Department of Human Services
Bureau of Human Service Licensing

October 1, 2021

[redacted]
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 [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/06/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *MARIS GROVE* **License #:** *13466* **License Expiration Date:** *03/11/2022*
Address: *500 MARIS GROVE WAY, 1ST AND 3RD FLOORS, GLEN MILLS, PA 19342*
County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *6103874630* **Email:** [redacted]

Legal Entity

Name: *MARIS GROVE INC*
Address: *500 MARIS GROVE WAY, GLEN MILLS, PA, 19342*
Phone: *6103874630* **Email:** [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *89* **Waking Staff:** *67*

Inspection

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Incident* **Exit Conference Date:** *08/06/2021*

Inspection Dates and Department Representative

08/06/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served:** *53*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *22* **Residents Served:** *22*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *53*
Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *36* **Have Physical Disability:** *0*

Inspections / Reviews

08/06/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/26/2021*

Inspections / Reviews *(continued)*

8/30/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/06/2021*

10/1/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

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.
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 [redacted] did not receive first day orientation until 6/23/21.

Staff person C, whose first day of work was [redacted], did not receive first day orientation until 9/28/20.

Staff person D, whose first day of work was [redacted] did not receive orientation on the following topics:

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.

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

Plan of Correction **Accept**

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/team members found to have been affected by the deficient practice? Staff member B was hired on [redacted], not [redacted] as indicated in the deficiency. Staff member B did not receive first day orientation until [redacted]. The community NEO schedule had been changed by the communities Staff Development Coordinator in order to accommodate a scheduling conflict with the trainer on these topics, not realizing that this is a day 1 requirement in order to accommodate DHS regulations. Additionally, the Administrator did not catch that the training had been moved to day 3 until after day 1 of NEO had already started. The Administrator immediately educated the Staff Development Coordinator on the regulation requirement and asked that that training not be switched to a different day moving forward.
Staff person C, whose first day of work was [redacted], did not receive first day orientation until 9/28/2020. It was identified that a number of staff who were hired prior to the arrival of the current Administrator had attended NEO but there was no document of record to indicate that this training was completed on day 1 so a follow up day 1 training in 2020 was done with the team.
Staff person D, whose first day of work was [redacted] did receive orientation on the following topics:
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.
However, this training was not completed until 12/9/2020. (See attached sign in sheet and NEO schedule.) The NEO schedule had been modified due to COVID, and date of training was changed.
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 audit will be conducted by the SDC to determine if any other employee received the required training either late, or not at all. This audit will be completed every two weeks in conjunction with New Employee Orientation. There will also be a follow up review completed by the PC Administrator. Any existing employee identified to not have the required training as per the regulation, will be scheduled to receive the training within 1 week of the audit. A record of these trainings will be kept in the employee's file as well as the Administrator's office.
What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The Staff Development Coordinator has been educated about the training requirements and timing of these trainings as per DHS regulations. Moving forward, all NEO training records will be kept in the Administrator's office and the Administrator will conduct a monthly audit to ensure compliance is 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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *08/31/2021*

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

Document Submission **Implemented**

Prior to be cited this deficiency, the Staff Development Coordinator (SDC) was educated by Personal Care Administration on regulation 2600.65a and the need to not move this education within the New Employee Orientation schedule. The deficient practice was corrected for subsequent new employee orientation.

For Staff Person D, upon return of the Personal Care Administrator [redacted]) the first day orientation Checklist was identified and located for the staff person D.

For Staff person C, in identifying the deficient practice an audit was completed of employee files and required education was completed at that time, 9/2020 for all staff out of compliance.

65b - Rights/Abuse 40 Hours

1. Requirements

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

Staff person C's first day of work was [redacted] However, this staff person did not complete training in the following topics until 9/28/2020:

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.

Staff person D's first day of work was [redacted] 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 **Accept**

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/team members found to have been affected by the deficient practice? Staff person C's first day of work was [redacted] However, this staff person did not complete training on the above topics. An audit will be conducted by the SDC to determine if any other employee received the required training either late, or not at all. This audit will be completed every two weeks in conjunction with New Employee Orientation. There will also be a follow up review completed by the PC Administrator.

Staff person D did complete training on the required topics. This training occurred on 12/8/2020. It is included in the Ethical Behaviors presentation. (Please see attached NEO schedule, sign in sheet, and copy of the Ethical Behaviors Power Point presentation.)

How will you identify other employees having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit will be conducted by the SDC to determine if any other employee received the required training either late, or not at all. This audit will be completed every two weeks in conjunction with New Employee Orientation. There will also be a follow up review completed by the PC Administrator. Any existing employee identified to not have the required training as per the regulation, will be scheduled to receive the training within 1 week of the audit. A record of these trainings will be kept in the employee's file as well as the Administrator's office.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The Staff Development Coordinator has been educated about the training requirements and timing of these trainings as per DHS regulations. Moving forward, all NEO training records will be kept in the Administrator's office and the Administrator will conduct a monthly audit to ensure compliance is 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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *08/31/2021*

Document Submission **Implemented**

Staff person D did complete training on the required topics. This training occurred on 12/8/2020. It is included in the Ethical Behaviors presentation. (Please see attached NEO schedule, sign in sheet, and copy of the Ethical Behaviors Power Point presentation.) Additionally, for Staff Person D, upon return of the Personal Care Administrator [redacted]) the first day orientation Checklist was identified and located for the staff person D.

For Staff person C, in identifying the deficient practice an audit was completed of employee files and required education was completed at that time, 9/2020 for all staff out of compliance.

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 Repeat Violation

Resident #2 is prescribed Ipratropium-albuterol .5mg-3mg(2.5mg base)/3ml nebulization soln as needed every 4 hours and Aspercreme 4% (lidocaine) topical patch as needed. On 8/6/21 the medications were not available in the home.

Resident #2 is prescribed Oxycodone 5mg tablet as needed 1 max. On the blister pack pills #26, #27, and #28 are partially punched then taped over. Pill #27 it is 2 half tabs instead of 1 whole tab.

Plan of Correction **Accept**

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/team members found to have been affected by the deficient practice? After Resident #2's medications were discovered as being unavailable, further investigation revealed those medications had not been ordered in over a year, however, the order was still listed as an active order. The medications were reordered on 8/6/21 and received in the community on 8/7/21.
Upon further investigation, it was found that the team was grouping the overflow of medications too tightly together and the partially punched tabs on the blister pack were a direct cause of the pack in front of it being pushed too tightly into the pack behind it, causing some of the tabs to become partially punched. The floor nurse will be responsible for completing daily audits of medication cards to ensure medication integrity. Wellness Manager will then conduct a separate weekly audit of medication cards to ensure consistency with auditing. Findings will be reported to the Director of Nursing during weekly operations meetings. Formal audits to begin the week of September 7, 2021.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? In relation to unavailable PRN orders, on 8/24/21 the community reached out to the clinical contractor for Omnicare, the pharmacy that fills the resident prescriptions and delivers them to the community. We requested that [redacted] do an audit of all PRN medications for our Personal Care, Memory Care, and Assisted living neighborhood's that are still an active order, but have not been ordered or used recently so that we can discontinue the PRN orders or ensure they are re-ordered immediately. Goal is to have initial audit completed by October 1, 2021.
The floor nurse will be responsible for conducting an audit of the blister packs in use, and the overflow blister packs once a week to ensure none are partially punched. A record of this audit will be kept in a binder and will be checked by the Wellness Nurse weekly to ensure compliance. This audit will start on September 7, 2021.
What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? In addition to the Omnicare audit, medication cabinet audits are to be completed daily and weekly to ensure compliance.
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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *10/01/2021*

Document Submission **Implemented**

Please see attached for PRN medication audit. Medication competencies were completed with staff, as well as, education on proper medication administration guidelines was conducted

187c - Refusal of Medication

1. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

From 7/1/21 to 7/16/21 at 9:00pm and 7/18/21 to 7/20/21 at 9:00pm, resident #2 refused to take a scheduled dose of oxycodone 5mg tablet. The home did not report the refusal to the prescriber within 24 hours.

Plan of Correction **Accept**

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/team members found to have been affected by the deficient practice? On 8/20/21, the Wellness Manager changed Resident #2's dosage in the emar system to say ½ tab at bedtime instead of .25mg at bedtime, in order to provide more clarity to the Medication Technicians administering [redacted] medications.

Upon further review of Resident #3's Famotidine order, it was discovered that the order had been changed on 6/24/21 to read 20mg two times daily, which is the equivalent of 2.5ml. This caused confusion with staff member A who thought the dosage read 20ml instead of 20mg, as the original order had been prescribed in ml's. The order has since been changed back to the original prescription to read give 2.5ml two times daily. Staff member A will be competencied by the SDC or the Wellness Manager to determine if she is able to safely pass medications. Additionally, new medication ordering tool has been established to document when a care associate informs a nurse if there is an issue ordering a medication or if it needs a new script.

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 Nurses are required to conduct weekly medication cabinet audits. An adjustment to this process will be made to include weekly narcotic audits as well. This adjustment will go into effect after the team has been re-educated on this process during the monthly staff meetings which are set to occur the week of August 30, 2021.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The Staff Development Coordinator will be completing medication competencies with all medication technicians in our program as part of a previous plan of correction. This will be completed by September 30, 2021.

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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *09/30/2021*

Document Submission **Implemented**

Per the [redacted] Policy, physician's do not require notification unless the resident refuses a medication or treatment for 3 consecutive days. Additionally, the Staff Development Coordinator and RN designee completed medication competencies with all medication technicians in our program as part of a previous plan of correction.

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #2 is prescribed Lorazepam .5mg tablet 1 tablet (.5mg) as directed in AM and ½ tab (.25mg) at bedtime. However, on 7/30/21 and 8/5/21 the resident was administered .5mg tablet at bedtime.

Resident #3 is prescribed Famotidine 40mg/5ml oral suspension give 2.5ml two times daily, however on 6/28/21 staff member A administered 20ml.

Plan of Correction **Accept**

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/team members found to have been affected by the deficient practice? On 8/20/21, the Wellness Manager changed Resident #2's dosage in the emar system to say ½ tab at bedtime instead of .25mg at bedtime, in order to provide more clarity to the Medication Technicians administering her medications.
Upon further review of Resident #3's Famotidine order, it was discovered that the order had been changed on 6/24/21 to read 20mg two times daily, which is the equivalent of 2.5ml. This caused confusion with staff member A who thought the dosage read 20ml instead of 20mg, as the original order had been prescribed in ml's. The order has since been changed back to the original prescription to read give 2.5ml two times daily. Staff member A will be competencied by the SDC or the Wellness Manager to determine if [redacted] is able to safely pass medications.
Additionally, new medication ordering tool has been established to document when a care associate informs a nurse if there is an issue ordering a medication or if it needs a new script.
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 Nurses are required to conduct weekly medication cabinet audits. An adjustment to this process will be made to include weekly narcotic audits as well. This adjustment will go into effect after the team has been re-educated on this process during the monthly staff meetings which are set to occur the week of August 30, 2021.
What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The Staff Development Coordinator will be completing medication competencies with all medication technicians in our program as part of a previous plan of correction. This will be completed by September 30, 2021.
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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *09/30/2021*

Document Submission **Implemented**

The Staff Development Coordinator and RN designee completed medication competencies with all medication technicians in our program as part of a previous plan of correction.

2. **Requirements**

2600.

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

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

Description of Violation

Resident 1 is prescribed Lipitor 20mg tablet at hour of sleep, however it was not administered on 7/10/21 because the medication was not available in the home.

Resident 2 is prescribed Isopto Tears .5% eye drops three times a day. However, this medication was not administered to resident 2 on 7/6/21, 7/7/21, and 7/8/21 because the medication was not available in the home.

Resident 2 is prescribed Escitalopram 20mg one time daily. However, this medication was not administered to resident 2 on 7/14/21 because the medication was not available in the home.

Resident 2 is prescribed Brimonidine .15% eye drops, one drop in both eyes three times daily. However, this medication was not administered to resident 2 on 7/4/21 and 7/5/21 because the medication was not available in the home.

Resident 3 is prescribed Famotidine 40mg/5ml oral suspension give 2.5ml two times daily, However, this medication was not administered to resident 3 on 7/3/21, 7/4/21, 7/5/21, 7/13/21, 7/14/21 7/15/21, 7/16/21, and 7/17/21 it was not available in the home

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

Plan of Correction **Accept**

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.

1) What corrective action(s) will be accomplished for those residents/team members found to have been affected by the deficient practice? The Staff Development Coordinator will be completing medication competencies with all medication technicians in our program as part of a previous plan of correction. This will be completed by September 30, 2021. Additionally, it has been identified that our Pharmacy, Omnicare, has documentation that medications have been delivered to the community, however, some of these medications were unable to be located in the community. On 8/25/21, an agreement was made with Omnicare that includes the following new practice to start immediately: From now on the Omnicare delivery person will bring all ordered medications to the respective nurses stations for a nurse to review and sign off that proper medication has been received. The drivers will be instructed to wait until a nurse is able to properly check that correct medications are received. Nurses should be signing off on medication deliveries, not other parties. Receiving nurse will verify medications and deliver medications to the correct medication cabinets.

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Education has been provided to the Nursing Leadership team regarding this new process. The Wellness Manager or designee will conduct a weekly audit of our medication ordering communication tool to ensure that all medications have been delivered and are accounted for in the home. The results of these audits will be presented to the Director of Nursing once completed.

3) What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? If the Wellness Manager or designee finds through the weekly audit that the aforementioned process is not being followed by the team at Maris Grove, progressive disciplinary action will follow with staff members involved.

4) 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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *09/30/2021*

Document Submission **Implemented**

The Staff Development Coordinator and RN designee completed medication competencies with all medication technicians in our program as part of a previous plan of correction. A new medication delivery process was identified through partnership with the pharmacy and CAM's were educated on this new process as part of Medication in-service.

188b - Medication Error Reporting

1. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting *(continued)*

Description of Violation

Resident #2 is prescribed Isopto Tears .5% eye drops three times a day. However, this medication was not administered to resident 2 on 7/6/21, 7/7/21, and 7/8/21 because the medication was not available in the home. The medication error was not reported to the prescriber.

Resident #2 is prescribed Escitalopram 20mg one time daily. However, this medication was not administered to resident #2 on 7/14/21 because the medication was not available in the home. The medication error was not reported to the prescriber.

Resident #2 is prescribed Brimonidine .15% eye drops, one drop in both eyes three times daily. However, this medication was not administered to resident #2 on 7/4/21 and 7/5/21 because the medication was not available in the home. The medication error was not reported to the prescriber.

Resident #3 is prescribed Famotidine 40mg/5ml oral suspension give 2.5ml two times daily, However, this medication was not administered to resident #3 on 7/3/21, 7/4/21, 7/5/21, 7/13/21, 7/14/21 7/15/21, 7/16/21, and 7/17/21 it was not available in the home. The medication error was not reported to the prescriber.

Plan of Correction **Accept**

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.
1) What corrective action(s) will be accomplished for those residents/team members found to have been affected by the deficient practice? Incident reports are not being completed for medication errors. The current Nurses and medication technicians will be educated during the staff meetings which are scheduled for the week of August 30, 2021 to include that effective immediately, all medication errors will require an incident report to be completed by either the Nurse Supervisor, or the Nurse who received notification of the error. The incident report also requires the person completing the report to notify the family and the physician of the medication error which then becomes part of the residents electronic record. Nurse Supervisor will also be required to put the medication erros on the 24 hour report which is reviewed daily by the Wellness Manager. Additionally, this training will be added to community New Employee Orientation and conducted by the SDC.
2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Monthly audits will take place by the Wellness Manager or designee to ensure compliance is maintained.
3) What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? After the required education has been completed with all staff. If further medication errors are found and there is not a corresponding incident report, then progressive disciplinary action will follow with the staff members involved.
4) 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? Compliance will be monitored through our monthly QAPI meeting. Additional training and support will be provided as needed based on any deficiencies identified during these meetings.

Completion Date: *09/30/2021*

188b - Medication Error Reporting *(continued)*

Document Submission **Implemented**

The current Nurses and medication technicians will be educated during the staff meetings which are scheduled for the week of August 30, 2021 to include that effective immediately, all medication errors will require an incident report to be completed by either the Nurse Supervisor, or the Nurse who received notification of the error. The incident report also requires the person completing the report to notify the family and the physician of the medication error which then becomes part of the residents electronic record. Nurse Supervisor will also be required to put the medication errors on the 24 hour report which is reviewed daily by the Wellness Manager. Additionally, this training will be added to community New Employee Orientation and conducted by the SDC.

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's power of attorney participated in the development of [redacted] support plan. However, the resident did not sign the support plan.

Plan of Correction **Accept**

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.
1) What corrective action(s) will be accomplished for those residents/team members found to have been affected by the deficient practice? We are challenging this deficiency. Please see attached support plan (reference last page where it indicates resident was unable to participate and unable to sign) Also, please see attached certification from the Physician stating that the resident is incapable of making medical decisions due to her Dementia.

Completion Date: *08/26/2021*

Document Submission **Implemented**

We dispute this violation. Email proof is attached verifying communication and receipt of the support plan. Additionally the family did sign the support plan and email verification serves as a timestamp.

Update - 10/01/2021

SP- 10-01-2021

Residents inability to sign shall be reflected of the RASP by individual completing it.