administrator had a resident meeting asking residents to not take snacks or tobacco into their bedrooms. Adm/ supervisor and staff will check daily to ensure beds are crumb free and stain free daily. Documentation will be kept. Staff education will take place on 05/25/2021

Completion Date: *05/25/2021*

101j7 - Lighting/Operable Lamp

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The following residents had no operable source of light that could be turned on/off at bedside:
** The lightbulb was unscrewed from resident #5's bedside lamp.*
** An inoperable, battery operated, push-button lamp was across the room in resident #8's top dresser drawer.*
** The lightbulb was missing from the lamp on resident #9's dresser, approximately 5' from [redacted] bed.*

Plan of Correction **Accept**

Resident #5 unscrews and screws [redacted] bulb in according to [redacted] "habit" Administrator sat down to explain the violation issue and ask the resident to use the switch. Resident #8 has removed every light ever put on [redacted] nightstand. Administrator glued, and screwed a touch lamp down to [redacted] nightstand and the resident still removed it. Administrator spoke to the resident repeatedly about [redacted] bedside light but no matter what [redacted] refuses to keep it there. Administrator moved the bedroom around so that the resident now has the ceiling light access at [redacted] bedside. The lightbulb was replaced in resident #9's lamp immediately and all lamps checked. Currently all lamps are being checked weekly, New checks will be done on each shift to ensure all bedside lamps/lights are functional. Administrator will check daily until she feels she can check weekly again. Staff education will be done on 05/25/2021.

Completion Date: *06/15/2021*

102i - Soap Dispenser

1. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

102i - Soap Dispenser *(continued)*

Description of Violation

There was no hand soap in the 1st floor common bathroom by the dining room.

Plan of Correction **Accept**

Soap was replaced immediately and all other bathrooms checked for soap in dispensers. Soap dispensers were to be filled by midnight shift and checked each shift. There will be a sign off sheet for shift change to check supplies have been restocked. Adm/ supervisor and staff will check daily and staff will be held accountable. Documentation will be kept. Staff education will take place on 05/25/2021

Completion Date: *05/25/2021*

103d - Storing Food Off Floor

1. **Requirements**

2600.
103.d. Food shall be stored off the floor.

Description of Violation

There was a case of twelve 50 ounce Libby chicken noodle soup cans stored on the floor of the basement pantry.

There was a half full, 10 pound bag of potatoes stored on the floor of the kitchen pantry.

Plan of Correction **Accept**

The soup was delivered but staff did not make it down to unpack at time of inspection. Staff will walk down with delivery guys and ensure they place all food products on the shelf. Potatoes were moved immediately and Adm checked all pantries for any other food products to be on the floor. Staff will receive education on 05/25/2021. Adm/ supervisor and staff will check daily that no food is on the floor for any amount of time. documentation will be kept. Staff education will take place on 05/25/2021

Completion Date: *05/25/2021*

103f - Refrigerator/Freezer Temps

1. **Requirements**

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

There was no thermometer in the refrigerator section of the white refrigerator/freezer in the basement.

Plan of Correction **Accept**

Thermometer was replaced immediately with replacements that are kept on hand. Adm checked all refrigerators and freezers to ensure thermometers were in each. Staff will check daily with temperatures to ensure the thermometers do not come up missing without being immediately replaced. Documentation will be kept. Staff will be educated on 05/25/21.

Completion Date: *05/25/2021*

105g - Lint Removal and Duct Cleaning

1. **Requirements**

2600.

105g - Lint Removal and Duct Cleaning *(continued)*

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 Repeat Violation

There was an approximate 1/4" accumulation of lint in the lint trap of the white Amana clothes dryer in the basement.

Repeat Violation: 11/06/2019

Plan of Correction **Accept**

Dryer lint was removed immediately. A reminder sign was placed on the dryer to help staff remember to remove lint after a load instead of before a new load. Staff will be educated on 05/25/21. Administrator or supervisor will check daily and each shift will be asked to hold each other accountable. Documentation will be kept.

Completion Date: *05/25/2021*

121a - Unobstructed Egress

1. Requirements

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 9:15 AM, the home's front door was locked from the inside by both a turn lock and a dead bolt lock. Staff and resident interviews indicate the door is locked at night; however, resident #10 and resident #11 were unable to independently disengage the locks, blocking egress.

Plan of Correction **Accept**

Maintenance removed the dead bolt from the door. Administrator had residents open the door while locked and unlocked and were all able to easily exit the door. Administrator will ensure that all new residents can open the door with ease. Staff education will be on 05/25/2021 and ensure that all doors open with ease for residents and staff. Monitoring will be done daily to ensure nothing is blocking an egress at anytime.

Completion Date: *06/15/2021*

125a - Combustible Storage

1. Requirements

2600.

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

Description of Violation

4 electrical cords were plugged into a 6 outlet power strip, stored under a sheet and 2 blankets at the foot of resident #3's bed, posing a fire hazard.

125a - Combustible Storage *(continued)*

Plan of Correction **Accept**

Resident #3's cords were removed immediately from the outlet. The resident packed in [redacted] suitcase for [redacted] soon to be move. Staff will check daily to ensure no resident is hiding cords of any kind in their beds. Administrator had a resident meeting on 05/21/2021 explaining the dangers of too many cords and the possibility of a fire hazard. Staff will be educated on what to look for and how to identify problems on 05/25/2021.

Completion Date: *05/25/2021*

141b1 - Annual Medical Evaluation

1. **Requirements**

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Repeat Violation

Resident #12's most recent medical evaluation, dated 6/26/20, does not include a list of [redacted] current medications.

Repeat Violation: 11/06/2019

Plan of Correction **Accept**

Administrator has checked every resident file to ensure nothing is missing from yearly or prn updates. Administrator has asked residents doctor to sign off on a replacement list for the missing medication list. Residents medical evaluation did include an attached med list per the Dr orders. Staff will receive education on what should be done annually per resident file and on being careful when going through files to not lose papers. Administrator/ supervisor will check at least 5 random files monthly to ensure nothing has gone missing and sign off on the residents folder.

Completion Date: *05/25/2021*

183d - Prescription Current

1. **Requirements**

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current *(continued)*

Description of Repeat Violation

Resident #12's Lispro Kwickpen was opened on 2/11/21 and expired per manufacturers instructions 28 days later on 3/11/21. Resident #12 is prescribed Lispro Kwickpen Insulin – Inject subcutaneously 4 times daily with meals and at bed per sliding scale as follows:

60 -150 = 0U
151 - 200 =2U
201 - 250 = 6U
251 - 300 = 8U
301 - 350 =10U
351 - 400 = 2U
>400 = Call MD

Resident #12 was administered expired Lispro Kwickpen Insulin on multiple occasions after 3/11/21, to include:

** 3/12/21 – 2 units at 8:00 AM*
** 3/20/21 – 2 units at 8:00 AM, 2 units at 4:00 PM*
** 3/24/21 – 2 units at 8:00 AM, 6 units at 4:00 PM*
** 3/30/21 – 6 units at 8:00 AM, 2 units at 4:00 PM*

Repeat Violation: 11/06/2019

Plan of Correction **Accept**

Administrator checked the entire medication cart and MAR to ensure no other medications were expired or missing open dates. Staff received Diabetic training on April 23rd and April 26th. All staff trained for medications were educated regarding expiration dates and open dates on 05/25/21. Administrator will check all dates weekly to ensure nothing expired gets administered. Supervisor and/or administrator will monitor weekly and then monthly to ensure staff are checking calibration of monitor, testing correctly, administering according to MAR, and making sure medications are not expired. Documentation will be kept.

Completion Date: *06/15/2021*

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

Resident #12's glucometer was not calibrated to the correct time.

Plan of Correction **Accept**

All glucometers have the correct date and time on them. Administrator checked all glucometers to ensure they were all calibrated. Staff will check daily with each blood sugar check. Staff received diabetic training on 04/23/21 and 04/26/21 Staff was educated on 05/25/21

Completion Date: *05/25/2021*

2. **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

Resident #12 is prescribed Lispro Kwickpen Insulin – Inject subcutaneously 4 times daily with meals and at bed per sliding scale as follows:
60 -150 = 0U
151 - 200 =2U
201 - 250 = 6U
251 - 300 = 8U
301 - 350 =10U
351 - 400 = 2U
>400 = Call MD
However, the home does not document the amount of Insulin administered on the resident's medication administration record. The home documents blood glucose readings and Insulin administered on a separate glucometer log.

Plan of Correction **Accept**

Administrator asked the pharmacy to give extra MAR to make it possible to record units of insulin on the MAR instead of the blood sugar sheets. Administrator will ensure all units are being written for each dose of insulin given.

The staff will document the units of insulin on a new MAR with spaces for the extra insulin administered. Staff education was done on 05/25/2021. Supervisor and/or administrator will monitor weekly and then monthly to ensure staff are checking calibration of monitor, testing correctly, administering according to MAR, and making sure medications are not expired. Documentation will be kept.

Completion Date: *06/15/2021*

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 #12 is prescribed Lispro Kwickpen Insulin – Inject subcutaneously 4 times daily with meals and at bed per sliding scale as follows:
60 -150 = 0U
151 - 200 =2U
201 - 250 = 6U
251 - 300 = 8U
301 - 350 =10U
351 - 400 = 2U
>400 = Call MD
Daily at lunch time from 3/1/21 - 3/31/21, the home failed to obtain resident #12's blood glucose readings and administer Insulin in accordance with the prescriber's orders.

Daily before bedtime from 3/3/21 - 3/31/21, the home obtained resident #12's blood glucose readings; however, no Insulin was administered in accordance with the prescriber's orders.

On 3/4/21 at 8:00 AM, resident #12's blood glucose reading was 154 and no Insulin was administered; however, according to the prescriber's orders, 2 units of Insulin should have been administered. Staff person A, who has not successfully completed a Department-approved diabetes patient education program since 12/11/19, performed the blood glucose reading.

On 3/15/21 at 8:00 AM, resident #12's blood glucose reading was 157 and no Insulin was administered; however, according to the prescriber's orders, 2 units of Insulin should have been administered. Staff person A, who has not successfully completed a Department-approved diabetes patient education program since 12/11/19, performed the blood glucose reading.

On 3/18/21 at 8:00 AM, resident #12's blood glucose reading was 231 and no Insulin was administered; however, according to the prescriber's orders, 6 units of Insulin should have been administered. Staff person A, who has not successfully completed a Department-approved diabetes patient education program since 12/11/19, performed the blood glucose reading.

Plan of Correction **Accept**

As of 06/17/2020 resident #12's blood sugar only had to be done the 4th time if needed. (Proof of dr order attached). Staff received diabetic training as soon as it was possible. Diabetic trainer was not willing to train due to covid. In February we scheduled 2 classes for 4/23 and 4/26/2021. Those classes were completed. Supervisor and/or administrator will monitor weekly and then monthly to ensure staff are checking calibration of monitor, testing correctly, administering according to MAR, and making sure medications are not expired. Documentation will be kept.

Completion Date: *06/15/2021*

190b - Insulin Injections

1. **Requirements**

2600.

190b - Insulin Injections *(continued)*

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person A, who has not successfully completed a Department-approved diabetes patient education program since 12/11/19, performed blood glucose readings and administered Insulin to resident #12 on multiple occasions to include:

** 3/1/21 – 2 units at 8:00 AM*

** 3/9/21 – 6 units at 8:00 AM*

** 3/30/21 – 6 units at 8:00 AM*

Plan of Correction **Accept**

Staff person A who has worked and had [redacted] diabetes training every year since [redacted] hire date in 2004. Due to COVID we could not get our trainer to come at the time of expiration since our expiration date was March 2020 when Covid was in full swing. We were finally able to schedule in February for April. All staff took all of the diabetic training course as soon as it was available to us. Certificate attached. Administrator will keep training due dates in each employee files to alert management of due dates for certifications.

Completion Date: *06/15/2021*