Department of Human Services
Bureau of Human Service Licensing

December 28, 2021

[redacted], NHA
[redacted]

RE: MON VALLEY CARE CENTER
200 STOOPS DRIVE
MONONGAHELA, PA, 15063
LICENSE/COC#: 41816

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/08/2021, 11/09/2021, 11/12/2021 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: *MON VALLEY CARE CENTER* **License #:** *41816* **License Expiration:** *02/27/2022*

Address: *200 STOOPS DRIVE, MONONGAHELA, PA 15063*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-1* **Date:** *11/14/2002* **Issued By:** *PA Dept of Health*

Type: *Other* **Date:** *11/18/2002* **Issued By:** *Carroll Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *54* **Waking Staff:** *41*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *11/12/2021*

Inspection Dates and Department Representative

11/08/2021 - On-Site: [redacted]

11/09/2021 - On-Site: [redacted]

11/12/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *41* **Residents Served:** *35*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *35*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *19* **Have Physical Disability:** *1*

Inspection Dates and Department Representative *(continued)*

Inspections / Reviews

11/08/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/17/2021*

11/08/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/20/2021*

12/21/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/26/2021*

12/28/2021 - Document Submission

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 11/8/21 at 11:12 p.m., there was a purple binder labeled "Narcotic Accountability" setting on a table, unattended and accessible, in the Activities/Dining room with narcotic count sheets on which were written resident names and medications to include:

** Resident #1 –* [redacted]
** Resident #2 –* [redacted]
** Resident # 3 –* [redacted]
** Resident #4 –* [redacted]

On 11/8/21 at 11:15 a.m., the following binders with resident information were, unattended and accessible, on an approximately 3' high blue linen cart near the windows in the Activities/Dining Room:

** A white binder labeled "Insulin sign off sheets" which included individual count sheets used to log the amount of insulin remaining for residents to include: resident #5,* [redacted]*, 10/19/21; resident #6,* [redacted]*, 10/19/21; resident #7,* [redacted]*, 10/19/21.*

** A blue binder labeled "Communication Binder PCH" which included ongoing resident notes to include:*

"... from OSTPA was here for resident #8. [redacted] *is ordering wound care supplies for* [redacted]

"Resident #7 will be discharged to rehab in [redacted]*.* [redacted] *is not holding* [redacted] *bed."*

"Resident #9 ringing constantly for bed pan and then not going – Yelling at us that [redacted] *pays our bills and we have to do whatever* [redacted] *says – will not stop ringing."*

On 11/8/21 at 11:28 a.m., the third floor Personal Care Coordinator's office was unlocked and unattended. Located in the office are lateral files containing all of the home's residents' records to include:

**Resident #10's COVID vaccination card, Face Sheet that includes social security number, date of birth, insurance information and diagnoses, COVID test results, Preadmission Screening, Documentation of Medical Evaluation, Resident Assessment-Support Plan (RASP)*

**Resident #11's Monongahela Valley Hospital three-page Consultation Record and Monongahela Valley Hospital six-page History and Physical*

Plan of Correction ***Accept***

Binders removed from accessible area immediately. Staff educated on resident confidentiality. Administrator will ensure staff is following proper procedure. Administrator will audit to ensure confidential material is secured and non accessible to non authorized personnel.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

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Completion Date: *12/14/2021*

25a - Written Contract and Review

1. Requirements

25a - Written Contract and Review *(continued)*

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

The Admission Agreement for resident #12 completed [redacted] does not include the Base Fee for room and board accommodations. This line is blank.

Plan of Correction ***Do Not Accept***

After designated person completes contract the Administrator will review that the document is filled out in it's entirety. Administrator will educate responsible employee on completion of contract. Administrator will audit contracts to ensure it's completion.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Resident #12's admission agreement was updated on [redacted] to include base fee. Administrator discussed form with resident and resident signed and dated acknowledged base fee. Administrator will do audit of all current resident contracts to ensure all areas are documented completely by 1/4/22. Going forward Administrator will do thorough review of document at time of admission to ensure all areas are completed.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See attached copy of updated agreement including base fee and signatures

Completion Date: *12/14/2021*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The Admission Agreement for resident #10 completed [redacted] was not signed by the resident.

Plan of Correction ***Do Not Accept***

After designated employee completes Admission Agreement the Administrator will review the document is signed by the appropriate party/parties. Administrator will educate responsible employee on completion of agreement. Administrator will audit for completion.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Administrator discussed contract again with resident #10 and contract was updated with resident's signature on 12/14/21. Administrator will audit all current resident contracts to make sure they are all signed by 1/4/22. Going forward Administrator will do thorough review of new contracts at time of admission to ensure all areas requiring signatures are signed.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See attached updated resident agreement

Completion Date: *12/14/2021*

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:
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person A, hired [redacted], did not receive training in telephone use and notification of emergency services prior to or during his/her first day of work.

Direct care staff person B, hired [redacted], did not receive training in telephone use and notification of emergency services prior to or during his/her first day of work.

Ancillary staff person C, hired [redacted], did not receive training in telephone use and notification of emergency services prior to or during his/her first day of work.

Plan of Correction ***Do Not Accept***

All current staff will receive in service training on telephone usage and how to contact emergency services. HR will educate all new hires during general orientation.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Staff persons A,B and C received training on telephone use and notification of emergency services on [redacted] HR will audit all current employee files to ensure staff had training by [redacted]. HR will include this training going forward for all new hires as part of orientation.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

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Completion Date: *12/14/2021*

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:
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 [redacted], has provided unsupervised direct care services to residents on multiple dates to include: 10/27/21, 10/29/21, 10/30/21, 10/31/21, 11/1/21 and 11/3/21. However, direct care staff person A did not successfully complete and pass the Department-approved direct care training course and competency test until 11/8/21.

Plan of Correction ***Do Not Accept***

Staff will be educated on requirements for unsupervised direct patient care. Trainee will complete PCH training checklist and Department competency test prior to unsupervised care. Administrator will keep documentation and audit training competency and certificate of completion of test.

Completion Date: *01/04/2022*

65d - Initial Direct Care Training *(continued)*

Plan of Correction ***Accept***

Staff person A took the Department approved training course and successfully completed the test on 11/8/21. Administrator will review all current employee files by 1/4/22 to ensure all employees have completed the Department approved training and test. Administrator will make a checklist of tasks that are to be completed for new hires prior to providing unsupervised care and keep documentation.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See attached for Staff Person A completion certificate. Additionally included is new hire competency checklist to be used by administrator going forward.

Completion Date: *12/17/2021*

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 11/12/21 at 1:00 p.m. the home did not have documentation that the following staff persons received training in emergency medical plan and reporting of reportable incidents and conditions within 40 scheduled working hours:

** Direct care staff person A, hired* [redacted]

** Direct care staff person B, hired* [redacted]

** Ancillary staff person C, hired* [redacted]

Plan of Correction ***Do Not Accept***

Administrator will educate during department orientation the emergency medical plan to include hospital or health care to use in emergency. Administrator will ensure staff know who to contact and how to contact in an emergency. Administrator will educate staff on reportable incidents on orientation.

Completion Date: *01/04/2022*

Plan of Correction ***Directed***

Staff persons A, B and C were trained on emergency medical plan and reporting reportable incidents 12/14/21. Going forward the Administrator or Department head will see that new hires receive this required training within the 40 scheduled working hours and keep documentation.

DIRECTED

Within five calendar day of receipt of the plan of correction: The administrator shall create a system to document all staff training which includes all components of Regulation 2600.65(i). 12/21/21 JK

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. Administrator has created a training log workbook to document all staff training received.

Completion Date: *12/23/2021*

82c - Locking Poisonous Materials

1. Requirements

2600.

82c - Locking Poisonous Materials *(continued)*

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 11/8/21 at approximately 10:50 a.m., in the bathroom in resident #10's room, there was a denture cleaner tablet in foil wrapper setting on the sink and a box of Efferdent denture cleaner in a drawer that was slightly open. The box of Efferdent had a warning that indicates "in case of accidental ingestion, seek professional assistance or contact the Poison control Center right away. Resident #10 indicated that he did not know for what the box of foil packets was used.

On 11/8/21 at 11:50 a.m., the following items were in the unlocked third floor laundry room:
** A 20oz spray bottle of yellow Peroxide Multi-surface Cleaner and disinfectant with warning: If in eyes: Hold eye open and rinse slowly and gently . . . Call poison control center or doctor for treatment advice.*
If inhaled, move to fresh air . . . call 911 . . . Call a Poison Control Center or doctor for further advice.
** A nearly full 75 fluid oz bottle of Gain laundry detergent with warning: Eye irritant. Harmful if swallowed. Keep out of reach of children. In case of eye contact, flush with water. If swallowed, drink a glass of water. In either case, call a physician.*

Resident #10's medical evaluation completed [redacted] does not indicate that resident can safely use or avoid poisonous materials.

Plan of Correction ***Do Not Accept***

Laundry room was locked immediately. Staff was educated on importance of keeping laundry room with poisonous materials locked for patient safety. Administrator will monitor staff is following procedure. Administrator will audit DME's for completion and educate responsible employee of completion of DME.
Completion Date: *01/04/2022*

Plan of Correction ***Directed***

Denture cleaner was removed from Resident's room immediately, along with anything marked poisonous and stored for safe keeping. Staff will routinely monitor resident does not have anything in room that is harmful if ingested. Number for poison control also posted by phone in case of an emergency.

DIRECTED
Within five calendar day of receipt of the plan of correction: The administrator shall complete a weekly audit of the home to ensure poisonous materials are kept locked and inaccessible to residents. 12/21/21 JK
Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. Weekly poison control audit conducted on 12/22/21 and will be continued weekly going forward.
Completion Date: *12/22/2021*

96a - First Aid Kit

1. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 11/8/21 at 12:23 p.m., the first aid kit located in the unlocked linen/shower room did not include the following items: adhesive bandages, thermometer, adhesive tape, eye coverings or tweezers.

96a - First Aid Kit *(continued)*

Plan of Correction ***Accept***

List of items to be contained in first aid kit will be listed inside kit. Staff to check daily all items are included. Administrator will audit staff is completing task.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. New correct first aid kits obtained, checklist developed to ensure staff maintain kits properly.

Completion Date: *12/23/2021*

103e - Left Overs

1. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 11/8/21 at 12:10 p.m., the following unlabeled, undated items were in the refrigerator/freezer in the third floor pantry:

** A round, black and clear to-go container with 2 slices of leftover pizza.*

** Two clear plastic containers with red lids that contained slices of what was identified by staff as cheesecake.*

** A rectangular container with blue lid which contained 2 slices of cheesecake.*

On 11/8/21 at 12:15 p.m., there was an undated clear six-pack cupcake container containing one Halloween cupcake in an upper cabinet to the right of the refrigerator/freezer in the 3rd floor pantry.

Plan of Correction ***Accept***

Fridge was checked and items removed immediately. Staff educated on labeling and dating food. Staff will check fridge and pantry daily for proper labeling and dispose of expired or unlabeled items and sign off that check was completed. Administrator will audit staff is completing task.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. Food Safety checklist developed and posted to encourage staff to ensure proper food handling techniques are utilized.

Completion Date: *12/23/2021*

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 11/8/21 at 12:17 p.m., there were mesh banners with the word "STOP" in the middle of the banner hanging across the door frame approximately 4 feet off the floor at each of the three third-floor stairwell exits. The banners were fastened to the walls beside the door frames with Command Strip hooks.

Plan of Correction ***Accept***

Mesh banners removed immediately. Staff educated that doorways can not be obstructed to immediate use in event of emergency. Administrator will monitor hallways and doorways are free from obstruction.

Completion Date: *01/04/2022*

121a - Unobstructed Egress *(continued)*

Document Submission ***Implemented***

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Completion Date: *12/14/2021*

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 11/8/21, at 10:30 a.m., there was an unlocked, unattended medication cart with drawers labeled "north 8am", "8p, 4pm" and "6am, North PRNs" setting along the wall near the telephone outside of the dining/activities area. The cart included blister packs of medication with pharmacy labels to include:

** Resident #6's* [redacted]
** Resident #9's* [redacted]
** Resident #12's* [redacted]
** Resident #14's* [redacted]

Plan of Correction ***Accept***

Staff was corrected on non compliance. Carts locked immediately. Staff educated on safety and confidentiality of residents. Administrator will ensure staff is following proper procedure.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

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Completion Date: *12/14/2021*

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:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #5 is ordered [redacted] *– take 1 tablet 2 times daily. However, the pharmacy label for this medication indicates* [redacted] *– Take 1 tablet orally twice per day for 30 days.*

Resident #10 is ordered [redacted] *– take one tablet by mouth daily. However, the pharmacy label for this medication indicates* [redacted] *– take one tablet by mouth nightly. The resident's November 2021 medication administration record indicates that this medication is administered at 8:00 a.m.*

Resident #13 is ordered [redacted] *– 17gm by mouth daily as needed. However, the pharmacy label for this medication indicated Clearlax powder* [redacted] *– Mix 17 grams (one capful) into 8oz of beverage of choice and take by mouth daily.*

Plan of Correction ***Do Not Accept***

Administrator notified pharmacy. Directions changed label placed on bottles. Staff will review that pharmacy

184a - Labeling OTC/CAM (continued)

label matches MAR and make corrections if needed. Administrator will observe med pass to ensure staff is reading labels. Administrator will audit meds and mar.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Administrator addressed the labeling immediately and checked charts for orders. Resident's were not harmed by pharmacy mislabeling. Administrator will do MAR and medication audit monthly to ensure MAR and labels match.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

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Completion Date: *12/14/2021*

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #5 is ordered [redacted] (U-100) insulin coverage before meals as follows: 150-200 Give 2 units, 201-250: 4 units, 251-300: 6 units, 301-350: 8 units, 351-400: 10 units and call MD over 400. On 11/9/21 at 8:43 a.m. (7:43 a.m. after daylight savings time adjustment) the reading in the resident's glucometer was 165 requiring 2 units of insulin be administered. However, the entry on the resident's November 2021 medication administration record (MAR) for this reading was 149 and therefore, zero units of insulin were administered.

Resident #13 is ordered digoxin 0.125mgtablet – 1 tablet by mouth daily for AFib. However, this medication was not available and not administered at 8:00 a.m. on the following dates: 11/3/21, 11/4/21, 11/8/21 and 11/9/21.

Plan of Correction ***Do Not Accept***

Administrator will ensure Diabetic Training is done by CDE [Certified Diabetic Educator]. Administrator will educate staff on reading glucometer and documenting Blood Glucose and administering med per MD order. Administrator will educate staff on procedure for contacting MD and reordering medication when running low.

Completion Date: *01/04/2022*

Plan of Correction ***Directed***

Resident #5 was assessed by Administrator upon notification and experienced no side effects or any s/s of hypo/hyperglycemia.
Resident #13 Administrator notified Physician and Hospice that resident missed doses. Resident was assessed and experienced no side effects from missing doses. Administrator will have training for staff on medication administration and notifying MD on missed medications.

DIRECTED
Within five calendar day of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall observe each staff person, qualified to administer medications, administer medications once a week for two months to ensure the home's policies and procedures are followed. 12/21/21 JK

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. Administrator began observing med pass on 12/22/21. Additionally, administrator obtained med

187d - Follow Prescriber's Orders (continued)

pass checklist from pharmacy that will be utilized going forward.

Completion Date: *12/23/2021*

190b - Insulin Injections

1. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person D who has passed the Department approved medications administration course, received diabetic training on 8/31/21. However, the home does not have documentation that the individual who provided the diabetic training is a Certified Diabetic Educator. Staff person D administered insulin to resident #5 on the following dates at 4:30 p.m.: 11/1/21 – 11/4/21 and 11/6/21 – 11/8/21.

Plan of Correction ***Do Not Accept***

Administrator will ensure Diabetic training is done by qualified diabetic educator with certificate. Administrator will review proper documentation prior to training.

Completion Date: *01/04/2022*

Plan of Correction ***Directed***

Resident #5 was unharmed by this violation. Administrator is scheduling diabetic training by a Certified Diabetic Educator asap. Administrator will keep record of Educators certification and documentation staff completed required training. Administrator will keep schedule of all responsible employees renewal date for continued Diabetic training.

DIRECTED
Within five calendar day of receipt of the plan of correction: The administrator shall review all staff records to ensure any staff administering medications including insulin medications is qualified to administer such medications.
12/21/21 JK

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. Administrator reviewed staff training records, and insulin training was conducted on 12/23/21 for all staff required. Have not received completion certificates yet, however including photos of trainers credentials.

Completion Date: *12/23/2021*

224a - Preadmission Screen Form

1. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #12's preadmission screening, completed [redacted], does not indicate that the needs of the resident can by met by the home. This area is blank.

Plan of Correction ***Do Not Accept***

Administrator will educate responsible employee on completion of screening. Administrator will review screenings

224a - Preadmission Screen Form (continued)

to check for completion.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Resident #12's pre admission screening was updated to include home can meet the needs of resident. Administrator discussed form with resident and resident acknowledged its content 12/14/21. Administrator will do audit of all current resident charts to ensure pre admission screenings are completed properly.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See attached corrected form

Completion Date: *12/14/2021*

251b - Record Entries Legible

1. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used to correct the date on page 1/12 and to correct the assessor's title on page 12/12 of resident #12's assessment and support plan completed [redacted].

Plan of Correction ***Do Not Accept***

Administrator will educate responsible employees on documentation and the procedure for proper error correction.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Administrator using new pages re wrote page 1/12 and 12/12 on resident #12's assessment and support plan. Reviewed pages with resident who acknowledged the update with signature and date. Administrator will audit all current residents assessments and support plans to ensure corrective fluid was not used and make any corrections.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See Attached. Administrator corrected appropriate pages

Completion Date: *12/14/2021*

141a - Medical Evaluation

1. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The only medical evaluation (DME) that the home has for resident #5, admitted [redacted], *was completed on* [redacted]
The DME does not include the medical professional's name or license number. These areas are blank.

REPEAT VIOLATION 1/6/21

141a - Medical Evaluation *(continued)*

Plan of Correction ***Do Not Accept***

Administrator will educate responsible employee on completion of DME. Administrator will audit and review DME is filled out with all the required information. Administrator will have checklist on required time frames of completion of medical evaluations.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Administrator had new DME completed on resident #5. Administrator will audit all current resident charts to ensure DME's are up to date. Administrator will make a chart for all residents with their annual medical evaluation dates and keep record of completion.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

Corrected

Completion Date: *12/14/2021*

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

The most recent medical evaluation (DME) for resident #13, admitted [redacted], was completed [redacted]. T he resident's previous DME was completed 12/17/18.

Repeat violation 1/6/21

Plan of Correction ***Do Not Accept***

Administrator will review charts and make calendar of annual DME due dates. Administrator will audit completion of annual evaluations and ensure all required information in on DME.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Administrator had new DME completed on resident # 13. Administer will audit all current resident charts to ensure DME's are up to date. Administrator will make chart to track residents annual medical evaluation due dates and keep record of completion.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

.

Completion Date: *12/14/2021*

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #5 is ordered [redacted] (U-100) insulin coverage before meals as follows: 150-200 Give 2 units, 201-250: 4 units, 251-300: 6 units, 301-350: 8 units, 351-400: 10 units and call MD over 400. According to the readings in the resident's glucometer, the incorrect blood glucose readings were entered on the resident's November 2021 medication administration record (MAR) as follows:

** 11/2/21 7:30 a.m. MAR entry is 163, however the glucometer reading on 11-2 at 8:06 a.m. was 179*

** 11/4/21 7:30 a.m. MAR entry is 123, however the glucometer reading on 11-4 at 7:51 a.m. was 110*

** 11/9/21 7:30 a.m. MAR entry is 149, however the glucometer reading on 11-9 at 8:43 a.m. (7:43 a.m. after daylight savings time adjustment) was 165*

REPEAT VIOLATION 10/19/19

Plan of Correction ***Do Not Accept***

Administrator will ensure Diabetic Training is done be CDE. Administrator will educate staff on reading glucometer and documenting results and administrating medication per MD order.

Completion Date: *01/04/2022*

Plan of Correction ***Accept***

Resident #5 was assessed upon notification and noted resident was unharmed by this violation and experienced no ill side effects. Administrator will do weekly checks of all glucometer machines to ensure MAR documentation is the same as meter.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

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Completion Date: *12/14/2021*

225a - Assessment 15 Days

1. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

The initial assessment for resident #5, admitted [redacted] was completed on [redacted]

The initial assessment for resident #10, admitted [redacted], was completed on [redacted]

The initial assessment for resident #12, completed [redacted], does not include the following diagnoses as indicated on the resident's medical evaluation completed [redacted]: history of [redacted],

REPEAT VIOLATION 1/6/21

Plan of Correction ***Do Not Accept***

Administrator will make admission checklist with required time frames of completion. Administrator will audit and review RASPS are completed properly and contain pertinent information from the DME.

Completion Date: *01/04/2022*

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept***

Administrator reviewed initial assessments on Residents #5, #10 and #12. Administrator updated Resident #12's initial assessment to include the diagnoses as indicated on DME and reviewed with resident who acknowledged by signing and dating 12/14/21. Administrator will audit all current residents initial assessments and support plans to ensure they were done correctly. Going forward Administrator will have a checklist attached to admission packet stating requirements and deadlines for completion and keep documentation that tasks were completed.

Completion Date: *01/04/2022*

Document Submission ***Implemented***

See attached. Resident #12's assessment has been updated. Administrator also has a pre admission checklist to use going forward with new admisions.

Completion Date: *12/14/2021*