Department of Human Services
Bureau of Human Service Licensing

November 4, 2022

[redacted]
PRESBYTERIAN SENIOR CARE INC
1215 HULTON ROAD
OAKMONT, PA, 15139

RE: WESTMINSTER PLACE OF OAKMONT
1215 HULTON ROAD
OAKMONT, PA, 15139
LICENSE/COC#: 42962

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/26/2022, 10/25/2022 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *WESTMINSTER PLACE OF OAKMONT* **License #**: *42962* **License Expiration**: *06/30/2023*

Addre : *1215 HULTON ROAD, OAKMONT, PA 15139*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*

Address: *1215 HULTON ROAD, OAKMONT, PA, 15139*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/07/2015* **Issued By**: *Borough of Oakmont*

Type: *I-1* **Date**: *12/19/2011* **Issued By**: *Borough of Oakmont*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *10/25/2022*

Inspection Dates and Department Representative

09/26/2022 - On-Site [redacted]

10/25/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *69*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

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

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

09/26/2022 - Partial

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *11/04/2022*

11/04/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *11/04/2022*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/11/2022*

11/04/2022 Document Submi ion

Submitted By: [redacted] **Date Submitted:** *11/04/2022*

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #3 is prescribed [redacted] 100mg/5mL (20mg/mL) oral solution-Take 5mg (0.25mL) by mouth/sublingually every 2 hours as needed [redacted] On [redacted]/22 at approximately [redacted] a.m., resident #3 [redacted] requested a dose of [redacted] from staff person A. The medication was unable to be located in the home until approximately [redacted] a.m., when staff person A administered 100mg (5mL) [redacted] by mouth to resident #3, 20 times the prescribed dosage of 5mg (0.25mL). Emergency personnel were called at [redacted] p.m. and arrived at [redacted] p.m. They found the resident to be lethargic and hypertensive and administered [redacted] intravenously. At [redacted] p.m., the resident arrived at the hospital, was diagnosed with [redacted] and received [redacted] until approximately [redacted]/22 at [redacted] a.m. when the resident's respiratory rate and mental status returned to baseline.

POC Submission ***Accept (JK - 11/04/2022)***

Resident #3 was ordered and receiving [redacted] for pain management in addition to the [redacted] which was prescribed as needed [redacted]. On [redacted]/2022 when the resident requested [redacted] for increased pain, nursing discovered that the prescribed [redacted] had not been delivered from pharmacy. Nursing located the resident's home emergency kit which contained a [redacted] with pharmacy label directions to give 5mg (0.25ml) by mouth/sublingually every 2 hours as needed [redacted] Staff person A administered 100mg (5ml) to the resident as noted in the (MAR) Medication Administration Record directions. When completing the documentation of the remaining quantity, the discrepancy of the dose entered in the MAR was discovered, as 5ml was entered vs 5mg. Emergency services was called. Resident was transported to the hospital for medical intervention and treatment. Family and PCP were made aware. Nursing corrected the physicians order on [redacted] (See physicians order for [redacted]/2022)

On [redacted], Staff person "A" was re-educated by the certified medication trainer on the procedure for checking the pharmacy label directions and comparing with the information on the MAR. (See Attachment A) On [redacted] Staff Person A completed a med pass observation by the certified medication trainer, observing for pharmacy label to MAR comparison and reviewed the process to stop and seek clarification before proceeding with medication administration if information does not match. (Attachment A1)

On 9/14, nursing received education by the certified medication trainer to complete a double check of all [redacted] orders, to ensure that the right dosage is entered into physician's orders as prescribed. (Attachment B)

On 9/15 and 9/22, an interdisciplinary team meeting with pharmacy was conducted to determine root cause for med error and delay in medication delivery. Noted factors included medication was profiled in pharmacy system, therefore was not filled on admission. Physician's orders noted the information was correct, but data was entered incorrectly at time of admission. Hospice emergency kit was brought in was for home use, [redacted] packaging and labeling unfamiliar and unclear.

On 9/23/22, Administrator completed a [redacted]/physician orders audit for all residents [redacted]. (Attachment C) No other dosage discrepancies were noted.

42b - Abuse (continued)

The administrator will complete education (Attachment D1) for all nurses and med techs regarding the changes to policies and procedures for medication administration (Attachment D2) and physician orders. (Attachment D3) In addition, the administrator will review the abuse policy and procedure for all team members will and complete all education Nov 12, 2022. (Attachment D4)

On 9/23- Changes were made to the Hospice Program Policy, to include Emergency Medication Kits will not be accepted by the community unless the medications are packaged in a single use syringe with clear labeling. (Attachment E)

A medication audit tracker will be completed by nursing on a weekly basis x 2 months, comparing the pharmacy label to MAR for data accuracy or change in direction sticker to alert of new changes. (Attachment F) Results to be reviewed weekly by the administrator with findings to be shared at the monthly Quality Management meetings for any additional recommendations.

Licensee's Plan Completion Date: *11/03/2022*

Implemented (- 11/04/2022)

183d - Prescription Current

2. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #1 was prescribed [redacted] The medication was discontinued on 9/14/22; however, the medication was stored in the medication cart on 9/26/22.

REPEAT VIOLATION: 5/18/2022 et al.

POC Submission ***Accept (JK - 11/04/2022)***

Resident #1 discontinued [redacted] patch was removed for the medication cart on [redacted] Nursing completed a Medication cart audit of all residents' meds by 10/7, to review and remove any medications that are not current. (Attachment F)

The administrator completed education for all nurses and med techs by 11/1 (Attachment D1), to ensure discontinued medications are pulled from medication carts at the time physician's orders are completed and noted. Copies of medication orders are placed in the 24 hour nursing communication binder for a second check process to ensure discontinued meds have been removed.

A medication cart audit will be completed by nursing on a weekly basis x 2 months, checking for any discontinued meds. (Attachment F) Results to be reviewed weekly by the administrator with findings to be shared at the monthly Quality Management meetings for any additional recommendations.

Licensee's Plan Completion Date: *11/03/2022*

Implemented - 11/04/2022)

183d - Prescription Current *(continued)*

183e - Storing Medications

3. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #2's [redacted] was opened on 5/2/22. According to manufacturer's instructions, the [redacted] expire 3 months after opening; however, the medication was stored in the medication cart on 9/26/22.

Resident #2's [redacted] at bedtime every [redacted] however, the tube was not labeled with the date the bottle was opened.

POC Submission ***Accept (JK - 11/04/2022)***

Resident #2's expired [redacted] and undated [redacted] was removed from the medication cart on [redacted] and re-ordered.

Nursing completed a Medication cart audit of all residents' meds by 10/7, to review and pull any expired meds or undated open bottles or vials of medications and reorder as necessary. (Attachment F)

The administrator completed education for all nurses and med techs by 11/1 (Attachment D1), for checking for expiration dates and dates opened labels on any medication containers before preparing medications for administration.

A medication cart audit will be completed by nursing on a weekly basis x 2 months, checking for expired or undated opened eye drops. (Attachment F) Results to be reviewed weekly by the administrator with findings to be shared at the monthly Quality Management meetings for any additional recommendations.

Licensee's Plan Completion Date: *11/03/2022*

Implemented [redacted] 11/04/2022)

184a - Resident's Meds Labeled

4. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed [redacted] 1 drop [redacted] daily as needed; however, the pharmacy label indicates-[redacted] twice daily as needed.

POC Submission ***Accept (JK - 11/04/2022)***

Resident #2's [redacted] was removed from med cart on 9/26 and re-ordered. Nursing completed

184a - Resident's Meds Labeled (continued)

a Medication cart audit (Attachment F) of all residents' meds by 10/7, to review and compare orders with pharmacy abels for any discrepancies. A change in direction sticker is applied to pharmacy label for any medication with directional changes.

The administrator completed education for all nurses and med techs by 11/1 (Attachment D1), to ensure directional change alerts are applied to pharmacy label of any medication with dose or instruction changes. Copies of medication orders are placed in the 24 hours nursing communication binder for a second check process to review and check for placement of directional change stickers.

Nursing will utilize a medication cart audit to monitor all residents' medications, comparing pharmacy label to MAR checks for data and information accuracy on a weekly basis x 2 months. (Attachment F) A change in direction sticker will be applied to pharmacy label for any updated changes. Results of audits to be reviewed at the monthly Quality management meetings for any additional recommendations.

Licensee's Plan Completion Date: *11/03/2022*

Implemented (- 11/04/2022)

187a - Medication Record

5. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident #3 is prescribed -Take 5mg (0.25mL) by mouth/sublingually every 2 hours However, the resident's September 2022 medication administration record (MAR) indicates-Take 5mL by mouth every 2 hours as needed .

POC Submission ***Accept (JK - 11/04/2022)***

Resident #3's prescribed dosage amount was entered incorrectly in the physician's order of the Electronic Health Record. On , the order was corrected for Take 5mg (0.25ml) by mouth/sublingually every 2 hours as needed . (see physician order) On 9/23, the administrator completed a audit to review for any order discrepancies Attachment E) No other dosage discrepancies were noted.

On 9/14, Nursing was educated by the Medication certified trainer on the procedure for checking the physician's orders and comparing the information on the pharmacy label to the MAR before placing medication in the med cart. Attachment A) A double check process was added to ensure any new narcotic medication orders entered into the medical record contains the correct information and dosage as prescribed in the physician's orders. (Attachment B) Copies of medication orders are placed in the 24 hours nursing communication binder for review to ensure double check of data entry is complete.

The administrator will complete staff education (Attachment D1) for all nurses and med techs regarding the changes to policies and procedures for double check process of narcotic dose entry for Physicians orders. (Attachment D3) All education to be completed by Nov 12, 2022.

187a - Medication Record (continued)

A medication cart audit will be completed by nursing on a weekly basis x 2 months, checking to make sure the dose n the medication record is accurate and matches the pharmacy label. (Attachment F) Results to be reviewed weekly by the administrator with findings to be shared at the monthly Quality Management meetings for any additional recommendations.

Licensee's Plan Completion Date: *11/03/2022*

Implemented [redacted] - 11/04/2022)

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident #3 is prescribed [redacted] 100mg/5mL (20mg/mL) oral solution-Take 5mg (0.25mL) by mouth/sublingually every 2 hours as needed [redacted]. On [redacted]/22 at approximately [redacted] a.m., resident #3 [redacted] requested a dose of [redacted] from staff person A. The medication was unable to be located in the home until approximately [redacted] a.m., when staff person A administered 100mg (5mL) [redacted] concentrate by mouth to resident #3, 20 times the prescribed dosage of 5mg (0.25mL). Emergency personnel were called at [redacted] p.m. and arrived at 1[redacted] p.m. They found the resident to be lethargic and hypertensive and administered .5mg of [redacted] intravenously. At [redacted] p.m., the resident arrived at the hospital, was diagnosed with [redacted], and received 2 additional infusions of [redacted] until approximately [redacted]/22 at [redacted] a.m. when the resident's respiratory rate and mental status returned to baseline.

POC Submission ***Accept ([redacted] - 11/04/2022)***

Resident #3 was ordered and receiving [redacted] medication [redacted] in addition to the [redacted], which was prescribed as needed every 2 hours [redacted] On [redacted]/2022 when the resident requested [redacted] nursing discovered that the prescribed [redacted] had not been delivered from pharmacy. Nursing ocated the resident's home emergency kit which contained a bottle of [redacted] with pharmacy label directions to give 5mg (0.25ml) by mouth/sublingually every 2 hours as needed [redacted] Staff person A administered 100mg (5ml) to the resident as noted in the (MAR) Medication Administration Record directions. When completing the documentation of the remaining quantity, the discrepancy of the dose entered in the MAR was discovered, as 5ml was entered vs 5mg. Emergency services was called. Resident was transported to the hospital for medical intervention and treatment. Residents POA and PCP were notified.

On 9/15, Staff person A completed a remediation med pass observation (Attachment A1) by the medication certified trainer on the procedure for checking the pharmacy label directions and comparing with the information on the MAR. Education provided If a discrepancy is noted, the process is to stop and seek clarification before proceeding with medication administration.

The administrator will complete education (Attachment D1) for all nurses and med techs regarding the changes to policies and procedures for medication administration (Attachment D2) and physician orders. (Attachment D3) All education to be completed by Nov 12, 2022. (Attachment D4)

187d - Follow Prescriber's Orders (continued)

A medication cart audit will be completed by nursing on a weekly basis x 2 months, checking for pharmacy label and data accuracy of physicians order . (Attachment F) Results to be reviewed weekly by the administrator with findings to be shared at the monthly Quality Management meetings for any additional recommendations.

Licensee's Plan Completion Date: *11/03/2022*

Implemented ([redacted] - 11/04/2022)