



CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: August 19, 2022

[REDACTED]
Fair Oaks OpCo LLC
2200 W. Liberty Avenue
Pittsburgh, Pennsylvania 15226

RE: Fair Oaks Senior Living
2200 W. Liberty Avenue
Pittsburgh, Pennsylvania 15226
License/COC #: 452861

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 1, 2021, November 2, 2021, November 3, 2021, March 18, 2022, and March 21, 2022, 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), the Department hereby REVOKES your certificate of compliance (license number 452860) dated October 1, 2021 – October 1, 2022, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 19, 2022 to February 19, 2023.

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:

Jeanne Parisi, Bureau Director
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 Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: FAIR OAKS SENIOR LIVING License #: 45286 License Expiration: 10/01/2022
Address: 2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226
County: ALLEGHENY Region: WESTERN

Administrator

Name: [REDACTED] Phone: 412-344-9915 Email: [REDACTED]

Legal Entity

Name: FAIR OAKS OPCO LLC
Address: 2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226
Phone: 4123449915 Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 01/16/2017 Issued By: City of Pittsburgh

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 69 Waking Staff: 52

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 11/03/2021

Inspection Dates and Department Representative

11/01/2021 - On-Site: [REDACTED]
11/02/2021 - On-Site: [REDACTED]
11/03/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 100 Residents Served: 54

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 9 Are 60 Years of Age or Older: 53
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 15 Have Physical Disability: 0

Inspections / Reviews

11/01/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/27/2021

Inspections / Reviews *(continued)*

01/05/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *01/07/2022*

01/12/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *01/17/2022*

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.

Description of Violation

The Influenza Awareness Act, enacted 11/21/16, requires influenza information to be posted in a public and conspicuous place in the facility year-round. On 11/1/21 at approximately 10:50 a.m., the poster was not posted in a public and conspicuous place in the home.

Plan of Correction

Accept

On 11/01/21 this violation was corrected on site at the time of the inspection. Influenza information which was kept in the public information binder, was posted in a conspicuous place, by the elevators in the main lobby at the main entrance. The Administrator will ensure that this information is maintained in public view for all residents, staff & visitors. (See Photo 2600-18)

Completion Date: 11/01/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK Implemented

41c - Rights Poster

1. Requirements

2600.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

On 11/1/21, at approximately 10:50 a.m., the Department's posters for the listing of resident rights and the Rights violated poster was not posted in a public and conspicuous place in the home.

Plan of Correction

Accept

On 11/01/21 this violation was corrected at the time of the inspection. The list of resident's rights, which was kept in the public information binder, was posted in a conspicuous place, by the elevators in the main lobby at the main entrance. The Administrator will ensure that this information is maintained in public view for all residents, staff & visitors. (See Photo 2600-18)

Completion Date: 11/01/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK Implemented

42s - Privacy

1. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 11/1/21, there was no lock on the door to ensure privacy in the Community Shower room on the second floor of Oak Hall.

Plan of Correction

Accept

On 11/05/21 the damaged door handle was replaced with a new one that had a properly working locking mechanism. Health Services staff will report damaged door handles and locks to Security/Maintenance as they occur. Also, the Security Manager will inspect the locks and handles to the Oak Hall shower rooms during monthly inspections of the building. Work orders will be filed if they are in need of service and repairs made within 24

42s - Privacy (continued)

hours. Documentation will be kept. (See Photo 2600-42s)

Completion Date: 11/02/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Implemented

51 - Criminal Background Check

1. Requirements

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

On 11/2/21, direct care staff person B's record did not include that a criminal background check was requested or completed. Direct care staff person B was hired on [REDACTED] 21,

Plan of Correction

Direct care staff person B was [REDACTED] before the personal care home was sold and assumed our current name. The Administrator failed to run a new background check on the employee. On 11/02/21 a background check was completed and returned with "No Record". The Administrator will ensure that ALL newly hired staff will have a background check performed prior to working. (See ATT 2600-51)

Completion Date: 11/02/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Implemented

65i - Training Record

1. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

On 11/2/21, the homes record for direct care staff person B, did not include the document supporting the completion of the Department-approved direct care training course and passing of the competency test.

Plan of Correction

Direct care staff person B was [REDACTED] before the personal care home was sold and assumed a new name. The staff member was previously certified as a Certified Nursing Assistant. That certification expired and the staff member did not take the Direct Care Staff Training. Staff person B passed the Direct Care Staff Training Course & Competency on [REDACTED] 21. The Administrator will ensure that ALL newly hired staff will have ALL required training and documentation will be kept. (ATT 2600-65i)

Completion Date: 11/04/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Implemented

VIOLATION WITHDRAWN 7/22/22 JK

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/1/21, at approximately 11:10 a.m., there was approximately 1/4" layer of dust and dirt accumulated on slats of the air vent in the private bathroom of bedroom #101.

On 11/1/21, at approximately 11:20 a.m., there was a white plastic bin on the tile floor in the community shower room with assorted unlabeled containers of liquid soaps, shampoos, conditioners, several packages of wipes and an unlabeled white hairbrush with brown hair in the bristles.

On 11/1/21, at approximately 11:40 a.m., the white-Hot Point refrigerator/freezer in the dining room of Oak Hall on the second floor, had a yellowish and red liquid that appeared to be spilt over the bottom of the freezer section and had frozen.

Plan of Correction

Accept

The air vent in Apt. 101 was cleaned immediately. Housekeeping will clean these vents weekly and the Operations Director will inspect the vents monthly to ensure that they are clean and free of dust.

At the time of the inspection the white bin was disposed of and all of its contents. Effective immediately, all resident toiletries will be kept in labeled bins and maintained by the Health Services staff. Labeled bins will be brought to the shower at the time of the shower and removed from the shower at its conclusion. The Health Services of Director will monitor and documentation will be kept on the shower sheet.

At the time of inspection the refrigerator was cleaned. A sign will be placed on the refrigerator stating "Wipe all spills immediately" as a reminder to staff when something is spilled. The Administrator will do weekly inspections of the equipment to ensure its cleanliness. Documentation will be kept.

Completion Date: 12/29/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK Implemented

85e - Trash Outside Home

1. Requirements

85e - Trash Outside Home (continued)

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

There is a silver domed trash can at the front entrance does not have a lid to cover the circular opening measuring approximately 13". On 11/1/21 at 9:00 a.m. and 11/2/21 at 12:30 p.m., the trash can was overflowing with trash up past and sticking out of the opening, to include soda cups with straws, assorted plastic grocery bags with trash inside.

Plan of Correction

Accept

On 11/02/21, the trash can was replaced with one that had a lid to completely cover the opening. The Director of Operations and/or Security Department will ensure that the trash is emptied when the can is full. (Photo 2600-85e)

Completion Date: 11/02/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK

88a - Surfaces

Implemented

1. Requirements

2600.

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

Description of Violation

On 11/1/21, there is a slight ramp in the floor at the entrance of the Community Shower Room. There are four 2" tiles missing at the top of the ramp where the floor levels out and another tile with approximately 1" piece of the left corner broken off the tile in Community Shower Room on the second floor of Oak Hall.

Plan of Correction

Accept

On 11/05/21 the ramp to the shower room on Oak Hall was repaired. Health Services staff will report damaged floor tiles to Security/Maintenance as they occur. Also, the Security Manager will inspect the floor of the Oak Hall shower rooms during monthly inspections of the building. Work orders will be filed if they are in need of service and repairs made within 24 hours. Documentation will be kept. (See Photo 2600-88a)

Completion Date: 11/05/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Implemented

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

On 11/1/21, at approximately 11:40 a.m., there was no hot water at the kitchenette sink in the dining room of Oak Hall on the second floor. The water for both the hot and cold ran cold when turned on.

Plan of Correction

Accept

On 11/01/21 the water tank was replaced with a tank-less hot water heater during the state inspection. The water temperature is within the hot water range as per the regulation. The Security Manager will add the Oak Hall Dining Room to monthly check of sink temperatures for apartments. will report temperature discrepancies to the Operations Director by way of work order so that it can be corrected or replaced. Documentation will be kept. (See Photo 2600-89a)

Completion Date: 11/01/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Implemented

95 - Furniture and Equipment

1. Requirements

2600.

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

Description of Violation

On 11/1/21, at approximately 11:40 a.m., a small recess light in the ceiling above the microwave in the dining room of Oak Hall on the second floor, has no light cover or light bulb. The light fixture is not set in place and the wires are exposed.

On 11/3/21 at approximately 11:30 a.m., the ceiling light is missing the light cover and one of the two bulbs in the hallway by the bathroom in bedroom #411.

Plan of Correction

Accept

On 11/04/21 the light fixture was removed from the Oak Hall Dining Room and the resulting hole was patched and painted. The Security Manager will submit work orders for repairs to lighting & electrical fixtures during monthly inspection. The Director of Operations will make the repairs within 72 hours of receiving the work order. Documentation will be kept. (See Photo 2600-95)

On 11/03/21 the light cover to the ceiling light was replaced and the bulbs replaced in the hallway light fixture. The Security Manager will place a work order with the Director of Operations during apartment inspections for lighting & electrical needs. The work will be performed within 72 hours and documentation will be kept.

Completion Date: 11/04/2021 Licensee's Proposed Date for POC Implementation 7/22/22 JK

Implemented

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

On 11/3/21, at approximately 11:10 a.m., the bedside lamp for resident #6 in bedroom # is inoperable. The resident does not have any source of light than can be turned on/off from bedside

Plan of Correction

Accept

At the time of the inspection, the lamp in Rm# was in operable condition. After the state inspector left the room, it was discovered that the lamp was plugged into a power strip that was plugged in but the power strip switch was off. The lamp is plugged directly into the wall while other non-essential electronics are plugged into the power strip. Each day as housekeeping is cleaning the room and changing the sheets, they will check to ensure that lamps are operable. Any lamps that are not in working order will be reported via the work-order system for inspection/replacement.

Completion Date: 01/10/2022 Licensee's Proposed Date for POC Implementation 7/22/22 JK

Implemented

101o - Walls, Floors, Ceilings

1. Requirements

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

101o - Walls, Floors, Ceilings (continued)

Description of Violation

On 11/1/21, there is a crack approximately 8" long in the ceiling by the door of the private bathroom of bedroom #101. Approximately 4" of the 8" crack has split open the drywall with water marks around it.

Plan of Correction

Accept

This repair was made on 12/29/21 by the Maintenance Department. All staff will be trained to report any finished walls, floors and ceilings that are in disrepair to the Security Department at that time. Using the work-order system, the Security Manager will submit a work ticket with the Director of Operations. The work will be performed within 48 hours and documentation will be kept.

Completion Date: 12/29/2021 Licensee's Proposed Date for POC Implementation 7/22/22 JK Implemented

103c - Food Protected

1. Requirements

2600. 103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 11/1/21, at approximately 10:29 a.m., there were three uncovered chocolate cream pies being stored in the walk-in cooler in the kitchen on the top shelf.

Plan of Correction

Accept

The chocolate cream pies were served during lunch on 11/01/21 and were waiting to have whipped cream topping added. The Dietary Director will keep all food protected from contamination while being stored, prepared, transported and served. The Dietary Director will train all of [redacted] staff on the importance of protected food, even through the serving process, by 12/31/21. Documentation will be kept.

Completion Date: 01/11/2022 Licensee's Proposed Date for POC Implementation 7/22/22 JK Implemented

103i - Outdated Food

1. Requirements

2600. 103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 11/1/21, at approximately 10:20 a.m., the following foods were open, undated, and labeled in the walk-in freezer in the kitchen, to include:

- A 5lb. bag of Cold-n-Spicy Chicken Breast Cutlets, approximately ¼ full.
- A 5lb. bag of breaded chicken breasts, approximately ½ full.

Plan of Correction

Accept

The two bags of chicken were immediately disposed of and not used for meals. The Dietary Director is responsible for ensuring that outdated or spoiled food will not be used. The Dietary Director will immediately train the cooks on the importance of proper labeling and storage of opened items to ensure that residents are not served outdated or spoiled food. Documentation will be kept.

Completion Date: 01/11/2022 Licensee's Proposed Date for POC Implementation 7/22/22 JK Implemented

181c - Self-administration Assessment

1. Requirements

2600.

181.c. The resident’s assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician’s assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2’s support plan, dated [redacted]/21, and physician order indicate the prescribed Combigan Eye drops -instill one drop into left eye every 12 hours is the only medication that can be kept at bedside. However, on 11/3/21 at 1:15 p.m., resident #2 could not find the medication, forgetting where it was stored, leading to a search of the room to locate the medication. The resident had multiple OTC medications that were stored in multiple areas of the residents bedroom, to include in the seat of the wheeled walker. None of the OTC medications are indicated for self- administration and are not stored or secured in an organized safe, secured manner, to include:

- Pepto Bismol (2) bottles
- Phillip Laxative Tablets (24 count) 8 remaining
- Equate pain relief cream.4oz tube
- a tube of Neosporin
- A tube of Hydrocerin Dry skin care cream

Plan of Correction

Accept

Doctor order on 11/10/21 states that resident may not self-administer any medication. All medication is to be administered ONLY by staff. Family members notified on 11/10/21 to stop bringing over-the-counter medications to [redacted] apartment. Health Services Director will inspect apartments weekly for four weeks and then monthly thereafter to ensure no medications are in the apartment. Documentation will be kept.

Completion Date: 12/28/2021 Licensee’s Proposed Date for POC Implementation

7/22/22 JK

Implemented

182c - Medication Administration

1. Requirements

2600.

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

1. Identify the correct resident.
2. If indicated by the prescriber’s orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident’s hand.

Description of Violation

On 11/1/21, at approximately 11:00 a.m., the following prescribed medications were in a med cup on the kitchenette counter in the resident #2 room (room # [redacted]), identified as: Amlodipine Besylate 5mg tablet; Lisinopril 10mg tablet, and Tamsulosin HCL 0.4mg capsule that were to be administered at approximately 9:00 a.m. The residents is not assessed to be able to self-administer these medications.

Resident #2 is prescribed Pain Relief liquid 160MG/5ML LIQ- take one tablespoon (15ml) three times a day (9:00 a.m., 12:00 p.m. and 5:00p.m.) On 11/3/21, at approximately 1:15 p.m., there was med cup containing approximately 15ml of a red liquid later identified as Pain Relief 100mg/5ml liquid in resident #2’s living room on the end table next to the couch. Interviews indicated direct care staff person C, brought medication to administer to the resident sometime in late morning. However, left the Pain Relief 100mg/5ml liquid on the end table. The resident is not assessed to self-administer the medication.

Plan of Correction

Accept

The medication for resident #2 found in a med cup at approximately 11:00 AM was not administered and was

182c - Medication Administration (continued)

disposed of and recorded as a missed dose. The resident's dose of 15ml Pain Relief was also disposed of and indicated on the MAR that it was not administered. On 11/08/21 the Med Techs responsible for these violations received one-on-one training and observation as to the 5 Rights of Medication Administration and the importance of observing a resident taking medication. On 11/09/21 ALL Med Techs were retrained on the 5 Rights of Medication Administration and medication errors. Effective immediately, the Health Services Director will monitor the proper administration of medication during med passes once per week for four weeks and then monthly. Documentation will be kept.

Completion Date: 12/29/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Not Implemented

183b - Meds and Syringes Locked

1. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 11/1/21 at approximately 11:50 a.m., a large metal grey cabinet with glass doors in hallway to the nurse's station on second floor. The handle was locked; however, the door is broken and by pulling on handle door opened. The cabinet contains multiple medical equipment and OTC medications and supplies that are unlocked and accessible, to include:

- 2 Medi honey 1.5 Fl oz. wound and urn dressing
- 4- 100g tube Diclofenar Sodium Topical Gel 1% with a label indicating: follow directions, consult dr. prior to use and do not use more than prescribed. Consult physician or Poison Control center if have side effects or symptoms.
- Perrigo Muscle Rub 3oz tube with a label indicating: If swallowed call PCC or Doctor.

Multiple 15 or more packets with 6 tablets each of Efferdent denture tablets with a label: if swallowed seek medical treatment immediately, contact Poison control center or a physician immediately.

Resident #2's support plan, dated [redacted] 21, and physician order indicate the prescribed Combigan Eye drops -instill one drop into left eye every 12 hours is the only medication that can be kept at bedside. However, on 11/3/21 at 1:15 p.m., resident #2 could not find the medication, forgetting where it was stored, leading to a search of the room to locate the medication. The resident had multiple OTC medications that were stored in multiple areas of the residents bedroom, to include in the seat of the wheeled walker. None of the OTC medications are indicated for self- administration and are not stored or secured in an organized safe, secured manner, to include:

- Pepto Bismol (2) bottles
- Phillip Laxative Tablets (24 count) 8 remaining
- Equate pain relief cream.4oz tube
- a tube of Neosporin
- A tube of Hydrocerin Dry skin care cream

Plan of Correction

Accept

On 11/04/21 ALL medications were removed from this gray storage cabinet. Effective immediately, the Director of Health Services will educate Health Services staff to the change in storage procedures and ensure, daily, that the storage cabinet is to be stocked ONLY with medical supplies such as bandages, gauze and medical tapes. Creams, ointments and other medications will be kept locked in the nurse's station. Documentation will be kept.

Completion Date: 12/29/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Not Implemented

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 11/2/21, at approximately 2:10 p.m., there two medication tablets (a pink and a white tablet) loose on the bottom of the second drawer in the med cart 1 & 2. The staff person was unable to identify the medication or who's medication it was.

On 11/3/21, the homes policy for the "Accountability of medication & controlled Substances indicates the following: If not a straight order, each time a narcotic/controlled substance is given to a resident, an entry will also be made on the Pharmacy Controlled Substance sheet, indicating the drug dispensed and the number of remaining tablets or milliliters of liquid remaining.

• A shift count of ALL narcotics/controlled substances will be done at 7:00 a.m., 3:00 p.m. and 11:00 p.m. by the Health Services director or Med Techs who have been trained. The home is not following their policies as set forth in Accountability of Medication and Controlled Substances.

Resident #5 is prescribed Morphine Sulf 20mg/1M- give 5 mg (0.25ml) sublingually on every one hour as needed. On 11/2/21, at approximately 2:10 p.m., a medication audit was conducted for resident #5. The Controlled Substance Sheet indicated resident #5 was administered .25ml of morphine on 11/1/21 at 8:00 p.m. with a remaining amount of 21.75ml. However, there was only 16 ml remaining in the morphine vial, a difference of 5.75ml, that was unaccounted for. The Controlled Substance Sheet for resident #5's morphine indicates dates/times of administration and amount of remaining morphine are out of sequence or recorded incorrectly, as follows:

On 10/23/21 at 9:00 p.m. .25ml administered morphine remaining 22.75ml.

On 10/31/21 at 6:00 p.m. .25ml administered morphine remaining 22.50ml.

On 10/31/21 at 9:00 a.m. .25ml administered morphine remaining 22.25ml.

On 10/24/21 at 9:00 p.m. .25ml administered morphine remaining 22.00ml.

On 11/1/21 at 8:00 p.m. .25ml administered morphine remaining 21.75ml.

On 11/3/21, the home's Shift-to-Shift Narcotic Sign-Off Sheet indicated on 10/30/21, 10/31/21, 11/1/21, 11/2/21 and 11/3/21, the Med Techs departing /entering each shift at 7:00 a.m., 3:00 p.m. and 11:00 p.m. signed- off on the sheet indicating that ALL narcotics counts were accurate and accounted for.

Resident #4 is prescribed blood glucose checks to be done weekly on Thursdays (8:00 a.m.). On 11/2/21, the residents 2021 October MAR indicate blood glucose levels were recorded on 10/07/21, 10/14/21, 10/21/21 and 10/28/21. However, the blood glucose readings were not indicated on the resident's glucometer. Per staff person A, resident #4's blood glucose history is deleted usually on the first of each month, therefore the accuracy of the blood glucose readings recorded could not be verified.

On 11/1/21 at 7:30 a.m., a blood glucose reading of 233 was recorded in resident #7's 2021 November MAR. However, the reading was not on the glucometer. Per staff person A, the blood glucose history is deleted on the first of each month, therefore the accuracy of the blood glucose readings recorded in the residents MAR could not be verified.

Resident #8 is prescribed blood glucose checks twice a week (Monday and Thursday). There are no blood glucose readings on resident #8's glucometer. Per staff person A, the blood glucose history is deleted on the first of each month, therefore the accuracy of the blood glucose readings recorded in the residents MAR could not be verified.

185a - Implement Storage Procedures (*continued*)**Plan of Correction****Accept**

The Health Services Director will inspect medication blister packs each week for four weeks, and then once per month, for damaged cells. The HS Director will also inspect Med Carts for loose pills during Med Cart audits and cycle days when the pharmacy reclaims medication cards. Documentation will be kept.

On 11/09/21 ALL Med Techs reviewed the home's policy and the importance of counting controlled substances. Effective immediately, the Health Services Director and Administrator will continue to educate on the proper counting and monitoring of controlled substances at monthly Med Tech meetings. Documentation will be kept.

Effective immediately, all morphine bottles were replaced with single-use dose syringes to alleviate potential spills or vial tampering when dispensing and to account for the narcotics more accurately. Documentation will be kept.

On 11/02/21 the Administrator trained the Health Services Director about the importance of not clearing glucometer readouts. Effective immediately NO glucometer will have its history cleared. Weekly glucometer checks will be performed by the Administrator and Health Services Director. Documentation will be kept.

Completion Date: 11/02/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK

Not Implemented

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:

8. Frequency of administration.

9. Administration times.

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

Description of Violation

Resident #3 is prescribed Sertraline HCL100mg tablet -take one tablet by mouth daily (6:00 a.m.). However, the residents October and 2021 November MAR's indicate Sertraline HCL 100mg tablet – take one tablet by mouth daily (6:00 a.m. and 9:00 a.m.)

Resident #2's October and November 2021 MAR's do not include a diagnosis or purpose for the following medications, to include:

- Buprenorphine 10mcg/HR Patch-
- Amlodipine Besylate 5 mg tablet.
- Fiber Therapy S/F/q/c 283/GM
- Pain Relief liquid 160MG/5ML LIQ- .
- Atorvastatin-10mg tablet.

Resident #4's October and 2021 November MARs do not include a diagnosis or purpose for the following medications, to include:

- Aspirin 81 mg chewable tablet
- Clopidogrel 75mg tablet
- Omeprazole DR 20mg tablet
- Simvastatin 10mg tablet
- Tamsulosin HCl 0.4mg capsule

187a - Medication Record (continued)

- Vitamin D3 1,000IU tablet

Resident #5's 2021 November MAR's do not include a diagnosis or purpose for the following medications, to include:

- Divalproex DR125mg capsule SP
- Escitalopram 10 mg tablet
- Furosemide 10mg /ML solution
- Metoprolol Succ ER 25mg tablet
- Polyethylene Glycol 3350 PO

Plan of Correction

Accept

The Health Services Director is responsible to ensure that all medication on the eMAR contain frequency of administration, administration times and the diagnosis or purpose of the medication. Effective immediately, the Health Services Director will ensure that the eMAR lists the diagnosis for which they are prescribed and will check monthly. Doctor orders that do not list the diagnosis will be followed up on and corrected by the Health Services Director in conjunction with the doctor and pharmacy. Documentation will be kept.

Completion Date: 01/11/2022 Licensee's Proposed Date for POC Implementation

7/22/22 JK

Not Implemented

187b - Date/Time of Medication Admin.

1. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed the following medications.

- Amlodipine Besylate - 5mg tablet take one tablet daily (9:00 a.m.)
- Lisinopril 10mg tablet - take one tablet daily (9:00 a.m.)
- Tamsulosin HCL 0.4mg capsule- take one capsule daily (9:00 a.m.)

The resident's November 2021 MAR was not initialed by the staff member who administered the medication on 11/1/21 for 9:00 a.m.

Resident #2 is prescribed the following medications.

- Amlodipine Besylate - 5mg tablet take one tablet daily (9:00 a.m.)
- Lisinopril 10mg tablet - take one tablet daily (9:00 a.m.)
- Tamsulosin HCL 0.4mg capsule- take one capsule daily (9:00 a.m.)
- Pain Relief liquid 160MG/5ML LIQ- take one tablespoon (15ml) three times a day (9:00 a.m., 12:00 p.m. and 5:00p.m.)

Interviews indicated on 11/3/21, direct care staff person C was administering the morning medications to resident #2 and the resident dropped one of the pills. The resident or staff person could find the medication or determine which of the medications that fell and not administered. During that time, direct care staff person C did not administer the prescribed Pain Relief Liquid (15ml), but left it in a med cup on the resident's end table and was still. However, the medications were initialed as being administered in the 2021 November MAR.

Resident #3 is prescribed Sertraline HCL100mg tablet -take one tablet by mouth daily (6:00 a.m.). However, the residents October and 2021 November MAR's indicate Sertraline HCL 100mg tablet – take one tablet by mouth daily (6:00 a.m. and 9:00 a.m.) Interviews indicate staff persons are administering the medication as prescribed at 6:00 a.m.; however, signing off as administered at 6:00 a.m. and 9:00 a.m.

187b - Date/Time of Medication Admin. (continued)

Plan of Correction

Accept

The Med Tech is designated to sign-off on medication that they administer. On 11/08/21, Health Services Director provided one-on-one training for the Med Tech who was signing off a medication, but not administering but not administering it because she knew the eMAR was incorrect. The Med Tech was instructed to report pharmacy errors to have them corrected, rather than sign off that it was given. On 11/09/21 ALL Med Techs were retrained on the 5 Rights of Medication Administration and medication errors, with a focus on accurate documentation of medication administration. Effective immediately, the Health Services Director monitor the proper recording of medication by overseeing med passes once per week for four weeks and then once a month thereafter. Documentation will be kept. (See ATT Train 1 & 2)

Completion Date: 01/11/2022 **Licensee's Proposed Date for POC Implementation**

7/22/22 JK
Not Implemented

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 is prescribed Novolog flexpen syringe- 4 times a day with sliding scale ((7:30a.m., 11:30a.m., 4:30a.m. and 9:00p.m.) SS: 70-140=0u; 141-180=2u; 181-220=4u; 221-260=6u; 261-300=8u; 301-340=10u; 341-400=12u

Novolog Flexpen Syringe -inject 20units subcutaneously in morning (9:00 a.m.)

Novolog Flexpen Syringe-inject 30 units subcutaneously with lunch (12:00 p.m.)

Novolog Flexpen Syringe inject 24units subcutaneously with dinner (5:00 p.m.)

Levemir 100u /ML vial inject 36units subcutaneously twice daily (9:00 a.m. & 9:00 p.m.)

* At 4:30p.m. on 11/1/21, resident #1's 2021 November Medication Administration Record (MAR) indicated a blood glucose level of 146, which per the sliding scale required 2 units of insulin to be administered; however, the 2021 November MAR indicates the resident received 24 units.

* At 5:00 p.m. on 11/1/21, resident #1's 2021 November MAR indicated the resident received 2 units of insulin; however, the resident is prescribed 24 units of insulin.

* At 11:30 p.m. on 11/2/21, resident #1's 2021 November MAR indicated a blood glucose level of 142, which per the sliding scale required 2 units of insulin to be administered; however, the resident's 2021 November MAR indicated the resident received 40 units of insulin and on 11/3/21 at 10:05 a.m., the 40 units recorded in the residents November 2021 MAR had been changed to 0 units given.

* At 12:00 p.m., on 11/2/21, resident #1's 2021 November MAR indicated the resident received 2 units of insulin. However, the resident is prescribed 30 units of insulin.

On 11/1/21, at approximately 11:00 a.m., the following prescribed medications were in a med cup on the kitchenette counter in the resident #2 room (room # [REDACTED]), identified as: Amlodipine Besylate 5mg tablet; Lisinopril 10mg tablet, and Tamsulosin HCL 0.4mg capsule that were to be administered at approximately 9:00 a.m. The residents is not assessed to be able to self-administer these medications.

Resident #2 is prescribed Pain Relief liquid 160MG/5ML LIQ- take one tablespoon (15ml) three times a day (9:00 a.m., 12:00 p.m. and 5:00p.m.) On 11/3/21, at approximately 1:15 p.m., there was med cup containing approximately 15ml of a red liquid later identified as Pain Relief 100mg/5ml liquid in resident #2's living room on the end table next to the couch. Interviews indicated direct care staff person C, brought medication to administer to the resident sometime in late morning. However, left the Pain Relief 100mg/5ml liquid on the end table. The resident is not assessed to self-administer the medication.

187d - Follow Prescriber's Orders (continued)

Plan of Correction

Accept

It is the Health Services Director's responsibility to ensure that the eMAR matches the prescriber's orders. The dosages were correct and the medication was administered correctly, however, the system by which they were recorded on the eMAR did not allow for separate entries on the MAR to differentiate between the standing order and a sliding scale. On 11/05/21 this was corrected on TabulaPro and with [redacted] Pharmacy to allow separate entries for blood glucose and dosages given. Effective immediately, all residents who have sliding scale insulin in addition to a standing order will be entered and recorded using this method.

On 11/09/21 ALL Med Techs were retrained on the 5 Rights of Medication Administration and medication errors. Effective immediately, the Health Services Director monitors the proper recording of medication by overseeing med passes once per week for four weeks and then once a month thereafter. Documentation will be kept.

(See ATT Train 1 & 2)

Completion Date: 01/11/2022 Licensee's Proposed Date for POC Implementation

7/22/22 JK

Not Implemented

225c - Additional Assessment

1. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #5 had an assessment completed on [redacted] 21, Since that time the resident has had significant increases in care needs and services to include:

- The resident began receiving hospice services on [redacted] 21
- The resident's progress notes, dated [redacted] /21, indicate the resident has had multiple falls
- The resident's progress notes, dated [redacted] 21, indicate the residents increased swelling and weight loss

The resident's assessment was not updated to include the resident's needs related to these changes,

Plan of Correction

Accept

Resident #5's care plan was updated on 11/04/21. Effective immediately, the Health Services Director will update a resident's care plan to reflect significant changes that impact the level of care of the resident. Effectively immediately, care plans will be reviewed monthly by the Administrator and Health Service Director. Documentation will be kept.

Completion Date: 12/29/2021 Licensee's Proposed Date for POC Implementation

7/22/22 JK
Implemented