

Department of Human Services
Bureau of Human Service Licensing

December 20, 2021

[REDACTED], VICE PRESIDENT
VS WALLINGFORD LLC
2700 CHESTNUT PARKWAY
CHESTER, PA, 19013

RE: CHESTNUT RIDGE RETIREMENT
LIVING
2700 CHESTNUT PARKWAY
CHESTER, PA, 19013
LICENSE/COC#: 14141

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/03/2021, 11/04/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

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: CHESTNUT RIDGE RETIREMENT LIVING License #: 14141 License Expiration:
Address: 2700 CHESTNUT PARKWAY, CHESTER, PA 19013
County: DELAWARE Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: 6104470710 Email: [REDACTED]

Legal Entity

Name: VS WALLINGFORD LLC
Address: 2700 CHESTNUT PARKWAY, CHESTER, PA, 19013
Phone: 6104470710 Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 09/19/1998 Issued By: City of Chester

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 112 Waking Staff: 84

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 11/04/2021

Inspection Dates and Department Representative

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

11/04/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 130 Residents Served: 75

Secured Dementia Care Unit

In Home: Yes Area: 4th Floor Capacity: 22 Residents Served: 19

Hospice

Current Residents: 8

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 73
Diagnosed with Mental Illness: 5 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 37 Have Physical Disability: 1

Inspections / Reviews

11/03/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/26/2021

Inspection Dates and Department Representative (*continued*)

11/30/2021 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *12/10/2021*

12/20/2021 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 11/3/2021 the home's current violation report, dated 5/4/2021, and a copy of 55 Pa.Code Chapter 2600, were not posted in a conspicuous and public place in the home.

Plan of Correction

Accept

Directors, managers and concierge employees were educated on 11/5/2021 on regulation #2600.3c Post Current License. See attachments A- A1.

Areas of citation were correct day of survey 11/4/2021.

The Administrator and/or designee will audit the concierge desk daily x 1month, then weekly x 2 weeks, then randomly monitored to ensure ongoing compliance. See attachment _.

The Administrator is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 01/17/2022

Document Submission

Implemented

Directors, managers & concierge staff were informed that LIS current violation report & Chapter 2600 Regs must be posted in a conspicuous and public place (front desk) for public review when requested.

Completion Date: 11/17/2021

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 1. Training that includes a demonstration of job duties, followed by supervised practice.
- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [REDACTED], began providing unsupervised ADL services on approximately [REDACTED]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until [REDACTED].

Plan of Correction

Accept

Directors and managers were educated on 11/5/2021 on regulation #2600.65d on initial direct care training/certification being completed during orientation. See attachment B.

Area of citation was correct 10/19/2021.

The Administrator will audit the personnel files of all new employees within one week of hire x 1month, then randomly monitored to ensure ongoing compliance. See attachment B1.

The Administrator and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 01/17/2022

65d - Initial Direct Care Training (*continued*)**Document Submission****Implemented**

Identified employee completed & passed the DHS training/ certification course on October 19, 2021. All new employees will complete the DHS online certification/ training within one week of hire, during the orientation process. Directors & managers were in-serviced on November 5, 2021.

Completion Date: 10/19/2021

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/4/21 at approximately 11:00am, The floor of the homes trash compactor room is wet with both clear standing water as well as large puddles of blackish/brown liquid. Multiple puddles are located all the way around and under the dumpster/compactor machine. There are forklift tire-tread marks and foot prints located around the area as well, indicating that staff have stepped into these puddles and tracked the liquid to other locations.

On 11/2/21 at 8:17am there is a reading of 66 on resident#1's glucose log, there is no corresponding reading in the residents meter. This reading was found on resident #2's glucometer on 11/2/21 at 7:56am.

On 11/04/21 at approximately 10:00am, the carpet in resident #3's room is heavily stained with brown, red, and yellow areas of various sizes of an unknown substance. There is also dried red drips of an unknown substance present on the baseboard trim located near the dresser in resident's room.

Plan of Correction**Accept**

Building Engineer, Maintenance manager, and maintenance techs were educated on 11/5/2021 on regulation #2600.85a on sanitary conditions being maintained. See attachment C.

Area of citation was correct day of survey 11/4/2021. Building Engineer looking into better trash compactor options to fit the needs of the community.

Building Engineer and/or designee will audit the trash compactor area to ensure all areas are clean and sanitized daily x 1month, then daily x 2weeks, and then randomly monitored to ensure ongoing compliance. See attachment C1-C2.

Building Engineer and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Health & Wellness Director, Nurses/ LPN's, and med techs were educated on 11/8/2021 on regulation #2600.85a Sanitary Conditions, See attachment.

All glucometers were cleaned and re-calibrated to correct date and time on day of survey 11/4/2021.

Glucose logs were made for all residents. All glucose readings will be logged in the glucose log and Eldermark

Health & Wellness Director and/or designee will conduct audits of the glucometers, logs, and Eldermark weekly x 8 weeks, then weekly x 2 weeks, then randomly monitored to ensure ongoing compliance. See attachment.

Health & Wellness Director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 02/14/2022

85a - Sanitary Conditions (continued)**Document Submission****Implemented**

Building Engineer, maintenance manager, maintenance techs & housekeepers were educated on November 4, 2021. Moving forward the trash room will be cleaned and sanitized daily until a better compactor is identified, purchased and put in place.

Completion Date: 11/04/2021

85e - Trash Outside Home**1. Requirements**

2600.

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

Description of Violation

On 11/4/21, there is a very large dumpster present just off the loading dock that is overflowing with garbage, broken furniture, cardboard and other debris. There is an accumulation of cardboard and other various garbage that appears to have overflowed or fallen out of the dumpster, and is caught between the dumpster and the concrete loading dock. This large dumpster is uncovered. Staff report that this dumpster is here daily, is never covered, and is emptied only once a week. Additionally, there is smaller dumpster located to the left of the loading dock that is also overflowing with garbage in a way that it is preventing the lid of the dumpster from closing properly,

Plan of Correction**Accept**

Building Engineer, Maintenance manager, and maintenance techs were educated on 11/5/2021 on regulation #2600.85e on trash maintenance outside of home. See attachment D.

Area of citation was correct day of survey 11/4/2021.

Building Engineer and/or designee will audit large dumpster just off loading dock and surrounding area to ensure all areas are clean and free of debris daily x 1month and then randomly monitored to ensure ongoing compliance. See attachment D1.

Trash pickup will increase to 5days weekly. Large dumpster pick up will also increase to prevent overflow.

Building Engineer and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 01/17/2022

Document Submission**Implemented**

Building Engineer, maintenance manager, maintenance techs & housekeepers were educated on November 4, 2021.

Trash pick-up will increase to 6 days a week starting Dec 2021.

Completion Date: 11/04/2021

88a - Surfaces**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 11/4/21, at approximately 9:45am, the sliding doors leading to the balcony/patio area off the lobby on the first floor are in disrepair and do not lock properly. There is a piece of plastic sheeting that is pulling away from the bottom of the left door on the outside, which is causing tearing of the screen on the screen door.

88a - Surfaces (continued)

On 11/4/21, the laminate counter top around the sink in resident #6's room is damaged. The edges of the counter has peeled off exposing a rough wood surface.

On 11/4/21, in the main kitchen area, there is a large ceiling tile above the double fridge that is falling down and actually hitting the top surface of the fridge.

Plan of Correction**Accept**

Building Engineer, maintenance director, and maintenance techs were educated on 11/5/2021 on regulation #2600.88a on surface conditions being in good condition. See attachment E.

Building Engineer and/or designee will conduct audits of patio doors, screens, counter tops and ceiling tiles to ensure they are in good condition weekly x 1month, then monthly x 1month, then randomly monitored to ensure ongoing compliance. See attachment E1.

Building Engineer and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 02/14/2022

Document Submission**Implemented**

Repair of plastic sheet at bottom of door and screen will be completed Dec. 21, 2021 and the lock is more secured.

New locks ordered and will be installed by end of Jan 2022. Ceiling tile in kitchen repaired 11/5/2021 and laminate countertop replaced Dec 10, 2021. Maintenance team was educated on 11/15/2021.

Completion Date: 12/10/2021

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

Resident #2, #4, and #5 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction**Accept**

Health & wellness director, residential service director, maintenance director, and maintenance techs were educated on 11/5/2021 on regulation #2600.101j7 on access to lighting/ operable lamp at bedside of residents apartments. See attachment F.

Areas of citation were corrected day of survey 11/4/2021.

Health & wellness director and/or designee will conduct audits of operable lighting at bedside weekly x 1month, then weekly x 2 weeks, then randomly monitored to ensure ongoing compliance. See attachment F1.

Health & wellness director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 01/17/2022

Document Submission**Implemented**

#2 & #4 lamps were moved closer to bedside and #5 lamp was not plugged in but was reconnected day of survey. All apartments will be checked according to the audit tool to ensure lighting is operable at all times. Health/Wellness & maintenance employees were educated on 11/5/2021.

Completion Date: 11/05/2021

101j7 - Lighting/Operable Lamp (continued)

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.

Description of Violation

There is a triangular shaped hole in the wall under the light switch by the entrance to resident #6's bathroom. The hole is approximately 3 inches wide by 3 inches high and appears to have been made from the room door handle hitting the wall.

Plan of Correction

Accept

Building Engineer, maintenance director, and maintenance techs were educated on 11/5/2021 on regulation #2600.101o walls, floors and ceilings maintaining good repair. See attachment G.

Areas of citation were correct 11/8/2021.

Building Engineer and/or designee will conduct audits of bedroom floors, walls and ceilings to ensure they are in good condition daily x 1month, then weekly x 2 weeks, then randomly monitored to ensure ongoing compliance. See attachment G1.

Building Engineer and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 01/17/2022

Document Submission

Implemented

Building Engineer, maintenance manager and maintenance techs were educated on 11/5/2021 on timely repairs of damaged walls, ceilings and flooring/ carpeting. Repair to wall was completed Nov 8, 2021

Completion Date: 11/08/2021

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

On 11/4/21 at approximately 11:30am, a build up of rock salt that solidified on the threshold of the doorway, blocked egress from the home's emergency stairwell #3.

Plan of Correction

Accept

Building Engineer, Maintenance manager, and maintenance techs were educated on 11/5/2021 on regulation #2600.121a on Unobstructed Egress. See attachment H.

Area of citation was correct day of survey 11/4/2021.

Building Engineer and/or designee will audit all egresses to ensure all doors are unobstructed, clean and free of salt buildup and/ or debris daily x 1month, then weekly x 2weeks and then randomly monitored to ensure ongoing compliance. See attachment H1.

Building Engineer and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

121a - Unobstructed Egress (continued)**Completion Date:** 01/17/2022**Document Submission****Implemented**

Building Engineer and maintenance staff were educated on unobstructed egress from rooms and the building. Obstructed egress was corrected day of survey. Maintenance will check all egresses as described in POC to ensure areas are clean and free of debris.

Completion Date: 11/04/2021**144d - Smoking Outside****1. Requirements**

2600.

144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 11/4/21 at 10:45am, a staff person was smoking out back, on the homes loading dock/ dumpster area which is not the home's designated smoking area. The home's designated smoking area is located in the front of the building to the far left of front patio area.

Plan of Correction**Accept**

All employees where educated on 11/9/2021 on regulation #2600.144d Smoking permitted only in designated area. See attachment I.

Area of citation was correct day of survey 11/4/2021.

The Administrator and/or designee will place no smoking signs at the doors leading to the loading dock and dumpster area and randomly monitor to ensure ongoing compliance. See attachment I1-5.

The Administrator is responsible for ongoing compliance.

Results of the monitoring will be discussed via monthly QA process.

Completion Date: 01/17/2022**Document Submission****Implemented**

All employees were educated on 11/9 & again on 12/13/2021, for new employees, on the designated smoking area of the community. Signs were placed on the doors leading to the loading dock and the dumpster area. ED will monitor for ongoing compliance.

Completion Date: 12/13/2021**183f - Discontinued Medications****1. Requirements**

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

A bottle of [REDACTED] belonging to resident #7, were expired as of 5/2021 and were still present on the medication cart on 11/4/2021. This medication was not destroyed or removed from the cart in an appropriate manner.

Plan of Correction**Accept**

Health & Wellness Director, Nurses/ LPN's, and med techs where educated on 11/8/2021 on regulation #2600.183f

183f - Discontinued Medications (continued)

safely destroying Discontinued Medications. See attachment J.

Area of citation was corrected day of survey 11/4/2021.

Health & Wellness Director and/or designee will conduct audits of the med carts daily x 1 month, then weekly x 1 month, then randomly monitored to ensure ongoing compliance. See attachment J1-3.

Health & Wellness Director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 02/14/2022

Document Submission

Implemented

Discontinued medication was removed from the med cart day of survey and disposed of in a safe manner. Health & Wellness Director, Nurses, LPN's and Med Techs were educated, and carts will be audited to maintain ongoing compliance.

Completion Date: 11/08/2021

184a - Labeling OTC/CAM

1. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #8 is prescribed [redacted] tablets. The current order is to Take one tablet by mouth two times daily, however the directions on the medication bottle indicates to Take one by mouth daily with food and there is no change of directions notice on the medication package.

Resident #8 is prescribed [redacted] tablets. The current order is to Take one tablet by mouth in the morning, however the directions on the medication bottle indicates to Take one by mouth at bed time and there is no change of directions notice on the medication package.

Resident #8 is prescribed [redacted] capsules. The current order is to Take one tablet by mouth three times a day, and is scheduled for 9am, 3pm and 8pm, however the directions on the medication bottle indicates to Take one by mouth every 8 hours and there is no change of directions notice on the medication package

Plan of Correction

Accept

Health & Wellness Director, Nurses/ LPN's, and med techs where educated on 11/8/2021 on regulation #2600.184a Labeling OTC/ CAM. See attachment K.

Area of citation was corrected day of survey 11/4/2021.

Health & Wellness Director and/or designee will conduct audits of all prescription medications daily x 1 months, then weekly x 1 month, then randomly monitored to ensure ongoing compliance. See attachment K1-2.

Health & Wellness Director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 02/14/2022

184a - Labeling OTC/CAM (continued)

Document Submission**Implemented**

All labels were corrected day of survey. Med Techs and nurses were educated on administering the medications following the 5 rights of medication administration.

Completion Date: 11/08/2021

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 #8's glucometer is not calibrated to the correct time. Meter time is set to 10:25 am and the actual time is 11:29am

Resident #9's glucometer is not calibrated to the correct time. Meter time is set to 11:12am and the actual time is 11:50am

The following instances of glucose log recordings not matching the reading in the meter were observed:

Resident #1 has an order to check fasting blood sugar level daily at 9am.

- There is a glucose level of 124 recorded on residents glucose log on 11/01 at 9:47a, the corresponding reading in the residents glucometer is 144.
- There is a glucose level of 124 recorded on residents glucose log on 10/19 at 8:30am, the corresponding reading in the residents glucometer is 104.

Resident #2 has an order to check blood sugar daily- scheduled at 9am

- There is a reading of 105 on 10/13 at 8:17am recorded on residents glucose log, however the corresponding reading in residents glucometer is 103
- There is a reading of 134 on 10/02 at 8:35am recorded on residents glucose log, however the corresponding reading in residents glucometer is 125

Resident #8 has an order to have blood sugar checked twice a day.

- There is a reading of 271 on 10/18 at 1:08pm recorded on residents glucose log, however the corresponding reading in residents glucometer is 241
- There is a reading of 119 on 10/17 at 8:35am recorded on residents glucose log, however the corresponding reading in residents glucometer is 112
- There is a reading of 197 on 10/10 at 4:03pm recorded on residents glucose log, however the corresponding reading in residents glucometer is 191
- There is a reading of 189 on 10/06 at 4:02pm recorded on residents glucose log, however the corresponding reading in residents glucometer is 185

Resident #9 has an order to check blood sugar levels twice daily- scheduled for 9am and 5pm.

- There is a reading of 217 on 10/19 at 8:58am recorded on residents glucose log, however the corresponding reading in residents glucometer is 172
- There is a reading of 113 on 10/7 at 8:41am recorded on residents glucose log, however the corresponding reading in residents glucometer is 118

185a - Implement Storage Procedures (continued)

Resident #10 has an order to check blood sugar level three times a day at 8am, 12pm and 4pm.

- There is a glucose level of 264 recorded on residents glucose log on 10/26 at 9:00a, the corresponding reading in the residents glucometer is 255.
- There is a glucose level of 151 recorded on residents glucose log on 10/08 at 8:56am, the corresponding reading in the residents glucometer is 149.
- There is a glucose level of 0 (resident listed as out of community) recorded on residents glucose log on 10/07 at 12:00pm, the corresponding reading in the residents glucometer is 278.
- There is a glucose level of 191 recorded on residents glucose log on 10/05 at 8:59am, the corresponding reading in the residents glucometer is 236.

Plan of Correction**Accept**

Health & Wellness Director, Nurses/ LPN's, and med techs were educated on 11/8/2021 on regulation #2600.85a Sanitary Conditions, #2600.185a Implement Storage Procedures, and 2600.187d Follow Prescriber's Orders. See attachment L.

All glucometers were cleaned and re calibrated to correct date and time on day of survey 11/4/2021.

Glucose logs were made for all residents. All glucose readings will be logged in the glucose log and Eldermark Health & Wellness Director and/or designee will conduct audits of the glucometers, med logs, and Eldermark weekly x 8 weeks, then weekly x 2 weeks, then randomly monitored to ensure ongoing compliance. See attachment L1-3.

Health & Wellness Director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process

Completion Date: 02/14/2022

Document Submission**Implemented**

All glucometers were cleaned and re calibrated, and glucose logs were made for all residents. Reading will be documented in glucose logs and the medical tracking system, Eldermark. Readings will be monitored for ongoing compliance.

Completion Date: 11/08/2021

187d - Follow Prescriber's Orders**1. Requirements**

2600.

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

Description of Violation

Resident #11 has an order to have [REDACTED] daily for supplement. This supplement was not administered as ordered to resident on dates 10/2, 10/3, 10/9, 10/10, 10/16, 10/17, 10/23, 10/24, 10/30 and 10/31.

The following instances of glucometer checks not being completed according to physician's orders were observed on 11/4/21 during inspection:

Resident #1 has an order to check fasting blood sugar level daily at 9am

- There is a glucose level of 147 recorded on residents glucose log on 10/25 at 10:09am, however there is no corresponding reading in the residents glucometer.

Resident #2 has an order to check blood sugar daily- scheduled at 9am

- On 11/02 at 8:17am there is a reading of 144 recorded on residents glucose log, there is no corresponding

187d - Follow Prescriber's Orders (continued)

reading in residents glucometer.

- *On 11/01 at 9:48am there is a reading of 155 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/25 at 10:11am there is a reading of 119 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/10 at 9:55am there is a reading of 118 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/04 at 11:31am there is a reading of 114 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*

Resident #9 has an order to check blood sugar levels twice daily- scheduled for 9am and 5pm

- *On 11/01 at 9:52am there is a reading of 108 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/31 at 5:51pm there is a reading of 140 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/30 at 5:31pm there is a reading of 140 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/29 at 5:38pm there is a reading of 144 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*
- *On 10/29 at 9:54am there is a reading of 125 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*

Resident #10 has an order to check blood sugar level three times a day at 8am, 12pm and 4pm.

- *On 10/18 at 8:00 am there is a reading of 252 recorded on residents glucose log, there is no corresponding reading in residents glucometer.*

Plan of Correction**Accept**

Health & Wellness Director, Nurses/ LPN's, and med techs were educated on 11/8/2021 on regulation #2600.85a Sanitary Conditions, #2600.185a Implement Storage Procedures, and 2600.187d Follow Prescriber's Orders. See attachment L.

All glucometers were cleaned and re calibrated to correct date and time on day of survey 11/4/2021.

Glucose logs were made for all residents. All glucose readings will be logged in the glucose log and Eldermark Health & Wellness Director and/or designee will conduct audits of the glucometers, med logs, and Eldermark weekly x 8 weeks, then weekly x 2 weeks, then randomly monitored to ensure ongoing compliance. See attachment L1-3.

Health & Wellness Director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process

Completion Date: 02/14/2022

Document Submission**Implemented**

Health & Wellness Director, Nurses, LPN's and med techs were educated on the importance of following the doctor's orders when administering medications and maintaining proper documentation. Glucometers, med logs and Eldermark will be audited to maintain ongoing compliance.

Completion Date: 11/08/2021

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 #10 participated in the development of his/her support plan on [REDACTED]. However, the resident did not sign the support plan.

Plan of Correction

Accept

Health & Wellness Director, Nurses/ LPN's, were educated on 11/8/2021 on regulation #2600.227g Support Plan Signatures of all participants. See attachment M.

Area of citation was corrected day of survey 11/4/2021.

Health & Wellness Director and/or designee will conduct audits of residents charts for completion and signature, 10 per week x 10 weeks, then randomly to ensure ongoing compliance. See attachment M1-10.

Health & Wellness Director and/or designee is responsible for ongoing compliance.

Results of the audit will be reviewed via monthly QA process.

Completion Date: 02/14/2022

Document Submission

Implemented

Health/Wellness director, Nurses/ LPN's were educated on 11/8/2021 to make sure all support plans are dated and signed by residents and other participants present. Signature correct day of survey. Will monitor to ensure compliance.

Completion Date: 12/08/2021