Department of Human Services
Bureau of Human Service Licensing

July 15, 2022

[redacted], VICE PRESIDENT/TREASURER
[redacted]

RE: CELEBRATION VILLA OF CHIPPEWA
104 PAPPAN BUSINESS DRIVE
BEAVER FALLS, PA, 15010
LICENSE/COC#: 44901

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/14/2021, 12/14/2021 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 - PUBLIC

Facility Information

Name: *CELEBRATION VILLA OF CHIPPEWA* **License #**: *44901* **License Expiration**: *05/05/2022*

Address: *104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010*

County: *BEAVER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *EC OPCO CHIPPEWA LLC*

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/22/1999* **Issued By**: *Dept. of L &I*

Type: *I-2* **Date**: *03/28/2011* **Issued By**: *Chippewa Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/07/2022*

Inspection Dates and Department Representative

12/14/2021 - On-Site: [redacted]

12/14/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *46*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *20* **Residents Served**: *18*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *25* **Have Physical Disability**: *0*

Inspections / Reviews

12/14/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/31/2022*

02/14/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/22/2022*

03/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/15/2022*

07/15/2022 - Document Submission

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

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 Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close-proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The home has multiple fossil fuel burning devices, including the following:

- *At 11:45 a.m. two gas hot water tanks were located in the utility room; however, a carbon monoxide detector was approximately 8 feet from the device.*
- *At 11:55 a.m., gas furnace #6 was located in the attic crawl space; however, the carbon monoxide detector was approximately 8 feet from the furnace and was not operable.*
- *At 12:00 p.m., gas furnaces #1 through #5 and #7 through #10 were located in the attic crawl space; however, the carbon monoxide detectors were approximately 10 feet from each furnace.*

Plan of Correction ***Accept***

On day of inspection 12-14-22 The Carbon Monoxide Alarms were fixed to support the Carbon Monoxide Alarms Standards Act by the Maintenance director while the state inspectors still onsite and both inspectors shown the correction.
The Maintenance Director Created a Map (attached) to show Where all the Alarms and Air handlers are to be located to ensure they are 15 feet or more away from the devices.
Training: Administrator re-educated leadership on 1-21-22on regulation 2600 .18 and Carbon Monoxide alarm standard. (attached).
Moving forward the Maintenance Director or designee will monitor for compliance quarterly to ensure all CO2 detectors are in the appropriate spots 15 feet or further away from fuel source.

Completion Date: *01/21/2022*

Document Submission ***Implemented***

all completed attachments added

42d - Home Rules

1. Requirements

2600.
42.d. A resident shall be informed of the rules of the home and given 30 days' written notice prior to the effective date of a new home rule.

Description of Violation

The home's resident handbook, dated June 2018, indicates, "The use of e-cigarettes, vaporizers, and smoking of tobacco or other substances, using any form of inhalation device, is NOT PERMITTED in your unit, or in any area within the building or community property. This policy applies to all residents, families, visitors, and associates." However, multiple residents, including resident #1, resident #2, resident #3, resident #4, and resident #5 were notified in writing in their resident agreement upon admission to the home, that the home's smoking policy indicates residents are permitted to smoke in designated smoking areas. Multiple residents, including resident #6, resident #7, and resident #8, were not given a written notice of the change in home rules.

42d - Home Rules *(continued)*

Plan of Correction ***Accept***

On December 16, 2021 A letter was sent to all current residents and families addressing the new smoking policy and a copy of the new smoking policy was signed by all resident and families. (attached). Administrator addressed the new smoking policy at resident counsel on 12-28-21 (attached) and will address in January's resident council meeting.
12-21-21 Administrator educated all staff on new Smoking policy and regulation 42d on 30 day written notice needed if any house change to house rules. (training attached).
Moving forward all residents and families will be notified in writing at a minimum 30 days prior to a change in house rules. The Administrator or designee will monitor for compliance.

Completion Date: *01/10/2022*

Document Submission ***Implemented***

all residents have signed the new smoking policy all families have been notified and all staff have been trained.

82a - Poisonous Materials

1. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 12/14/21 at 11:25 a.m., there was an unlabeled 800ml spray container, approximately 3/4 full of a yellow liquid, in the secure dementia care unit's (SDCU) cleaning supply closet. Staff indicated the liquid is a cleaning product.

On 12/14/21 at 12:16 p.m., there were (2) unlabeled 800 ml spray containers in the main kitchen supply closet:

- *The liquid in one bottle was clear, and staff indicated the liquid is a cleaning product.*
- *The liquid in the second bottle was blue, and staff indicated the liquid is Windex window cleaner. Original product labeling at the home says contact poison control if swallowed.*

Plan of Correction ***Accept***

Day of inspection unlabeled bottle was removed and disposed of by Maintenance Director in front of Inspector.
Training 12-21-21 Administrator reviewed regulation 82a with all staff (attached) Administrator discussed storage of all chemicals and how all chemicals in the building must have a label on the bottle to be used..
Maintenance Director or designee will walk community daily to monitor for compliance to ensure all chemical stored properly and labeled correctly.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

training was completed on 12/21/21 maintenance man walks the building daily.

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

85a - Sanitary Conditions *(continued)*

Description of Violation

On 12/14/21 at 11:31 a.m., there were no paper towels, mechanical blower, individual cloth towels or other sanitary means of hand drying in the common bathroom in the SDCU's resident lounge.

Plan of Correction ***Accept***

12/14/21 Paper towel dispenser installed in common area bathroom in SDCU by maintenance director.
12-21 -21 Administrator educated all staff meeting on regulation 85a with emphasis on all common bathrooms must have disposable paper towels.
Maintenance Director and or designee will monitor community daily to ensure sanitary conditions maintained with a focus on common bathrooms.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

The bathroom was set up for use. Housekeeping and maintenance check daily to make sure all proper items are in place. The papertowel dispenser was added and staff were trained.

85d - Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 12/14/21 at 11:24 a.m., there was a 1/3 full, uncovered, unattended black plastic garbage can in the SDCU's kitchen.

On 12/14/21, at 11:31 a.m. there was no trash receptacle in the common bathroom of the SDCU's resident lounge.

Plan of Correction ***Accept***

12-14-21 SDCU Kitchen Trash can without the proper lid was removed and a trash can was placed in the common bathroom in SDCU's resident lounge. 12-19-21 New SDCU kitchen trash can with lid was obtain and placed in kitchen.
12-21-21 Administrator educated all staff on regulation 85d Kitchen and common bathrooms must have trash can with lids.
The maintenance Director and or designee will monitor kitchen and common bathrooms for compliance.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

a new trash can was purchased on 12/19/21 a trash can was placed in the bathroom immediately and staff were trained.

86b - Bathroom

1. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

86b - Bathroom *(continued)*

Description of Violation

On 12/14/21, multiple bathrooms in the home's SDCU did not have an operable window or exhaust fan for ventilation, to include the following:

- *the common bathroom in the resident lounge*
- *resident #7's private bathroom*
- *resident #8's private bathroom*

Plan of Correction ***Accept***

All exhaust fans were replaced by 12-18-21 in SDCU Bathroom and resident 7 and 8 bathrooms by maintenance director. A full inspection of all other exhaust fans throughout the building were inspected and replaced if needed.
12-21-21 administrator educated all staff on regulation 86b. Bathrooms must have operating exhaust fans in bathrooms and process in who/how to report if find any issues with exhaust fans.
Maintenance Director, Housekeeper and or designee will monitor all bathrooms weekly for proper operational exhaust fans.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

Exhaust fans were checked and replaced. staff were all trained and maintenance and housekeeping check daily in bathrooms

102h - Toilet Paper

1. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 12/14/21, at 11:31 a.m. there was no toilet paper available in the common bathroom located in the SDCU's resident lounge.

Plan of Correction ***Accept***

12-14-21 toilet paper put in Common bathroom in SDCU
12-21-21 Administrator educated all staff on regulation .102a every bathroom to have toilet paper.
Housekeepers and or designee will monitor bathrooms daily to ensure to toilet paper available in all bathrooms.
Maintenance Director will oversee Housekeeping.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

12/24/21 replaced toilet paper trained all staff and housekeeping

103f - Refrigerator/Freezer Temps

1. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f - Refrigerator/Freezer Temps *(continued)*

Description of Violation

On 12/14/21 at 11:25 a.m., the temperature in the SDCU's kitchen refrigerator was 50 degrees Fahrenheit and at 3:15 p.m. it was 42 degrees Fahrenheit.

Plan of Correction ***Accept***

12-14-21 Day of inspection while inspector in community the SDCU refrigerator was emptied and unplugged. The Maintenance Director cleaned refrigerator and plugged it back in on 12-16-21. The temperature was turned down and set to 38 degrees. From the Dec 15- Dec 31st the temperatures were monitored 2 time a day to ensure it maintained below 40 degrees.
12-21-21 administrator educated all staff on regulation .103b Refrigerator and freezer temperature and how to report if the temps go above 40 degrees.
The Maintenance Director, Dietary Director and or designee will monitor refrigerator temperature daily to ensure proper temperature is maintained.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

temps are checked twice a day. everyone was educated.

141a 1-10 Medical Evaluation Information

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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #10's most recent medical evaluation, dated [redacted], does not indicate the resident's ability to self-administer medications. This area of the form is blank.

Plan of Correction ***Directed***

12-14-21 DME for resident 10 was update. (attached). A full audit of all current resident DME were conducted by the Director of Nursing and the Assistant Director of Nursing to ensure all DME are completed in entirety. This was completed by Jan 12,2022.
Training: Administrator reeducate nurses and leadership team on Regulation .141a and will discuss during Nursing Quality Assurance meetings.
Moving forward Nursing Director and or designee will monitor all new DME are completed in entirety weekly for 3 months (starting week of 2/14/22 and ending 5/14/22) then monthly after. This will be done at weekly DON Meeting and documented on the DON report. First documentation will be on 2/17/22 DON report. (attached).

141a 1-10 Medical Evaluation Information (continued)

Then it will be documented on our Month Quality Assurance Program meeting report. (attached).

(Directed) *Resident #10 will have a medical evaluation completed or updated by a physician, physician's assistant or certified registered nurse practitioner.* ***([redacted]3/1/22)***

Completion Date: *02/17/2022*

Document Submission ***Implemented***

The updated DME is attached that was completed on [redacted]. I also attached a new DME for 3/4/22 that was completed because it was Directed on the POC. Unclear of why it was directed on the POC when one was updated on [redacted]. All other documents are attached.

144c2 - Smoking Area Distance

1. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's smoking policy indicates that residents are permitted to smoke in a designated area outside of the home; however, the home does not have a designated area for smoking.

Plan of Correction ***Accept***

On 12-21-21 A designated smoking area was created. New smoking policy was discussed at 12-28-21 resident council meeting and will be addressed again at Januarys meeting.
On 12-21- 2021 administrator educated staff on smoking policy and the designated smoking areas was shown to all the staff.
Maintenance director and or designee will monitor smoking area daily for compliance. Administrator and or designee will educate all new residents and families on smoking area location and smoking policy at time of admission.

Completion Date: *12/21/2021*

Document Submission ***Implemented***

area created and residents, families and staff all educated.

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:
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.

187a - Medication Record *(continued)*

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

Description of Violation

Resident #7 is prescribed [redacted]-Take by mouth daily; however, the resident's December 2021 medication administration record (MAR) does not include the dosage form, dose, route of administration, frequency of administration, and diagnosis or purpose of the medication.

Plan of Correction ***Accept***

12-14-21 day of inspection the DC medication for resident #7 was removed form cart and disposed of by the nurse and MAR was shown to inspector. An audit of all current resident medication was conducted to ensure all DC meds out of carts and that all MAR are documented correctly with dose, route, frequency diagnosis/purpose by 12-31-21.
Nurse cart and Mar Audits will increase from weekly to 2 x week for the next 2 months January and February 2022.
Pharmacy provider also conducted an audit on 1- 12-22.
Administrator re-educated nurses and medication technicians on regulation 187a and with emphasis DC medications.
Nurse and or designee will monitor for compliance with use of MAR and Medication cart audits and results of audits will be reviewed at monthly QA meetings.

Completion Date: *01/12/2022*

Document Submission ***Implemented***

all documents attached

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

The preadmission screening completed for resident #1, admitted to the home on [redacted], does not include the date the screening was completed, the title, name and signature of the person completing the screening, and the name of the admitting personal care home.

Plan of Correction ***Accept***

This was corrected on 12/14/21 during the Inspection.
A full audit of all current resident charts was conducted by the Director of Nursing and the Assistant Director of Nursing to ensure all pre-screens were fully completed in entirety by 1-12-22.
Administrator educated all members of leadership and nurses on the regulation 224a and importance form completed in its entirety by 1-31-22.
Nurse and or designee will monitor all new residents have a fully completed pre-screen by day of physical move in. Moving forward Nursing Director and or designee will monitor all new DME are completed in entirety weekly for 3 months (starting week of 2/14/22 and ending 5/14/22) then monthly after. This will be done at our weekly DON Meeting and documented on the DON report. First documentation will be on 2/17/22 DON report. (attached) Then it will be documented on our Month Quality Assurance Program meeting report. (attached).

Completion Date: *02/17/2022*

224a - Preadmission Screen Form *(continued)*

Document Submission ***Implemented***

all documents attached

91 - Telephone Numbers

1. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 12/14/21, no emergency telephone numbers were posted on or near the telephones in the bedrooms of residents #1 and #9.

REPEAT VIOLATION: 10/23/2019 et. al.

Plan of Correction ***Accept***

12-14-21 Emergency phone number were put in residents 1 and 9 rooms by staff. An audit of all resident rooms was conducted and a new laminated emergency phone numbers place on the back of each residents apartment doors. (attached).

12-21-21 administrator re-educated all staff on regulation .91 During the staff meeting on December 21st and reviewed with residents at Resident Council meeting on December 28, 2021, and where can find emergency phone numbers.

The Maintenance and or designee will check residents rooms weekly to ensure numbers are posted in residents rooms.

Completion Date: *12/28/2021*

Document Submission ***Implemented***

all telephone numbers added to rooms all staff trained.

Department of Human Services
Bureau of Human Service Licensing

June 22, 2022

[redacted], OFFICER
[redacted]

RE: CELEBRATION VILLA OF CHIPPEWA
104 PAPPAN BUSINESS DRIVE
BEAVER FALLS, PA, 15010
LICENSE/COC#: 44901

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/06/2022 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 - PUBLIC

Facility Information

Name: *CELEBRATION VILLA OF CHIPPEWA* **License #:** *44901* **License Expiration:** *05/05/2022*

Address: *104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010*

County: *BEAVER* **Region:** *WESTERN*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/22/1999* **Issued By:** *Dept. L & I*

Type: *I-2* **Date:** *03/18/2011* **Issued By:** *Chippewa Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *73* **Waking Staff:** *55*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *06/06/2022*

Inspection Dates and Department Representative

06/06/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served:** *49*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care* **Capacity:** *20* **Residents Served:** *17*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *49*

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

Have Mobility Need: *24* **Have Physical Disability:** *0*

Inspections / Reviews

06/06/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/23/2022*

06/21/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/17/2022*

06/22/2022 - Document Submission

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

85d - Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 10:10 AM, there was a 1/4 full, uncovered metal trash can in the shared resident bathroom between resident rooms 206 and 208.

Plan of Correction ***Accept***

The trash can lid was on the floor and not on the trash can. The Trash can was immediately replaced with a different type of trash can that the lid does not fall off of. On 6/13/22 6 trash cans that the lid is attached were ordered to put in the Memory Care bathrooms to ensure there is always a lid left on the the trash can in bathrooms. (receipt will be attached).
On 6/15/22 a Quality Assurance training meeting was held with all staff and the POC inspection was addressed and 85d was addressed.
Moving forward the Memory Care Director, Maintenance Director or designee will check weekly to make sure all the bedrooms and kitchens have a trash can with a lid attached. (attached is the sign off sheet). This started on 6/13/2022 and continue weekly for 3 months then monthly after.
Completion Date: *06/15/2022*

Document Submission ***Implemented***

The trash can lid was on the floor and not on the trash can. The Trash can was immediately replaced with a different type of trash can that the lid does not fall off of. On 6/13/22 6 trash cans that the lid is attached were ordered to put in the Memory Care bathrooms to ensure there is always a lid left on the the trash can in bathrooms. (receipt will be attached).
Everything was completed by 06/15/22. All forms attached.
On 6/15/22 a Quality Assurance training meeting was held with all staff and the POC inspection was addressed and 85d was addressed.
Moving forward the Memory Care Director, Maintenance Director or designee will check weekly to make sure all the bedrooms and kitchens have a trash can with a lid attached. (attached is the sign off sheet). This started on 6/13/2022 and continue weekly for 3 months then monthly after.

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:

Description of Violation

Resident #1 was prescribed [redacted]-take two tablets by mouth every six hours as needed for pain; however, the resident's June 2022 Medication Administration Record (MAR) indicates take two tablets every four hours as need for pain.

Plan of Correction ***Accept***

The pharmacy was called and the order on the MAR was fixed to say every six hours.(attached).
We just changed pharmacies on 5/25/2022 and they had to create all new MAR and this was a typo by the new pharmacy when rewriting the MAR. The resident has not used her Tylenol at all since it was ordered so it was not red flagged by the staff as the wrong time on the MAR because it was a PRN that was never utilized.

187a - Medication Record (continued)

On 6/15/22 a Quality Assurance staff training was held and 187a was addressed.
The nursing department are doing Med audits 5 times a week this started on 6/6/22 due to getting a new pharmacy. (attached is the sign in sheet.) We are talking with the new pharmacy daily to go over all our policies and to ensure all the MAR's match the doctors orders and the medications in the Medication Carts.
5 days a week will happen for two months minimally and longer if we feel necessary. Once we are confident all issues have been resolved we will go to two days a week for audits for 2 months then monthly.
The new pharmacy did a cart audit on 6/7/2022(attached). They will be doing this once a month as well. And more if we feel it is necessary.
We also have a designated staff in the regional office working daily with the new pharmacy as well to ensure all Med carts are correct and all policies are being followed.
Completion Date: *06/15/2022*

Document Submission ***Implemented***

The pharmacy was called and the order on the MAR was fixed to say every six hours.(attached).
We just changed pharmacies on 5/25/2022 and they had to create all new MAR and this was a typo by the new pharmacy when rewriting the MAR. The resident has not used her Tylenol at all since it was ordered so it was not red flagged by the staff as the wrong time on the MAR because it was a PRN that was never utilized.
On 6/15/22 a Quality Assurance staff training was held and 187a was addressed.
The nursing department are doing Med audits 5 times a week this started on 6/6/22 due to getting a new pharmacy. (attached is the sign in sheet.) We are talking with the new pharmacy daily to go over all our policies and to ensure all the MAR's match the doctors orders and the medications in the Medication Carts.
5 days a week will happen for two months minimally and longer if we feel necessary. Once we are confident all issues have been resolved we will go to two days a week for audits for 2 months then monthly.
The new pharmacy did a cart audit on 6/7/2022(attached). They will be doing this once a month as well. And more if we feel it is necessary.
We also have a designated staff in the regional office working daily with the new pharmacy as well to ensure all Med carts are correct and all policies are being followed.
all completed and all forms attached.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #2 was prescribed [redacted] one tablet by mouth once daily; however, on 5/4/22 at 8:00 AM, the medication was not administered to the resident because it was not available in the home.

Resident #2 was prescribed [redacted] -take one by mouth twice daily; however, on 5/4/22 at 8:00 AM, the medication was not administered to the resident because it was not available in the home.

Plan of Correction ***Accept***

The Doctor was called when the medication was unavailable and she stated to give the next dose of Memantine if it arrived that evening or the next day when the medications arrive. (signed documentation from doctor attached). The [redacted] arrived that evening for the evening dose. The [redacted] was administered at 8:00am on 6/5/22 at its next schedule dose.
We just changed pharmacies on 5/25/2022 and they had to create all new MAR and this was a typo by the new

187d - Follow Prescriber's Orders (continued)

pharmacy when rewriting the MAR.
On 6/15/22 a Quality Assurance staff training was held and 187d was addressed.
The nursing department are doing Med audits 5 times a week this started on 6/6/22 due to getting a new pharmacy. (attached is the sign in sheet.) We are talking with the new pharmacy daily to go over all our policies and to ensure all the MAR's match the doctors orders and the medications in the Medication Carts.
5 days a week will happen for two months minimally and longer if we feel necessary. Once we are confident all issues have been resolved we will go to two days a week for audits for 2 months then monthly after.
The new pharmacy did a cart audit on 6/7/2022(attached). They will be doing this once a month as well. And more if we feel it is necessary.
We also have a designated staff in the regional office working daily with the new pharmacy as well to ensure all Med carts are correct to match the Doctor's orders and all policies are being followed.
Completion Date: *06/15/2022*

Document Submission ***Implemented***

The Doctor was called when the medication was unavailable and she stated to give the next dose of Memantine if it arrived that evening or the next day when the medications arrive. (signed documentation from doctor attached). The Memantine arrived that evening for the evening dose. The EscitalOrpam was administered at 8:00am on 6/5/22 at its next schedule dose.
We just changed pharmacies on 5/25/2022 and they had to create all new MAR and this was a typo by the new pharmacy when rewriting the MAR.
On 6/15/22 a Quality Assurance staff training was held and 187d was addressed.
The nursing department are doing Med audits 5 times a week this started on 6/6/22 due to getting a new pharmacy. (attached is the sign in sheet.) We are talking with the new pharmacy daily to go over all our policies and to ensure all the MAR's match the doctors orders and the medications in the Medication Carts.
5 days a week will happen for two months minimally and longer if we feel necessary. Once we are confident all issues have been resolved we will go to two days a week for audits for 2 months then monthly after.
The new pharmacy did a cart audit on 6/7/2022(attached). They will be doing this once a month as well. And more if we feel it is necessary.
We also have a designated staff in the regional office working daily with the new pharmacy as well to ensure all Med carts are correct to match the Doctor's orders and all policies are being followed.
Everything was completed and attached.