**Department of Human Services**
**Bureau of Human Service Licensing**

April 13, 2022

[redacted], REPRESENTATIVE
[redacted]

RE: NEWHAVEN COURT AT CLEARVIEW
100 NEWHAVEN LANE
BUTLER, PA, 16001
LICENSE/COC#: 42346

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/02/2022, 03/03/2022, 03/07/2022, 03/09/2022 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:** *NEWHAVEN COURT AT CLEARVIEW* **License #:** *42346* **License Expiration:** *04/25/2022*

**Address:** *100 NEWHAVEN LANE, BUTLER, PA 16001*

**County:** *BUTLER* **Region:** *WESTERN*

## Administrator

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

## Legal Entity

[redacted]

## Certificate(s) of Occupancy

**Type:** *C-2 LP* **Date:** *05/05/1996* **Issued By:** *L&I*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *128* **Waking Staff:** *96*

## Inspection Information

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

**Reason:** *Renewal* **Exit Conference Date:** *03/09/2022*

## Inspection Dates and Department Representative

*03/02/2022 - On-Site:* [redacted]
*03/03/2022 - On-Site:*
*03/07/2022 - Off-Site:*
*03/09/2022 - Off-Site:*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *115* **Residents Served:** *91*

### Secured Dementia Care Unit

**In Home:** *Yes* **Area:** *Memory Care* **Capacity:** *18* **Residents Served:** *17*

### Hospice

**Current Residents:** *0*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0* **Are 60 Years of Age or Older:** *91*

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

**Have Mobility Need:** *37* **Have Physical Disability:** *0*

## Inspections / Reviews

**03/02/2022 - Full**

**Lead Inspector**: [redacted]*iano* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/26/2022*

**04/01/2022 - POC Submission**

**Reviewer**: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/08/2022*

**04/13/2022 - Document Submission**

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

## 63a - First Aid/CPR Training

**1. Requirements**

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

**Description of Violation**

*On 2/26/22, there were 88 residents present in the home requiring two staff persons to be present who are training in first aid and certified in obstructed airway techniques and CPR. However, from 7:00 a.m. on 2/26/22 until 7:00 a.m. on 2/27/22 there was only one staff member who met this qualification present in the home.*

*On 2/27/22, there were 88 residents present in the home requiring two staff persons to be present who are training in first aid and certified in obstructed airway techniques and CPR. However, from 7:00 a.m. until 7:00 p.m. on 2/27/22 there was only one staff member who met this qualification present in the home. In addition, there was no staff from 7:00 p.m. on 2/27/22 until 7:00 a.m. on 2/28/22 who met this qualification present in the home.*

*On 2/28/22, there were 88 residents present in the home requiring two staff persons to be present who are training in first aid and certified in obstructed airway techniques and CPR. However, from 2:00 p.m. on 2/28/22 until 7:00 a.m. on 3/1/22 there was only one staff member who met this qualification present in the home.*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.63.a. - First Aid/CPR Training.*
*At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.*

*2. Violation Interpretative Statement:*
*On 2/26/22, there were 88 residents present in the home requiring two staff persons to be present who are training in first aid and certified in obstructed airway techniques and CPR. However, from 7:00 a.m. on 2/26/22 until 7:00 a.m. on 2/27/22 there was only one staff member who met this qualification present in the home.*

*On 2/27/22, there were 88 residents present in the home requiring two staff persons to be present who are training in first aid and certified in obstructed airway techniques and CPR. However, from 7:00 a.m. until 7:00 p.m. on 2/27/22 there was only one staff member who met this qualification present in the home. In addition, there was no staff from 7:00 p.m. on 2/27/22 until 7:00 a.m. on 2/28/22 who met this qualification present in the home.*

*On 2/28/22, there were 88 residents present in the home requiring two staff persons to be present who are training in first aid and certified in obstructed airway techniques and CPR. However, from 2:00 p.m. on 2/28/22 until 7:00 a.m. on 3/1/22 there was only one staff member who met this qualification present in the home.*

*3. Review the benefit of the Regulation, per RCG:*

## *63a - First Aid/CPR Training (continued)*

*Ensures that staff are appropriately trained to respond to an emergency, and that there are sufficient numbers of qualified staff to respond to simultaneous emergency situations (for example, if one resident is choking while another resident experiences cardiac arrest).*

*4. Description of the Repair of the Immediate Problem:*
*CPR and First Aid training scheduled for 4/6/22 and 4/7/22. The home will be in full compliance following the completion of these trainings.*

*5. Determine / document the Root Cause of the Violation:*
*The home found it challenging to find CPR/First Aid trainers willing to provide this training during the COVID-19 pandemic.*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*To establish the extent of compliance, staff CPR & First Aid training records and tickler were audited for compliance and for the condition identified on the visit relating to 2600.63.a. Staff identified as needing CPR & First Aid training will be attending training sessions on 4/6/22 or 4/7/22. Record of these trainings will be documented and kept on file.*

*The Executive Operations Officer and Administrative Services Director set a monthly tickler reminder via Outlook Calendar to verify that staff maintain current CPR and First Aid training and schedule trainings as needed to remain compliant with 2600.63.a.*

*7. Designated position responsible and specify target date for correction.*
*The Administrative Service Director will be responsible for maintaining the CPR and First Aid tickler and ensuring that annual trainings will be completed timely and within the timeframe set by DHS.*

*The Executive Operations Officer will verify that the CPR & First Aid tickler is maintained and will be reminded by Outlook Calendar to establish the habit and routine of the ASD. Target date is 4/1/22 and on-going.*
**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 81b - Resident Personal Equipment

**1. Requirements**

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**Description of Violation**

*Residents #1, #2, #3, #4, #5, #6, and #7 have enabler bars on their beds; however, they are not secured to the beds. The bars are attached to a strap that is positioned between the mattress and bed frame and can be moved significantly from the bed, posing an entrapment hazard.*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.81.b. - Resident Personal Equipment*

## 81b - Resident Personal Equipment (continued)

*Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.*

*2. Violation Interpretative Statement:*
*Residents #1, #2, #3, #4, #5, #6, and #7 have enabler bars on their beds; however, they are not secured to the beds. The bars are attached to a strap that is positioned between the mattress and bed frame and can be moved significantly from the bed, posing an entrapment hazard.*

*3. Review the benefit of the Regulation, per RCG:*
*Clean assistive devices that are in good repair are less likely to cause injury or illness to residents.*

*4. Description of the Repair of the Immediate Problem:*
*The bed enablers were properly secured and made flush with the mattress in the presence of the Licensing Representative from DHS.*

*5. Determine / document the Root Cause of the Violation:*
*Lack of process to ensure compliance with 2600.81.b.*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*An immediate audit was conducted on all enablers in the home to ensure safety and proper installation, to include that all enablers are secured to bed frames and flush with the mattress.*

*Each unit with a bed enabler will be checked on a weekly basis as part of the Hospitality Associate's cleaning duties as identified on the Cleaning Checklist to ensure compliance with this regulation. As a secondary audit, the Hospitality Executive Associate will conduct weekly audits on all bed enablers in the home to ensure compliance with this regulation. Documentation of the audit will be kept on file.*

*Bed enablers found not in compliance with the regulation will be communicated to the Hospitality Executive Associate and Safety & Maintenance Engineer to be immediately rectified.*

*Training was conducted by the Safety & Maintenance Engineer with all Hospitality Associates on the Cleaning Checklist form and regulation 2600.81.b. as it relates to bed enablers in the home on 3/4/22. Record of these trainings will be documented and kept on file.*

*All citations found in this violation report to include Regulation 2600.81.b. will be reviewed as part of the Quarterly Staff Meeting on 3/30/22. Record of this meeting will be documented and kept on file.*

*7. Designated position responsible and specify target date for correction.*
*The Hospitality Executive Associate is responsible to ensure this audit system and process stays in place by ensuring that all bed enablers are properly secured and flush to the mattress.*

*The Executive Operations Officer will monitor this checklist for progress and adherence to the plan, immediately and on-going.*
**Completion Date:** *03/25/2022*

## 81b - Resident Personal Equipment *(continued)*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 101j7 - Lighting/Operable Lamp

**1. Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

*Resident #6 does not have access to a source of light that can be turned on/off at bedside.*

*Resident #8 does not have access to a source of light that can be turned on/off at bedside. The resident's lamp was unplugged.*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.101.j.7. - Lighting/Operable Lamp*
*Each resident shall have the following in the bedroom. An operable lamp or other source of lighting that can be turned on at bedside. 7. An operable lamp or other source of lighting that can be turned on at bedside.*

*2. Violation Interpretative Statement:*
*Resident #6 does not have access to a source of light that can be turned on/off at bedside.*

*Resident #8 does not have access to a source of light that can be turned on/off at bedside. The resident's lamp was unplugged.*

*3. Review the benefit of the Regulation, per RCG:*
*Provides residents with sufficient light to move safely around their room in the dark, reducing the risk of falls and injury.*

*4. Description of the Repair of the Immediate Problem:*
*A bedside lamp was installed at the bedside for Resident #6 on 3/3/22. The Licensing Rep from DHS was informed and verified evidence of the lamp on 3/3/22.*

*Resident #8's bedside lamp was plugged in by the Safety & Maintenance Engineer on 3/2/22 in the presence of the Licensing Rep from DHS.*

*5. Determine / document the Root Cause of the Violation:*
*Lack of process to ensure compliance with 2600.101.j.7.*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*A complete audit was conducted of all resident units in the home to ensure that each resident had a operable bedside lamp within reach and can be turned on at bedside.*

*Each resident unit will be checked on a weekly basis as part of the Hospitality Associate's cleaning duties as identified on the Cleaning Checklist to ensure compliance with this regulation.*

## *101j7 - Lighting/Operable Lamp (continued)*

*Units found not in compliance with the regulation will be communicated to the Hospitality Executive Associate and Safety & Maintenance Engineer to be immediately rectified.*

*All citations found in this violation report to include Regulation 2600.101.j.7. will be reviewed as part of the Quarterly Staff Meeting on 3/30/22. Record of this meeting will be documented and kept on file.*

*7. Designated position responsible and specify target date for correction.*
*The Hospitality Executive Associate is responsible to ensure this audit system and process stays in place by ensuring that all resident units have a operable bedside lamp within reach and can be turned on at bedside.*

*The Executive Operations Officer will monitor this checklist for progress and adherence to the plan, immediately and on-going.*
**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 144b - Policy on Smoking

**1. Requirements**

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

**Description of Violation**

*The home's smoking policy states, "Residents desiring to smoke must have physician order to do so...Residents desiring to smoke will have a smoking assessment completed upon move in...The resident will be directly observed at all times while smoking cigarettes." However, the contract and home rules state, "Smoking by Residents...is strictly prohibited anywhere inside and outside the building."*
*In addition, the home is only prohibiting residents from smoking while providing a designated smoking area for staff.*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.144.b. - Policy on Smoking*
*The home rules shall specify whether the home is designated as smoking or nonsmoking.*

*2. Violation Interpretative Statement:*
*The home's smoking policy states, "Residents desiring to smoke must have physician order to do so...Residents desiring to smoke will have a smoking assessment completed upon move in...The resident will be directly observed at all times while smoking cigarettes." However, the contract and home rules state, "Smoking by Residents...is strictly prohibited anywhere inside and outside the building."*
*In addition, the home is only prohibiting residents from smoking while providing a designated smoking area for staff.*

*3. Review the benefit of the Regulation, per RCG:*
*Ensures that current and potential residents clearly understand the home's smoking policy.*

*4. Description of the Repair of the Immediate Problem:*

## *144b - Policy on Smoking (continued)*

*The home's Smoking Policy within the home rules (Resident Handbook) for Senior Living and Memory Care were revised on 3/18/22 to match the home's policy. The home's Smoking Policy is now all inclusive for residents, visitors, and staff. One designated outside smoking area will be used for residents, visitors, and staff.*

*5. Determine / document the Root Cause of the Violation:*
*Misinterpretation of the regulation as it relates to a previous DHS Licensing Inspection in August 2016.*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*A 30-day written notice and amendment to the Smoking Policy within the Resident Handbook will be mailed on 3/31/22 to Residents and Responsible parties notifying of a change in the home's rules related to the Smoking Policy effective 5/1/22. The letter provides notification that the home now provides one designated outside smoking area for residents, visitors, and staff.*

*The home's Smoking Policy was updated and posted on 3/25/22 for residents, visitors, staff indicating the revised Smoking Policy.*

*All citations found in this violation report to include Regulation 2600.144.b. will be reviewed as part of the Quarterly Staff Meeting on 3/30/22. Record of this meeting will be documented and kept on file.*

*7. Designated position responsible and specify target date for correction.*
*The Executive Operations Officer will ensure that the Notification Letter and Amendment to the Resident Handbook regarding the Smoking Policy will be mailed on 3/31/22.*

*The Executive Operations Officer will monitor the designated Smoking area for adherence to the plan, immediately and on-going.*
**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 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**

*The pharmacy label for resident #3's* [redacted] *indicates administer daily; however, this medication is prescribed administer daily and as needed.*

*There is no pharmacy label for resident #9's* [redacted] *indicating the prescribed sliding scale dosage.*
*In addition, there is no pharmacy label for resident #9's Tresiba insulin pen indicating dosage or directions.*

*The pharmacy label for resident #10's* [redacted] *indicates administer daily; however, this medication is prescribed administer as needed.*

## 184a - Labeling OTC/CAM *(continued)*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.184.a. - Labeling OTC/CAM*
*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.*

*2. Violation Interpretative Statement:*
*The pharmacy label for resident #3's [redacted] indicates administer daily; however, this medication is prescribed administer daily and as needed.*

*There is no pharmacy label for resident #9's [redacted] indicating the prescribed sliding scale dosage.*

*In addition, there is no pharmacy label for resident #9's [redacted] indicating dosage or directions.*

*The pharmacy label for resident #10's [redacted] indicates administer daily; however, this medication is prescribed administer as needed.*

*3. Review the benefit of the Regulation, per RCG:*
*Reduces the possibility that medication will be administered to the wrong resident or improperly administered.*

*4. Description of the Repair of the Immediate Problem:*
*The pharmacy label for resident #3's [redacted] was corrected to indicate "Direction change, see MAR" in the presence of the Licensing Representative from DHS.*

*The home ordered resident #9's [redacted] insulin pen from the home's contracted pharmacy on 3/3/22 to indicate current dosage and order. Both medications reflecting the correct dosage and directions were delivered to the home the evening of 3/3/22.*

*5. Determine / document the Root Cause of the Violation:*
*Resident #3 [redacted] - lack of process to ensure compliance with 2600.184.a. (primarily verification)*
*Resident #9 [redacted] – spouse of resident #9 was supplying insulin pens from private pharmacy.*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*Resident Wellness Director will provide re-education on the requirements of 2600.184.a. to all LPN's & Medication Associates. Documentation of training will be maintained. Target date is on or before 3/30/22.*

*To establish the extent of compliance, all medications will be audited for completeness and for the condition identified on the visit relating to 2600.184.a. Any discrepancies will be documented and corrected. Target is on or before 4/1/22.*

*New or changed medication or treatment orders will be documented on the Orders/Medication Verification Flow sheet by the accepting LPN Supervisor. The midnight LPN Supervisor will verify medication/treatment orders in the electronic MAR, medication label and medications are accurate. The use of the Orders/Medication Verification Flow sheet is to ensure all physician orders are transcribed and labeled accurately. Target date is 3/30/22 and on-going.*

*7. Designated position responsible and specify target date for correction.*

## *184a - Labeling OTC/CAM (continued)*

*The Resident Wellness Director will develop and conduct training on the new Flow sheet with all LPN's on or before 3/30/22.*

*The Director of Wellness will oversee the Flow Sheet audit of medications for compliance with 2600.184.a. A record of the audit will be maintained.*

*The Executive Operations Officer will verify that the verification is on-going and will be reminded by Outlook calendar Tickler for next 60 days to establish the habit and routine of the Resident Wellness Director.*

**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 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**

*On the following dates and times, staff person A, who has not completed a Department-approved diabetes patient education program within the past 12 months, tested the blood glucose for resident #12:*
*1/3/22 at 4:00 p.m.*
*1/8/22 at 7:00 a.m.*
*1/9/22 at 7:00 a.m.*
*1/24/22 at 4:00 p.m.*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.190.b. – Insulin Injections*
*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.*

*2. Violation Interpretative Statement:*
*On the following dates and times, staff person A, who has not completed a Department-approved diabetes patient education program within the past 12 months, tested the blood glucose for resident #12:*
*1/3/22 at 4:00 p.m.*
*1/8/22 at 7:00 a.m.*
*1/9/22 at 7:00 a.m.*
*1/24/22 at 4:00 p.m.*

*3. Review the benefit of the Regulation, per RCG:*
*Ensures that staff who administer insulin do so in a safe manner.*

*4. Description of the Repair of the Immediate Problem:*

## *190b - Insulin Injections (continued)*

*Staff person A was immediately removed from assignments involving the administration of insulin injections pending the successfully completion of a Department-approved Diabetes education program. Two Diabetes education programs were scheduled at the home on 3/25/22 and 3/28/22.*

*Staff person A successfully completed a Department-approved Diabetes education program on 3/25/22.*

*5. Determine / document the Root Cause of the Violation:*
*Lack of process to ensure compliance with 2600.190.b. (primarily verification)*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*To establish the extent of compliance, staff Diabetes education training records and tickler were audited for compliance and for the condition identified on the visit relating to 2600.190.b. Staff identified as needing Diabetes education training will be attending training sessions on 3/25/22 and 3/28/22. Record of these trainings will be documented and kept on file.*

*The Executive Operations Office and Resident Wellness Director set a monthly tickler reminder via Outlook Calendar to verify that staff maintain current Diabetes education training and schedule trainings as needed to remain compliant with 2600.190.b.*

*7. Designated position responsible and specify target date for correction.*
*The Resident Wellness Director will be responsible for maintaining the Diabetes education tickler and ensuring that annual trainings will be completed timely and within the timeframe set by DHS.*

*The Executive Operations Officer will verify that the Diabetes education tickler is maintained and will be reminded by Outlook Calendar to establish the habit and routine of the RWD. Target date is 4/1/22 and on-going.*
**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 234a - Admission Support Plan

**1. Requirements**

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

**Description of Violation**

*Resident #13 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on 2/21/22.*

**Plan of Correction** ***Accept***

*1. Violation Review: 2600.234.a. - Admission Support Plan*
*Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented, and documented in the resident record.*

*2. Violation Interpretative Statement:*

## *234a - Admission Support Plan (continued)*

*Resident #13 was admitted to the Secure Dementia Care Unit (SDCU) on 2/17/22. However, the resident's initial support plan was completed on 2/21/22.*

*3. Review the benefit of the Regulation, per RCG:*
*Ensures that there is a plan to serve residents with challenging behaviors as soon as possible.*

*4. Description of the Repair of the Immediate Problem:*
*The home is unable to correct a resident Support Plan that is one day late.*

*5. Determine / document the Root Cause of the Violation:*
*The Support Plan was not complete prior to the end of the business week. It was completed on the next business Monday, which was one day late.*

*6. Detail Action Steps / System Developed to prevent future occurrence:*
*Resident Support Plans were audited for compliance and for the condition identified on the visit relating to 2600.234.a.*

*All citations found in this violation report to include Regulation 2600.234.a. were reviewed with the Resident Wellness Director and will be reviewed as part of the Quarterly Staff Meeting on 3/30/22. Record of this meeting will be documented and kept on file.*

*The Resident Wellness Director is responsible for ensuring Resident Support Plans are completed timely to ensure compliance and accuracy of the information provided.*

*The Resident Wellness Director has developed a Support Plan tickler to ensure completion of Support Plans for the SDCU are timely and compliant with the regulation.*

*7. Designated position responsible and specify target date for correction.*
*The Resident Wellness Director will be responsible for maintaining the Support Plan tickler and ensuring that Support Plans will be completed timely and within the timeframe set by DHS.*

*The Executive Operations Officer will verify that the Support Plan tickler is maintained to establish the habit and routine of the RWD. Target date is 4/1/22 and on-going.*

*The Executive Operations Officer will review every new Resident Support Plan for timeliness and compliance of the information moving forward.*
**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*

## 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 #6 is prescribed [redacted], take one tablet every four hours as needed; however, this medication is not available in the home.*

*Resident #9's glucometer was not calibrated to the correct date. On 3/3/22, the glucometer indicated a date of 3/2/22.*

*Resident #11's glucometer was not calibrated to the correct date. On 3/3/22, the glucometer indicated a date of 3/2/22.*

*Repeat Violation: 3/11/21*

**Plan of Correction** ***Accept***

*1. Violation Review: 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.*

*2. Violation Interpretative Statement:*
*Resident #6 is prescribed Ondansetron HCL 4mg, take one tablet every four hours as needed; however, this medication is not available in the home.*

*Resident #9's glucometer was not calibrated to the correct date. On 3/3/22, the glucometer indicated a date of 3/2/22.*

*Resident #11's glucometer was not calibrated to the correct date. On 3/3/22, the glucometer indicated a date of 3/2/22.*

*3. Review the benefit of the Regulation, per RCG:*
*Reduces the risk that medications and medical equipment will be misplaced, lost, or misused.*

*4. Description of the Repair of the Immediate Problem:*
*Resident #6's medication was ordered from the home's pharmacy on 3/2/22 to have on-site at the home.*

*All glucometers in the home were calibrated on 3/17/22 to reflect the accurate year immediately following the licensing inspection.*

*5. Determine / document the Root Cause of the Violation:*
*Resident #6's utilizes VA Pharmacy for medications. PRN Ondansetron was ordered by the home through the VA pharmacy on 2/22/22, but not received at the time of the licensing inspection.*

*The home found that some glucometers did not reflect the correct year. This is due to lack of process to ensure compliance with 2600.185.a. (primarily verification)*

*6. Detail Action Steps / System Developed to prevent future occurrence:*

## 185a - Implement Storage Procedures (continued)

*The Resident Wellness Director will provide re-education on the requirements of 2600.185.a. to all LPN's & Medication Associates. Documentation of training will be maintained. Target date is on or before 3/30/22.*

*To establish the extent of compliance, all medications provided by the VA Pharmacy will be audited to ensure availability in the home and for the condition identified on the visit relating to 2600.185.a. Any discrepancies will be documented and corrected. Target date is 3/30/22.*

*The Resident Wellness Director will make phone calls to the Responsible Party of those Residents that utilize VA Pharmacy to communicate the importance of ensuring that prescribed medications are available in the home at all times. The home will submit a reorder of medications with the VA Pharmacy 7-10 days prior to the depletion of the medication and if the home does not receive the medication from the VA Pharmacy within 3 days, the home will place an order for the medication from the home's contracted pharmacy. Documentation of the phone conversation will be documented and kept on file. Target date is 3/30/22.*

*Weekly checks on glucometers to ensure accurate month, day, and year will be completed by the Resident Wellness Coordinator and documented in the electronic MAR. The home revised the current audit to include the year to ensure compliance with the regulation.*

*7. Designated position responsible and specify target date for correction.*
*The Resident Wellness Director will develop and conduct training on the procedure relating to VA medications with all Medication Associates and LPN's on or before 3/30/22.*

*The Resident Wellness Director will develop and conduct training on the proper calibration of glucometers with the Resident Wellness Coordinator on or before 3/30/22.*

*The Executive Operations Officer will verify that the verification is on-going and will be reminded by Outlook calendar Tickler for next 60 days to establish the habit and routine of the Resident Wellness Director.*
**Completion Date:** *03/25/2022*

**Document Submission** ***Implemented***

*Back-up Documentation attached*