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

December 21, 2022

LUTHER RIDGE FACILITY OPERATIONS LLC
160 RED HORSE ROAD
POTTSVILLE, PA, 17901

RE: LUTHER RIDGE AT SEIDERS HILL
160 RED HORSE ROAD
POTTSVILLE, PA, 17901
LICENSE/COC#: 22466

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/25/2022, 01/26/2022, 01/27/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **Licen e #**: *22466* **Licen e Expiration**: *03/12/2023*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

Phone **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/03/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *15* **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/27/2022*

Inspection Dates and Department Representative

01/25/2022 - On-Site:
01/26/2022 - On-Site:
01/27/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *135* **Re ident Served**: *78*

Special Care Unit

In Home: *No* **Area**: **Capacity**: **Re ident Served**:

Hospice

Current Re ident : *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

01/25/2022 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/05/2022*

Inspections / Reviews *(continued)*

06/23/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/16/2022*
Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/30/2022*

07/25/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/16/2022*
Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/01/2022*

11/09/2022 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/16/2022*
Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/16/2022*

12/21/2022 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/16/2022*
Reviewer: [redacted] **Follow-Up Type:** *Not Required*

18 Other laws, regs, ordins.

1. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The boiler certificate from Labor and Industry for the 3 gas fired boilers expired [redacted]/21.

POC Submission ***Accept***

Description of Violation
The boiler certificate from Labor and Industry for the 3 gas fired boilers expired.
Plan of Correction
The boiler system inspection was due to run out on 7/16/21. Traveler's inspector arrived at building on 6/21/21 to perform inspection. Luther Ridge received the Boiler-Fired Pressure Vessel Report of Inspection from Traveler's and all boilers were in good working condition and passed for inspection. During building walk-through with Maintenance Director and surveyor it was noted that Luther Ridge did not have the Certificate of Boiler or Pressure Vessel Operation posted in boiler room or on hand. Contact was made to the Department of Labor & Industry in Harrisburg, Pa by Executive Director to obtain a copy of the certificate with the new expiration date. New certificate received and posted in boiler room for reference with new issue date of 6/22/21 and expiration date of 6/22/23. Education provided to Maintenance Director on importance of having boiler certificate in the facility and posted at all times near boiler system for regulatory compliance. Quality Management template updated with new record keeping for Maintenance Department to monitor for compliance and follow up for obtaining all needed certificates to post to maintain compliance with facility equipment.
Completion Date 2/4/2022

Licensee's Proposed Overall Completion Date: *02/04/2022*

Document Submission ***Implemented ([redacted] - 11/09/2022)***

Description of Violation
The boiler certificate from Labor and Industry for the 3 gas fired boilers expired.
Plan of Correction
The boiler system inspection was due to run out on 7/16/21. Traveler's inspector arrived at building on 6/21/21 to perform inspection. Luther Ridge received the Boiler-Fired Pressure Vessel Report of Inspection from Traveler's and all boilers were in good working condition and passed for inspection. During building walk-through with Maintenance Director and surveyor it was noted that Luther Ridge did not have the Certificate of Boiler or Pressure Vessel Operation posted in boiler room or on hand. Contact was made to the Department of Labor & Industry in Harrisburg, Pa by Executive Director to obtain a copy of the certificate with the new expiration date. New certificate received and posted in boiler room for reference with new issue date of 6/22/21 and expiration date of 6/22/23. Education provided to Maintenance Director on importance of having boiler certificate in the facility and posted at all times near boiler system for regulatory compliance. Quality Management template updated with new record keeping for Maintenance Department to monitor for compliance and follow up for obtaining all needed certificates to post to maintain compliance with facility equipment.
Completion Date 2/4/2022

Licensee's Proposed Overall Completion Date: *02/04/2022*

65g Initial direct care training

2. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
3. Initial direct care staff person training to include the following:
xiv. The requirements of this chapter.

Description of Violation

Direct care staff member A hired /22, B hired /21, C hired 21 and D hired /21 did not receive training in the requirements of this chapter.

POC Submission ***Accept***

Description of Violation
Direct care staff member A hired /22, B hired /21, C hire /21 and D hired /21 did not receive training in the requirements of this chapter.
Plan of Correction
Previous form for direct care qualifications and trainings was revised to include the training of the requirements of chapter 2800.00. This informational training session of Chapter 2800.00 is now to be reviewed and completed by the Executive Director or assigned designee with new coworkers during our new hire onboarding process. The Executive Director or assigned designee and new co worker is required to sign off on the check list when training is complete and are aware that new co workers are not to provide unsupervised assisted living services until they have received the informational training. Co workers are also made aware of the location of the Chapter 2800. 00 Pennsylvania Code Book in the facility for future reference.
2/4/2022

Licensee's Proposed Overall Completion Date: *02/04/2022*

Document Submission ***Implemented (11/09/2022)***

Description of Violation
Direct care staff member A hired /22, B hired /21, C hire /21 and D hired /21 did not receive training in the requirements of this chapter.
Plan of Correction
Previous form for direct care qualifications and trainings was revised to include the training of the requirements of chapter 2800.00. This informational training session of Chapter 2800.00 is now to be reviewed and completed by the Executive Director or assigned designee with new coworkers during our new hire onboarding process. The Executive Director or assigned designee and new co-worker is required to sign off on the check list when training is complete and are aware that new co-workers are not to provide unsupervised assisted living services until they have received the informational training. Co-workers are also made aware of the location of the Chapter 2800. 00 Pennsylvania Code Book in the facility for future reference.
2/4/2022

Licensee's Proposed Overall Completion Date: *02/04/2022*

121a Unobstructed egress

3. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

121a Unobstructed egress *(continued)*

Description of Violation

The exit door from the enclosed dining room would not open all the way because of snow and ice preventing the door from fully opening.

POC Submission ***Accept***

Description of Violation
The exit door from the enclosed dining room would not open all the way because of snow and ice preventing the door from fully opening.
Plan of Correction
The exit door from the enclosed dining room was immediately corrected by removing snow and ice by the maintenance director at time of the discovered violation by inspector. Maintenance Director and Assistant Maintenance Director were verbally educated by Executive Director on 1/25/2022 on regulation 2800.121.a which states that stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed at all times and that this also includes monitoring and removal of snow and ice during times of inclement weather. Maintenance Department will do periodic checks of all stairways, hallways, doorways, passageways and egress routes to ensure that all areas are free and clear of obstructions. Quality Management template for maintenance department updated to include compliance with all building exit routes being unobstructed.
Completion 2/4/2022

Licensee's Proposed Overall Completion Date: *02/04/2022*

Implemented [redacted] - 12/21/2022)

124 Notice to fire department

4. Requirements

2800.
124. The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The notice to the fire department does not include the total capacity of the home and the number of residents with mobility needs is not accurate.

POC Submission ***Accept***

Description of Violation
The notice to the fire department does not include the total capacity of the home and the number of residents with mobility needs is not accurate.
Plan of Correction
Executive Director revised the notice to the fire department to include the total capacity of the home. Executive Director also revised the facility daily stand up form to include addressing on a daily basis with clinical team members and admissions director if any current resident's mobility needs have changed and/or assessment of new admissions mobility status. Assessing any changes in mobility status with the clinical staff and admissions director or a daily basis will ensure that the local fire department has the most current information on the mobility needs of Luther Ridge residents at all times.
Completed 2/4/22

124 Notice to fire department (continued)

Licensee's Proposed Overall Completion Date: *02/04/2022*

Implemented (12/21/2022)

141a Medical evaluation

5. Requirements

2800.
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:
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

Resident #1's ADME dated /21 does not indicate if the resident required a new TB skin test/chest X ray or date of the last one.

Resident #2's ADME dated /21 does not indicate if the resident required a new TB skin test/chest X ray.

POC Submission ***Accept***

Description of Violation
Resident #1 ADME dated /21 does not indicate if the resident required a new TB skin test/chest X ray or date of the last one.
Resident #2 ADME dated 21 does not indicate if the resident required a new TB skin test /chest X ray.
Plan of Correction
A full audit of all current resident ADME's was conducted by Admissions Director for any further errors and needed corrections between 1/28/22 and 2/4/22. Admissions Director and Director of Wellness were verbally educated by Executive Director at time of survey about reviewing ADME's for full completion of the Immunization and Tuberculosis Testing section. Admissions Director and Director of Wellness were also educated verbally on the full regulation 2800.141.a by Executive Director. Monthly Quality Management document revised by Executive Director. Document now includes compliance with ADME section for tuberculosis testing. Also, regulation 2800.141.a nformation about tuberculin skin testing was added to document for reference during monthly audits for QM meeting. Monthly audit is to be completed by Admissions Director. Admissions Director is also aware to notify Director of Wellness of any incomplete documentation or discrepancies noted on the monthly audit related to TB testing. Director of Wellness is aware that if any changes or added information needs to be made to the ADME the facility must contact the person who performed the medical evaluation on the resident and will then obtain verbal permission to correct the current DME and will need to document the date, time and person spoken to directly on the ADME when corrected.
Completed 2/4/22

Licensee's Proposed Overall Completion Date: *02/04/2022*

Implemented (- 12/21/2022)

144c1 Smoking area guidelines

6. Requirements

2800.
144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

2 cans of extinguished cigarette butts were located outside of the receiving area of the home. This area is not the designated smoking area.

10-15 cigarette butts were located on the ground outside of the exit of the resident designated smoking area. Evidence of extinguishing cigarette butts was noted on the wood railing of the ramp outside the doorway of the wooden ramp. Interviews indicated that Resident #2 will not go down the ramp to smoke but will smoke directly outside the doorway.

POC Submission ***Accept***

Description of Violation
2 cans of extinguished cigarette butts were located outside of the receiving area of the home. This area is not the designated smoking area.
10-15cigarette butts were located on the ground outside of the exit of the resident designated smoking area. Evidence of extinguishing cigarette butts was noted on the wood railing of the ramp outside the doorway of the wooden ramp. Interviews indicated that Resident #2 will not go down the ramp to smoke but will smoke directly outside the doorway.
Plan of Correction
Two cans of extinguished cigarette butts outside receiving area were disposed of immediately. Executive Director verbally educated staff on 1/28/22 about smoking policy. Message sent out on On-Shift (an in-house communication tool that sends informational texts out to all co-workers) on 1/28/22 by Executive Director to make co-workers aware that no smoking is permitted outside on loading dock area. Co-workers made aware that they are only permitted to smoke in their personal vehicles. Outside receiving dock marked with additional signage that states no smoking area and also signage stating that co-workers must smoke in their own vehicles. Housekeeping Supervisor will monitor for co-workers not following the smoking policy and immediately notify ED with any co-worker in violation of the smoking policy. Quality Management document updated to include compliance with co-workers and the smoking policy by Housekeeping Supervisor.
Executive Director met with resident # 2 about designated smoking area on [redacted] 22. Education provided to resident about smoking policy and that [redacted] is not permitted to smoke on ramp directly outside ground floor rear exit door. Resident was instructed on exact location of designated smoking area located down the ramp at the far end of the flower box area. Resident verbalized understanding of policy. Call also placed to POA of resident # 2 to make aware of smoking policy and that resident had been in violation of the policy on [redacted] /22. Executive Director also had an in person family meeting with both POA and resident to discuss smoking policy on 2/5/22. Both resident and POA are aware of the policy and verbalize understanding and importance of compliance of policy. Maintenance Director placed specific signs on wooden ramp to direct resident to the appropriate location which is also clearly marked on back patio area to remind resident of designated area to maintain compliance. Quality Management document updated by Executive Director to now include monitoring of smoking area by Housekeeping Department and to notify Executive Director if resident # 2 is in violation of the smoking policy.
This information was also made aware to staff again at the Executive Director Around the Clock Meeting on 2/10/2022.

144c1 Smoking area guidelines (continued)

Licensee's Proposed Overall Completion Date: *02/04/2022*

Document Submission ***Implemented (- 11/09/2022)***

Description of Violation
2 cans of extinguished cigarette butts were located outside of the receiving area of the home. This area is not the designated smoking area.
10-15cigarette butts were located on the ground outside of the exit of the resident designated smoking area. Evidence of extinguishing cigarette butts was noted on the wood railing of the ramp outside the doorway of the wooden ramp. Interviews indicated that Resident #2 will not go down the ramp to smoke but will smoke directly outside the doorway.
Plan of Correction
Two cans of extinguished cigarette butts outside receiving area were disposed of immediately. Executive Director erbally educated staff on 1/28/22 about smoking policy. Message sent out on On-Shift (an in-house communication tool that sends informational texts out to all co-workers) on 1/28/22 by Executive Director to make co-workers aware that no smoking is permitted outside on loading dock area. Co-workers made aware that they are only permitted to smoke in their personal vehicles. Outside receiving dock marked with additional signage that states no smoking area and also signage stating that co-workers must smoke in their own vehicles. Housekeeping Supervisor will monitor for co-workers not following the smoking policy and immediately notify ED with any co-worker in violation of the smoking policy. Quality Management document updated to include compliance with co-workers and the smoking policy by Housekeeping Supervisor.
Executive Director met with resident # 2 about designated smoking area on 1/25/22. Education provided to resident about smoking policy and that is not permitted to smoke on ramp directly outside ground floor rear exit door. Resident was instructed on exact location of designated smoking area located down the ramp at the far end of the flower box area. Resident verbalized understanding of policy. Call also placed to POA of resident # 2 to make aware of smoking policy and that resident had been in violation of the policy on 1/25/22. Executive Director also had an in person family meeting with both POA and resident to discuss smoking policy on 2/5/22. Both resident and POA are aware of the policy and verbalize understanding and importance of compliance of policy. Maintenance Director placed specific signs on wooden ramp to direct resident to the appropriate location which is also clearly marked on back patio area to remind resident of designated area to maintain compliance. Quality Management document updated by Executive Director to now include monitoring of smoking area by Housekeeping Department and to notify Executive Director if resident # 2 is in violation of the smoking policy.
This information was also made aware to staff again at the Executive Director Around the Clock Meeting on 2/10/2022.

Licensee's Proposed Overall Completion Date: *02/04/2022*

182b Prescript on medication

7. Requirements

2800.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2800.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

182b Prescript on medication *(continued)*

Description of Violation

One of the required two MAR reviews was completed for direct care staff member E's 2021 annual practicum.

Two of the required four medication observations was completed for direct care staff member C's initial training completed on /21.

Two of the required four medication observations was completed for direct care staff member D's initial training completed on 21.

POC Submission ***Accept***

Description of Violation
One of the required two MAR reviews was completed for direct care staff member E's 2021 annual practicum.
Two of the required four medication observations was completed for direct care staff members C's initial training completed on /21.
Two of the required four medication observations was completed for direct care staff members C's initial training completed on /21.
Plan of Correction
Luther Ridge has contracted with an outside Med-Tech Trainer who provides Med-Tech training and recertification for Luther Ridge Med-Techs on an ongoing basis. Med-Tech trainer was made aware of the violations listed above by surveyor during inspection. Med- Tech trainer made Executive Director aware tha had placed calls and emailed Temple for further guidance and education related to regulations. Med- Tech trainer was able to obtain needed nformation from Temple to clarify the required documentation for Med-Tech's to avoid further violations and correct current violations to remain compliant. Med-Tech trainer also has obtained additional resources and references to utilize in the future if has any questions or concerns relating to compliance of Med-Tech training. Med-Tech trainer will review the materials required for medications pass observation more frequently and stay up to date with any changes related to the Med-Tech program and continue to reach out to Temple as a resource as needed. Quality Management document revised to include meeting of Director of Wellness and Med-Tech trainer on a quarterly basis to ensure compliance with all Med-Tech required paperwork and updates as needed.
3/1/2022

Licensee's Proposed Overall Completion Date: *03/01/2022*

Document Submission ***Implemented 11/09/2022)***

Description of Violation
One of the required two MAR reviews was completed for direct care staff member E's 2021 annual practicum.
Two of the required four medication observations was completed for direct care staff members C's initial training completed on /21.
Two of the required four medication observations was completed for direct care staff members C's initial training completed on 21.
Plan of Correction
Luther Ridge has contracted with an outside Med-Tech Trainer who provides Med-Tech training and recertification for Luther Ridge Med-Techs on an ongoing basis. Med-Tech trainer was made aware of the violations listed above by surveyor during inspection. Med- Tech trainer made Executive Director aware that had placed calls and emailed Temple for further guidance and education related to regulations. Med- Tech trainer was able to obtain needed nformation from Temple to clarify the required documentation for Med-Tech's to avoid further violations and correct current violations to remain compliant. Med-Tech trainer also has obtained additional resources and references to

182b Prescription medication (continued)

utilize in the future if ██ has any questions or concerns relating to compliance of Med-Tech training. Med-Tech trainer will review the materials required for medications pass observation more frequently and stay up to date with any changes related to the Med-Tech program and continue to reach out to Temple as a resource as needed. Quality Management document revised to include meeting of Director of Wellness and Med-Tech trainer on a quarterly basis to ensure compliance with all Med-Tech required paperwork and updates as needed.
3/1/2022

Licensee's Proposed Overall Completion Date: *03/01/2022*

184a Resident meds labeled

8. Requirements

2800.
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.

Description of Violation

Resident #3's ██ does not include the initials of the staff member who opened the pen.

Resident #4's ██ does not have a pharmacy label attached.

POC Submission ***Accept***

Description of Violation
Resident # 3 ██ does not include the initials of the staff member who opened the pen.
Resident # 4 ██ does not have a pharmacy label attached.
Plan of Correction
Resident # 3 ██ does not include the initials of the staff member who opened the pen. Staff verbally educated by Director of Wellness on 1/27/2022 that going forward all ██ must have the date of opening and the initials of the individual who first opened the ██ to be written on the ██ label. Monthly medication cart audit form updated on 1/28/22 by Executive Director to include Med-Tech /LPN to initial ██ upon opening. Director of Wellness did a full audit on all medication carts on 1/28/2022.
Resident # 4 ██ does not have a pharmacy label attached. Resident #4 bottle was immediately corrected by the Director of Wellness. Director of Wellness printed and attached the medication order to the bottle upon discovery. Director of Wellness verbally educated staff on 1/27/22 that each individual bottle of ██ must have a pharmacy label attached to include all required medication label information. Monthly med cart audits were revised on 1/28/22 to include this check. Medication cart audit was completed on 1/28/2022 by Director of Wellness.
1/28/2022 . This information was also reviewed by the Executive Director on 2/10/2022 in the Around the Clock meeting with staff.

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *06/30/2022*

Implemented (██ - 12/21/2022)

187a Medication record

9. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
4. Strength.
6. Dose.

Description of Violation

Resident #5's MAR notes [redacted] 30mg 1 tablet daily, the bottle to the medication notes [redacted] 10mg 3 tablets daily. The MAR is incorrect.

Resident #3's [redacted] does not indicate the dose of the medication.

POC Submission ***Accept***

Description of Violation
Resident #5's MAR notes [redacted] 30mg 1 tablet daily, the bottle to the medication notes M[redacted] 10mg 3 tablets daily. The MAR is incorrect
Resident #3's [redacted] does not indicate the dose of the medication.
Plan of Correction
The [redacted] 30mg order for resident #5 was immediately corrected upon discovery in the EMAR to match the medication bottle by Director of Wellness to state [redacted] 10mg tablet give three tabs daily. The monthly Medication Cart audit was revised on 1/28/2022 to include all labels to match eMAR. Medication cart audit was done on 1/28/2022 by Director of Wellness to assess for any further errors of medication labels not matching the eMAR' s.
Resident #3's [redacted] does not indicate the dose of the medication. Resident #3's [redacted] order was correctly mmediately upon discovery by Director of Wellness to include dose of medication on EMAR. Medication cart audit was completed by Director of Wellness on 1/28/2022 to assess for any further errors of residents medication labels not matching what was put in eMAR.
This information was also reviewed again with staff on 2/10/22 with the Executive Director during [redacted] Around the Clock Meeting.
Completed 1/28/2022

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *06/30/2022*

Document Submission ***Implemented ([redacted] - 11/09/2022)***

Description of Violation
Resident #5's MAR notes [redacted] 30mg 1 tablet daily, the bottle to the medication notes [redacted] 10mg 3 tablets daily. The MAR is incorrect
Resident #3's [redacted] does not indicate the dose of the medication.
Plan of Correction
The [redacted] 30mg order for resident #5 was immediately corrected upon discovery in the EMAR to match the medication bottle by Director of Wellness to state [redacted] 10mg tablet give three tabs daily. The monthly Medication Cart audit was revised on 1/28/2022 to include all labels to match eMAR. Medication cart audit was done on 1/28/2022 by Director of Wellness to assess for any further errors of medication labels not matching the eMAR' s.
Resident #3's [redacted] does not indicate the dose of the medication. Resident #3's [redacted] order was correctly mmediately upon discovery by Director of Wellness to include dose of medication on EMAR. Medication cart audit was completed by Director of Wellness on 1/28/2022 to assess for any further errors of residents medication labels

187a Medication record (continued)

not matching what was put in eMAR.
This information was also reviewed again with staff on 2/10/22 with the Executive Director during the monthly Around the Clock Meeting.
Completed 1/28/2022

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *01/28/2022*

187d Follow prescriber’s orders

10. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 has an order for [redacted] 3000 iu's daily. The bottle the home is administering the medication from is 5000 iu's daily.

Resident #5 has an order for [redacted] 1 tablet twice daily hold for systolic blood pressure less than 120 or heart rate less than 50. The home is not taking the residents heart rate to determine if the medication should be administered or not.

POC Submission ***Accept***

Description of Violation
Resident #6 has an order for [redacted] 3000 iu daily . The bottle the home is administering the medication from is 5000iu daily.
Resident #5 has an order for [redacted] 1 tablet twice daily hold for systolic blood pressure less than 120 or heart rate less than 50 . The home is not taking the residents heart rate to determine if the medication should be administered or not
Plan of Correction
Resident #6 [redacted] was immediately removed from the medication cart upon discovery. Call was placed to family and PCP to make aware that the wrong dose of [redacted] was being administered to resident. Family supplies this medication for resident and Director of Wellness requested that family bring in correct does of 3000 iu daily for resident. Correct medication was then provided by family on 1/27/2022. Reeducation provided to staff about making sure that medications that are not supplied by pharmacy and brought in by family needs to be confirmed by staff that the family has provided the correct medication for resident to be administered. Director of Wellness preformed Medication Cart audit to assess for any further errors on 1/28/2022 ensuring all orders match the medication and matches the eMAR.
Resident# 5’s order for [redacted] was immediate corrected in EMAR upon surveyor’s discovery by Director of Wellness. Director of Wellness added to EMAR to include monitoring of resident’s heart rate to determine f medication is to be held or administered according to perimeters [redacted]. Director of Wellness also included area in EMAR for heart rate to be recorded directly into EMAR system. Staff was verbally reeducated by Director of Wellness on 1/27/2022 that the full medication order must be entered into EMAR system including drop down box for documentation of vital signs directly into EMAR for reference. Medication Cart audit performed by Director of Wellness on 1/28/2022 to assess for any other medication orders with perimeters for blood pressures and/or pulses to be added into eMAR and also have an area for documentation for holds.
This information was reviewed again on 2/10/2022 by the Executive Director during the monthly Around the Clock

187d Follow prescriber's orders (continued)

Meeting with Staff.
Completed 1/28/2022

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *06/30/2022*

Document Submission ***Implemented [redacted] - 11/09/2022)***

Description of Violation
Resident #6 has an order for [redacted] 3000 iu daily . The bottle the home is administering the medication from is 5000iu daily.
Resident #5 has an order for [redacted] 1 tablet twice daily hold for systolic blood pressure less than 120 or heart rate less than 50 . The home is not taking the residents heart rate to determine if the medication should be administered or not
Plan of Correction
Resident #6 [redacted] was immediately removed from the medication cart upon discovery. Call was placed to family and PCP to make aware that the wrong dose of [redacted] was being administered to resident. Family supplies this medication for resident and Director of Wellness requested that family bring in correct does of [redacted] daily for resident. Correct medication was then provided by family on 1/27/2022. Reeducation provided to staff about making sure that medications that are not supplied by pharmacy and brought in by family needs to be confirmed by staff that the family has provided the correct medication for resident to be administered. Director of Wellness preformed Medication Cart audit to assess for any further errors on 1/28/2022 ensuring all orders match the medication and matches the eMAR.
Resident# 5's order for [redacted] was immediate corrected in EMAR upon surveyor's discovery by Director of Wellness. Director of Wellness added to EMAR to include monitoring of resident's heart rate to determine if medication is to be held or administered according to perimeters [redacted] Director of Wellness also included area in EMAR for heart rate to be recorded directly into EMAR system. Staff was verbally reeducated by Director of Wellness on 1/27/2022 that the full medication order must be entered into EMAR system including drop down box for documentation of vital signs directly into EMAR for reference. Medication Cart audit performed by Director of Wellness on 1/28/2022 to assess for any other medication orders with perimeters for blood pressures and/or pulses to be added into eMAR and also have an area for documentation for holds.
This information was reviewed again on 2/10/2022 by the Executive Director during the monthly Around the Clock Meeting with Staff.
Completed 1/28/2022

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *01/28/2022*

227c Final support plan - revision

11. Requirements

2800.
227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident #7's ASP dated [redacted]/21 and #8's dated [redacted]/20 only had one of the required quarterly reviews completed.

227c Final support plan - revision *(continued)*

POC Submission ***Accept***

Description of Violation
Resident #7's ASP dated [redacted] 21 and #8's dated [redacted] /20 only had one of the required quarterly reviews completed.
Plan of Correction
Executive Director provided education to Director of Wellness and regional RN making them aware of requirements of ASP quarterly reviews and as needed reviews for any modifications according to resident's needs or significant changes in residents care. A full review of all resident ASP's was completed by 2/4/2022 by Director of Wellness. Quality Management document updated by Executive Director for Director of Wellness to document date of completion of quarterly reviews for compliance for both the Director of Wellness and/or regional RN for facility. Director of Wellness will review all initial, annual and any significant change ASP's with regional RN to ensure full involvement with the clinical team in the plan of care of all residents on a scheduled quarterly basis.
Completion 2/4/2022

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *06/30/2022*

Document Submission ***Implemented [redacted] - 11/09/2022)***

Description of Violation
Resident #7's ASP dated [redacted] /21 and #8's dated [redacted] /20 only had one of the required quarterly reviews completed.
Plan of Correction
Executive Director provided education to Director of Wellness and regional RN making them aware of requirements of ASP quarterly reviews and as needed reviews for any modifications according to resident's needs or significant changes in residents care. A full review of all resident ASP's was completed by 2/4/2022 by Director of Wellness. Quality Management document updated by Executive Director for Director of Wellness to document date of completion of quarterly reviews for compliance for both the Director of Wellness and/or regional RN for facility. Director of Wellness will review all initial, annual and any significant change ASP's with regional RN to ensure full involvement with the clinical team in the plan of care of all residents on a scheduled quarterly basis.
Completion 2/4/2022

On-going monitoring and compliance will be completed by Director of Wellness and/or designee.

Licensee's Proposed Overall Completion Date: *02/04/2022*