

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

January 3, 2023

[REDACTED]
TITHONUS GREENSBURG LP
[REDACTED]
[REDACTED]

RE: NEWHAVEN COURT AT LINDWOOD
100 FREEDOM WAY
GREENSBURG, PA, 15601
LICENSE/COC#: 42936

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/10/2022 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

Facility Information

Name: *NEWHAVEN COURT AT LINDWOOD* License #: *42936* License Expiration: *06/10/2023*
 Address: *100 FREEDOM WAY, GREENSBURG, PA 15601*
 County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *TITHONUS GREENSBURG LP*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C 2 LP* Date: *06/02/2006* Issued By: *PA Dept L&I*

Staffing Hours

Resident Support Staff: Total Daily Staff: *107* Waking Staff: *80*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *11/23/2022*

Inspection Dates and Department Representative

11/10/2022 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *131* Residents Served: *81*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Forest Hills - Memory Care* Capacity: *16* Residents Served: *15*

Hospice
 Current Residents: *7*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *81*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *26* Have Physical Disability: *1*

Inspections / Reviews

11/10/2022 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/16/2022*

12/16/2022 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *12/23/2022*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *12/26/2022*

Inspections / Reviews *(continued)*

01/03/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/23/2022

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

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.

Description of Violation

Resident #1 is ordered [redacted] Refer to sliding scale three times daily before meals; [redacted]

However, the resident's blood glucose readings were not documented on the resident's October 2022 medication administration record (MAR) on [redacted]/22 at [redacted] 00 p.m., [redacted]/22 at [redacted]:00 p.m. and on [redacted]/22 at [redacted]:00 p.m.

Resident #2 is ordered blood sugar checks four times daily before meals and at bedtime - [redacted] However, the resident's blood glucose reading was not documented on the resident's October 2022 MAR on [redacted]/22 at [redacted] p.m., [redacted]/22 at [redacted] p.m., [redacted]/22 at [redacted] p.m., and [redacted]/22 at [redacted] p.m.

Plan of Correction

Accept [redacted] - 12/16/2022)

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.

Violation Interpretative Statement: Resident #1 is ordered [redacted] Refer to sliding scale three times daily before meals [redacted] However, the Resident's blood glucose readings were not documented on the Resident's October 2022 medication administration record (MAR) on [redacted]/22 at [redacted] p., [redacted]/22 at [redacted] p and on [redacted]/22 at [redacted] p.

Resident #2 is ordered blood sugar checks four times daily before meals and at bedtime [redacted] However, the Resident's blood glucose reading was not documented on the Residents October 2022 MAR on [redacted]/22 at [redacted] p, [redacted]/22 at [redacted] p, [redacted]/22 at [redacted] p, [redacted]/22 at [redacted] p, and [redacted]/22 at [redacted] p.

Description of the Repair of the Immediate Problem: Trained personnel were immediately removed from doing insulins and blood sugars. Only the LPNs and Resident Wellness Director were permitted to do insulins and blood sugars in the community until retraining and re education was completed. The LPNs were also required to have a witness present to verify that the Residents blood glucose sugars were obtained, readings were documented on the MAR, and orders were followed/completed per the physicians orders.

Determine / document the Root Cause of the Violation: The home failed to do blood glucose checks for Resident #1 and Resident #2 on the dates listed.

Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice? The Resident Wellness Director and/or designee have been checking the medication administration records daily to ensure blood glucose sugars readings and insulins are being completed and documented per physician's orders. In addition, the Resident Wellness Director has been running exception reports daily in QuickMar for review and monitoring to monitor refusals (if applicable) and to ensure the physician is being notified per the order depending on the blood sugar reading.

b. Teaching or Training?

185a - Implement Storage Procedures (continued)

Immediately following the state exit on November 10th, the Executive Operations Officer addressed trained personnel on the concerns found during the survey as well as communicated the temporary process for blood sugars and insulins until retraining was completed. The Resident Wellness Director re-trained both the LPNs and trained personnel on November 18th and November 19th on blood sugars, refusals, documentation, physician's orders/labels, and insulins. Following the retraining and re-education, the Resident Wellness Director watched each trained personnel perform blood glucose sugars, insulins, and complete the medication administration record to ensure that all steps were followed before having them do blood glucose sugars and insulins on their own. The Resident Wellness Director also retrained all trained personnel during the November monthly meeting on November 30th. In addition, all trained personnel are scheduled to have their annual diabetic training on January 10th, 2023.

c. On-going Monitoring? The Resident Wellness Director and/or designee have been monitoring blood sugar readings and insulins daily since November 10th and will continue until full compliance is met by ensuring the physician's orders are followed completely per the label. At that time, the Resident Wellness Director and/or designee will then check blood sugar readings and insulins weekly and randomly.

Designated position responsible and specify target date for correction.

Full compliance will be met by January 10th, 2023. The Resident Wellness Director, the Executive Operations Officer, and/or designee are responsible to ensure that all Diabetic processes and systems are in place for compliance.

Licensee's Proposed Overall Completion Date: 01/10/2023

Implemented [redacted] - 01/03/2023)

187a Medication Record

2. 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 #1 is ordered [redacted] – Refer to sliding scale three times daily before meals [redacted] number of units of insulin administered was not documented on the resident's October 2022 medication administration record (MAR) on [redacted]/22 at [redacted] p.m., [redacted]/22 at [redacted] p.m. and on [redacted]/22 at [redacted] p.m.

Plan of Correction

Accept [redacted] - 12/16/2022)

Violation Review: 2600.187.a A medication record shall be kept to include the following for each resident for who medications are administered.

6. Dose.

Violation Interpretative Statement:

187a - Medication Record (continued)

Resident #1 is ordered [redacted] Refer to sliding scale three times daily before meals; [redacted] The number of units of insulin administered was not documented on the resident's October 2022 medication administration record (MAR) on [redacted]/22 at [redacted] p, [redacted]/22 at [redacted] p and on [redacted]/22 at [redacted] p.

Description of the Repair of the Immediate Problem: Trained personnel were immediately removed from doing insulins and blood sugars. Only the LPNs and Resident Wellness Director were permitted to do insulins and blood sugars in the community until retraining and re-education was completed. The LPNs were also required to have a witness present to verify that the Residents' blood glucose sugars were obtained, readings and insulins were documented on the MAR, and orders were followed/completed per the physicians' orders.

Determine / document the Root Cause of the Violation: The home failed to do blood glucose checks for Resident #1 on the dates listed.

Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice? The Resident Wellness Director and/or designee have been checking the medication administration records daily to ensure blood glucose sugars readings and insulins were completed and documented per physician's orders. In addition, the Resident Wellness Director has been running exception reports daily in QuickMar for review and monitoring to ensure the physician's orders are being completely followed through.

b. Teaching or Training? Immediately following the state exit on November 10th, the Executive Operations Officer addressed trained personnel on the concerns found during the survey as well as communicated the temporary process for blood sugars and insulins until retraining was completed. The Resident Wellness Director re-trained both the LPNs and trained personnel on November 18th and November 19th on blood sugars, refusals, documentation, physician's orders/labels, and insulins. Following the retraining and re-education, the Resident Wellness Director watched each trained personnel perform blood glucose sugars, insulins, and complete the medication administration record to ensure that all steps were followed before having them do blood glucose sugars and insulins on their own. The Resident Wellness Director also retrained all trained personnel during the November monthly meeting on November 30th. In addition, all trained personnel are scheduled to have their annual Diabetic training on January 10th, 2023.

c. On-going Monitoring? The Resident Wellness Director and/or designee have been monitoring blood sugar readings and insulins daily since November 10th and will continue until full compliance is met. by ensuring the physician's orders are followed completely per the label. At that time, the Resident Wellness Director and/or designee will then check blood sugar readings and insulins weekly and randomly.

Designated position responsible and specify target date for correction.

Full compliance will be met by January 10th, 2023. The Resident Wellness Director, the Executive Operations Officer, and/or designee are responsible to ensure that all Diabetic processes and systems are in place for compliance.

Licensee's Proposed Overall Completion Date: 01/10/2023

Implemented [redacted] 01/03/2023)

187b - Date/Time of Medication Admin.

3. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is ordered [REDACTED]

However, the resident's October 2022 medication administration record (MAR) was not signed off that the medication was administered on [REDACTED]/22 at [REDACTED] p.m. and on [REDACTED]/22 at [REDACTED] p.m. nor was there indication in the notes why the medication was not documented.

Plan of Correction

Accept [REDACTED] - 12/16/2022)

Violation Review: 2600.187.b The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Violation Interpretative Statement: Resident #2 is ordered [REDACTED]. However, the residents' October 2022 medication administration record (MAR) was not signed off that the medication was administered on [REDACTED]/22 at [REDACTED] p and on [REDACTED]/22 at [REDACTED] p nor was there indication in the notes why the indication was not documented.

Description of the Repair of the Immediate Problem: Trained personnel were immediately removed from doing insulins and blood sugars. Only the LPNs and Resident Wellness Director were permitted to do insulins and blood sugars in the community until retraining and re-education was completed. The LPNs and were also required to have a witness present to verify that the Residents' blood glucose sugars were obtained, readings were documented on the MAR, and orders were followed/completed per the physicians' orders.

Determine / document the Root Cause of the Violation: The home failed to do blood glucose checks for Resident #2 on the dates listed.

Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice? The Resident Wellness Director and/or designee have been checking the medication administration records daily to ensure blood glucose sugars readings and insulins are completed and documented per physician's orders as well as also ensuring that trained personnel are following through with the direction on the label. In addition, the Resident Wellness Director has been running exception reports daily in QuickMar for review and monitoring by ensuring that a physician's order is present to hold the insulin depending on the blood sugar reading.

b. Teaching or Training? Immediately following the exit on November 10th, the Executive Operations Officer addressed trained personnel on the concerns found during the survey as well as communicated the temporary process for blood sugars and insulins until retraining was completed. The Resident Wellness Director re-trained both the LPNs and trained personnel on November 18th and November 19th on blood sugars, refusals, documentation, physician's orders/labels, and insulins. Following the retraining and re-education, the Resident Wellness Director watched each trained personnel perform blood glucose sugars, insulins, and complete the medication administration record to ensure that all steps were followed before having them do blood glucose sugars and insulins on their own. The Resident Wellness Director also retrained all trained personnel during the November monthly meeting on November 30th. In addition, all trained personnel are scheduled to have an annual Diabetic training on January 10th, 2023.

c. On-going Monitoring?

187b - Date/Time of Medication Admin. (continued)

The Resident Wellness Director and/or designee have been monitoring blood sugar readings and insulins daily since November 10th and will continue until full compliance is met. by ensuring the physician's orders are followed completely per the label. At that time, the Resident Wellness Director and/or designee will then check blood sugar readings and insulins weekly and randomly.

Designated position responsible and specify target date for correction.

Full compliance will be met by January 10th, 2023. The Resident Wellness Director, the Executive Operations Officer, and/or designee are responsible to ensure that all Diabetic processes and systems are in place for compliance.

Licensee's Proposed Overall Completion Date: 01/10/2023

Implemented 01/03/2023

187c Refusal of Medication

4. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident s record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #1 is ordered three times daily before meals; Resident #1 is also ordered once daily in the morning and every evening.

Resident #1 refused these medications as follows:

Resident #1 refused medications on various dates in 2022, including 12/22/22, 12/23/22, 12/24/22, 12/25/22, 12/26/22, 12/27/22, 12/28/22, 12/29/22, 12/30/22, 12/31/22, 1/1/23, 1/2/23, 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/7/23, 1/8/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/13/23, 1/14/23, 1/15/23, 1/16/23, 1/17/23, 1/18/23, 1/19/23, 1/20/23, 1/21/23, 1/22/23, 1/23/23, 1/24/23, 1/25/23, 1/26/23, 1/27/23, 1/28/23, 1/29/23, 1/30/23, 1/31/23, 2/1/23, 2/2/23, 2/3/23, 2/4/23, 2/5/23, 2/6/23, 2/7/23, 2/8/23, 2/9/23, 2/10/23, 2/11/23, 2/12/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/17/23, 2/18/23, 2/19/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, 2/24/23, 2/25/23, 2/26/23, 2/27/23, 2/28/23, 2/29/23, 2/30/23, 3/1/23, 3/2/23, 3/3/23, 3/4/23, 3/5/23, 3/6/23, 3/7/23, 3/8/23, 3/9/23, 3/10/23, 3/11/23, 3/12/23, 3/13/23, 3/14/23, 3/15/23, 3/16/23, 3/17/23, 3/18/23, 3/19/23, 3/20/23, 3/21/23, 3/22/23, 3/23/23, 3/24/23, 3/25/23, 3/26/23, 3/27/23, 3/28/23, 3/29/23, 3/30/23, 3/31/23, 4/1/23, 4/2/23, 4/3/23, 4/4/23, 4/5/23, 4/6/23, 4/7/23, 4/8/23, 4/9/23, 4/10/23, 4/11/23, 4/12/23, 4/13/23, 4/14/23, 4/15/23, 4/16/23, 4/17/23, 4/18/23, 4/19/23, 4/20/23, 4/21/23, 4/22/23, 4/23/23, 4/24/23, 4/25/23, 4/26/23, 4/27/23, 4/28/23, 4/29/23, 4/30/23, 5/1/23, 5/2/23, 5/3/23, 5/4/23, 5/5/23, 5/6/23, 5/7/23, 5/8/23, 5/9/23, 5/10/23, 5/11/23, 5/12/23, 5/13/23, 5/14/23, 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/20/23, 5/21/23, 5/22/23, 5/23/23, 5/24/23, 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, 5/30/23, 5/31/23, 6/1/23, 6/2/23, 6/3/23, 6/4/23, 6/5/23, 6/6/23, 6/7/23, 6/8/23, 6/9/23, 6/10/23, 6/11/23, 6/12/23, 6/13/23, 6/14/23, 6/15/23, 6/16/23, 6/17/23, 6/18/23, 6/19/23, 6/20/23, 6/21/23, 6/22/23, 6/23/23, 6/24/23, 6/25/23, 6/26/23, 6/27/23, 6/28/23, 6/29/23, 6/30/23, 7/1/23, 7/2/23, 7/3/23, 7/4/23, 7/5/23, 7/6/23, 7/7/23, 7/8/23, 7/9/23, 7/10/23, 7/11/23, 7/12/23, 7/13/23, 7/14/23, 7/15/23, 7/16/23, 7/17/23, 7/18/23, 7/19/23, 7/20/23, 7/21/23, 7/22/23, 7/23/23, 7/24/23, 7/25/23, 7/26/23, 7/27/23, 7/28/23, 7/29/23, 7/30/23, 7/31/23, 8/1/23, 8/2/23, 8/3/23, 8/4/23, 8/5/23, 8/6/23, 8/7/23, 8/8/23, 8/9/23, 8/10/23, 8/11/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/18/23, 8/19/23, 8/20/23, 8/21/23, 8/22/23, 8/23/23, 8/24/23, 8/25/23, 8/26/23, 8/27/23, 8/28/23, 8/29/23, 8/30/23, 8/31/23, 9/1/23, 9/2/23, 9/3/23, 9/4/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/11/23, 9/12/23, 9/13/23, 9/14/23, 9/15/23, 9/16/23, 9/17/23, 9/18/23, 9/19/23, 9/20/23, 9/21/23, 9/22/23, 9/23/23, 9/24/23, 9/25/23, 9/26/23, 9/27/23, 9/28/23, 9/29/23, 9/30/23, 10/1/23, 10/2/23, 10/3/23, 10/4/23, 10/5/23, 10/6/23, 10/7/23, 10/8/23, 10/9/23, 10/10/23, 10/11/23, 10/12/23, 10/13/23, 10/14/23, 10/15/23, 10/16/23, 10/17/23, 10/18/23, 10/19/23, 10/20/23, 10/21/23, 10/22/23, 10/23/23, 10/24/23, 10/25/23, 10/26/23, 10/27/23, 10/28/23, 10/29/23, 10/30/23, 10/31/23, 11/1/23, 11/2/23, 11/3/23, 11/4/23, 11/5/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/11/23, 11/12/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/17/23, 11/18/23, 11/19/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/24/23, 11/25/23, 11/26/23, 11/27/23, 11/28/23, 11/29/23, 11/30/23, 12/1/23, 12/2/23, 12/3/23, 12/4/23, 12/5/23, 12/6/23, 12/7/23, 12/8/23, 12/9/23, 12/10/23, 12/11/23, 12/12/23, 12/13/23, 12/14/23, 12/15/23, 12/16/23, 12/17/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/22/23, 12/23/23, 12/24/23, 12/25/23, 12/26/23, 12/27/23, 12/28/23, 12/29/23, 12/30/23, 12/31/23.

However, the home does not have documentation that the resident #1's physician was notified of these refusals.

Resident #3 is ordered three times daily before meals. Resident #3 refused this medications as follows:

Resident #3 refused medications on various dates in 2022, including 12/22/22, 12/23/22, 12/24/22, 12/25/22, 12/26/22, 12/27/22, 12/28/22, 12/29/22, 12/30/22, 12/31/22, 1/1/23, 1/2/23, 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/7/23, 1/8/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/13/23, 1/14/23, 1/15/23, 1/16/23, 1/17/23, 1/18/23, 1/19/23, 1/20/23, 1/21/23, 1/22/23, 1/23/23, 1/24/23, 1/25/23, 1/26/23, 1/27/23, 1/28/23, 1/29/23, 1/30/23, 1/31/23, 2/1/23, 2/2/23, 2/3/23, 2/4/23, 2/5/23, 2/6/23, 2/7/23, 2/8/23, 2/9/23, 2/10/23, 2/11/23, 2/12/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/17/23, 2/18/23, 2/19/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, 2/24/23, 2/25/23, 2/26/23, 2/27/23, 2/28/23, 2/29/23, 2/30/23, 3/1/23, 3/2/23, 3/3/23, 3/4/23, 3/5/23, 3/6/23, 3/7/23, 3/8/23, 3/9/23, 3/10/23, 3/11/23, 3/12/23, 3/13/23, 3/14/23, 3/15/23, 3/16/23, 3/17/23, 3/18/23, 3/19/23, 3/20/23, 3/21/23, 3/22/23, 3/23/23, 3/24/23, 3/25/23, 3/26/23, 3/27/23, 3/28/23, 3/29/23, 3/30/23, 3/31/23, 4/1/23, 4/2/23, 4/3/23, 4/4/23, 4/5/23, 4/6/23, 4/7/23, 4/8/23, 4/9/23, 4/10/23, 4/11/23, 4/12/23, 4/13/23, 4/14/23, 4/15/23, 4/16/23, 4/17/23, 4/18/23, 4/19/23, 4/20/23, 4/21/23, 4/22/23, 4/23/23, 4/24/23, 4/25/23, 4/26/23, 4/27/23, 4/28/23, 4/29/23, 4/30/23, 5/1/23, 5/2/23, 5/3/23, 5/4/23, 5/5/23, 5/6/23, 5/7/23, 5/8/23, 5/9/23, 5/10/23, 5/11/23, 5/12/23, 5/13/23, 5/14/23, 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/20/23, 5/21/23, 5/22/23, 5/23/23, 5/24/23, 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, 5/30/23, 5/31/23, 6/1/23, 6/2/23, 6/3/23, 6/4/23, 6/5/23, 6/6/23, 6/7/23, 6/8/23, 6/9/23, 6/10/23, 6/11/23, 6/12/23, 6/13/23, 6/14/23, 6/15/23, 6/16/23, 6/17/23, 6/18/23, 6/19/23, 6/20/23, 6/21/23, 6/22/23, 6/23/23, 6/24/23, 6/25/23, 6/26/23, 6/27/23, 6/28/23, 6/29/23, 6/30/23, 7/1/23, 7/2/23, 7/3/23, 7/4/23, 7/5/23, 7/6/23, 7/7/23, 7/8/23, 7/9/23, 7/10/23, 7/11/23, 7/12/23, 7/13/23, 7/14/23, 7/15/23, 7/16/23, 7/17/23, 7/18/23, 7/19/23, 7/20/23, 7/21/23, 7/22/23, 7/23/23, 7/24/23, 7/25/23, 7/26/23, 7/27/23, 7/28/23, 7/29/23, 7/30/23, 7/31/23, 8/1/23, 8/2/23, 8/3/23, 8/4/23, 8/5/23, 8/6/23, 8/7/23, 8/8/23, 8/9/23, 8/10/23, 8/11/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, 8/17/23, 8/18/23, 8/19/23, 8/20/23, 8/21/23, 8/22/23, 8/23/23, 8/24/23, 8/25/23, 8/26/23, 8/27/23, 8/28/23, 8/29/23, 8/30/23, 8/31/23, 9/1/23, 9/2/23, 9/3/23, 9/4/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/11/23, 9/12/23, 9/13/23, 9/14/23, 9/15/23, 9/16/23, 9/17/23, 9/18/23, 9/19/23, 9/20/23, 9/21/23, 9/22/23, 9/23/23, 9/24/23, 9/25/23, 9/26/23, 9/27/23, 9/28/23, 9/29/23, 9/30/23, 10/1/23, 10/2/23, 10/3/23, 10/4/23, 10/5/23, 10/6/23, 10/7/23, 10/8/23, 10/9/23, 10/10/23, 10/11/23, 10/12/23, 10/13/23, 10/14/23, 10/15/23, 10/16/23, 10/17/23, 10/18/23, 10/19/23, 10/20/23, 10/21/23, 10/22/23, 10/23/23, 10/24/23, 10/25/23, 10/26/23, 10/27/23, 10/28/23, 10/29/23, 10/30/23, 10/31/23, 11/1/23, 11/2/23, 11/3/23, 11/4/23, 11/5/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/11/23, 11/12/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/17/23, 11/18/23, 11/19/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/24/23, 11/25/23, 11/26/23, 11/27/23, 11/28/23, 11/29/23, 11/30/23, 12/1/23, 12/2/23, 12/3/23, 12/4/23, 12/5/23, 12/6/23, 12/7/23, 12/8/23, 12/9/23, 12/10/23, 12/11/23, 12/12/23, 12/13/23, 12/14/23, 12/15/23, 12/16/23, 12/17/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/22/23, 12/23/23, 12/24/23, 12/25/23, 12/26/23, 12/27/23, 12/28/23, 12/29/23, 12/30/23, 12/31/23.

However, the home does not have documentation that the resident #3's physician was notified of these refusals.

Plan of Correction

Accepted 12/16/2022

Violation Review: 2600.187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Violation Interpretative Statement:

187c - Refusal of Medication (continued)

Resident #1 is ordered [redacted] three times daily before meals; [redacted]. Resident #1 is also ordered [redacted] once daily in the morning and [redacted] every evening. Resident #1 refused these medications as follows:

[redacted] /22 p, [redacted] /22 p, [redacted] /22 a, [redacted] /22 a, [redacted] /22 p, [redacted] /22 a, [redacted] /22 p, [redacted] /22 p, [redacted] /22 p, [redacted] /22 a, [redacted] /22 p, and [redacted] p

[redacted] /22 a, [redacted] /11 a. However, the home does not have documentation that the resident #1's physician was notified of these refusals.

Resident #3 is ordered [redacted] three times daily before meals. [redacted] Resident #3 refused this medication as follows:

[redacted] /22 p, [redacted] /22 p, [redacted] /22 a, [redacted] /22 a, [redacted] /22 a, and [redacted] p, [redacted] /22 a and [redacted] a, [redacted] /22 p, [redacted] /22 a, [redacted] /22 a, [redacted] /22 p, [redacted] /22 p, [redacted] /22 a, [redacted] /22 a and [redacted] a, [redacted] /22 p, and [redacted] /22 a.

Description of the Repair of the Immediate Problem: Trained personnel were immediately removed from doing insulins and blood sugars. Only the LPNs and Resident Wellness Director were permitted to do insulins and blood sugars in the community until retraining and re-training was completed. The LPNs were also required to have a witness present to verify that the Residents' blood glucose sugars were obtained, readings were documented on the MAR, and orders were followed/completed per the physicians' orders.

Determine / document the Root Cause of the Violation: Trained personnel failed to document if Resident #1 and Resident #3's physicians were notified when refusals occurred.

Detail Action Steps / System Developed to prevent future occurrence:

a. Changing practice? The Resident Wellness Director and/or designee have been checking the medication administration records daily to ensure blood glucose sugars readings and insulins were completed and documented per physician's orders. In addition, the Resident Wellness Director has been running exception reports daily in QuickMar for review and monitoring to ensure there is a note that the physician was notified/called (if applicable) per the order and that the physician was notified if a refusal (if applicable) occurred.

b. Teaching or Training? Immediately following the exit on November 10th, the Executive Operations Officer addressed trained personnel on the concerns found during the survey as well as communicated the temporary process for blood sugars and insulins until retraining and re-education was completed. The Resident Wellness Director re-trained both the LPNs and trained personnel on November 18th and November 19th on blood sugars, refusals, documentation, physician's orders/labels, and insulins. Following the retraining and re-education, the Resident Wellness Director watched each trained personnel perform blood glucose sugars, insulins, and complete the medication administration record (as well as monitored that physician's orders were followed) to ensure that all steps were completed before having them do blood glucose sugars and insulins on their own. The Resident Wellness Director also retrained all trained personnel during the November monthly meeting on November 30th. In addition, all trained personnel are scheduled to have additional full diabetic training on January 10th, 2023.

187c - Refusal of Medication (continued)

c. **On-going Monitoring?** The Resident Wellness Director and/or designee have been monitoring blood sugar readings and insulins daily since November 10th and will continue until full compliance is met. by ensuring the physician's orders are followed completely per the label. At that time, the Resident Wellness Director and/or designee will then check blood sugar readings and insulins weekly and randomly.

Designated position responsible and specify target date for correction.

Full compliance will be met by December 31st. The Resident Wellness Director, the Executive Operations Officer, and/or designee are responsible to ensure that all Diabetic processes and systems are in place for compliance.

Licensee's Proposed Overall Completion Date: 01/10/2023

Implemented [redacted] - 01/03/2023)

187d - Follow Prescriber's Orders

5. Requirements

2600.

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

Description of Violation

Resident #1 is ordered [redacted] once daily in the morning. However, on 1 [redacted] /22 at approximately [redacted] a.m., staff person A administered [redacted] to resident #1.

Resident #1 is ordered [redacted] Refer to sliding scale three times daily before meals; [redacted] On [redacted] 22 at [redacted] a.m., resident #1's blood glucose reading was [redacted] requiring four units of [redacted]. However, six units were administered.

Resident #1 is ordered [redacted] Refer to sliding scale three times daily before meals; [redacted] On [redacted] 22 at [redacted] p.m., resident #1's blood glucose reading was [redacted]. However, there is no documentation that the resident's physician was called.

Plan of Correction

Accept [redacted] - 12/16/2022)

Violation Review: 2600.187.d. The home shall follow the directions of the prescriber.

Violation Interpretative Statement: Resident #1 is ordered [redacted] once daily in the morning. However, on [redacted] /22 at approximately [redacted] a, staff person A administered [redacted] to resident #1.

Description of the Repair of the Immediate Problem:

187d - Follow Prescriber's Orders (continued)

Staff Person A realized the error and immediately reported the error to the Resident Wellness Director. The Resident Wellness Director immediately called Resident #1's physician to report the concern and to receive direction. Resident #1 was sent to the hospital for further observation and monitoring.

Resident #1 was discharged back to the community, the following day, with no new orders or concern. Staff Person A was immediately removed from administering blood glucose sugars and insulins in the community. All trained personnel were immediately removed from blood glucose sugars and insulins. Only LPNs and the Resident Wellness Director were permitted to do blood glucose sugars and insulins until retraining was completed. LPNs were also required to have a witness present to verify that the Residents' blood glucose sugars were completed and documented on the MAR, the correct units of insulin were administered, labels were being read correctly and followed per the physician's order.

Determine / document the Root Cause of the Violation: Staff Person A read the strength of the insulin instead of the units on the label.

Detail Action Steps / System Developed to prevent future occurrence:

- a. Changing practice?** The Resident Wellness Director and/or designee have been checking the medication administration records daily to ensure blood glucose sugars readings and insulins were completed and documented per physician's orders. In addition, the Resident Wellness Director has been running exception reports daily in QuickMar for review and monitoring to ensure there is a note that the physician was notified/called (if applicable) per the order and that the physician was notified if a refusal (if applicable) occurred.
- b. Teaching or Training?** Immediately following the state exit on November 10th, the Executive Operations Officer addressed trained personnel on the concerns found during the survey as well as communicated the temporary process for blood sugars and insulins until retraining and re-education was completed. Staff Member A had extra Diabetic training and attended an additional Diabetic class on November 17th. The Resident Wellness Director re-trained both the LPNs and trained personnel on November 18th and November 19th on blood sugars, refusals, documentation, physician's orders/labels, and insulins. Following the retraining and re-education, the Resident Wellness Director watched each trained personnel perform blood glucose sugars, insulins, and complete the medication administration record (as well as monitored that physician's orders were followed) to ensure that all steps were completed before having them do blood glucose sugars and insulins on their own. The Resident Wellness Director also retrained all trained personnel during the November monthly meeting on November 30th. In addition, all trained personnel are scheduled to have their annual Diabetic training on January 10th, 2023.
- c. On-going Monitoring?** The Resident Wellness Director and/or designee have been monitoring blood sugar readings and insulins daily since November 10th and will continue until full compliance is met. by ensuring the physician's orders are followed completely per the label. At that time, the Resident Wellness Director and/or designee will then check blood sugar readings and insulins weekly and randomly.

Designated position responsible and specify target date for correction.

Full compliance will be met by January 10th, 2023. The Resident Wellness Director, the Executive Operations Officer, and/or designee are responsible to ensure that all Diabetic processes and systems are in place for compliance.

187d - Follow Prescriber's Orders (continued)

Licensee's Proposed Overall Completion Date: 12/31/2022

Implemented (█ - 01/03/2023)

190a - Completion Medication Course

6. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

The Department-approved medication administration training course annual practicum for staff person A completed 8/4/22 was not signed by a certified Train the Trainer. Only the Practicum Observer signed the Annual Practicum. Staff person A administered medications to resident #4 on █/22 at █ a.m.

Plan of Correction

Accept █ - 12/16/2022)

Violation Review: 2600.190.a. A staff person who successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical, eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Violation Interpretative Statement: The Department-approved medication administration training course annual practicum for staff person A completed 8/4/22 was not signed by a certified Train the Trainer. Only the Practicum Observer signed the Annual Practicum. Staff person A administered medications to resident #4 on █/22 at █ a.m.

Description of the Repair of the Immediate Problem: The Team Member Development and Education Coordinator is now the assigned Train the Trainer and Practicum Observer for medication and MAR observations.

Determine / document the Root Cause of the Violation: The Resident Wellness Director, who was also our Practicum Observer, was previously signing the annual practicums since █ did the observations but was not the original Train the Trainer. The community was following the direction from the Train the Trainer Practicum Observer information (attached).

Detail Action Steps / System Developed to prevent future occurrence:

- a. **Changing practice?** Moving forward, the Practicum Observer will be transition to the Team Member Development and Education Coordinator, who is also the Train the Trainer.
- b. **Teaching or Training?** The Team Member Development and Education Coordinator will conduct quarterly and annual practicum observations moving forward. All medication associates will be re-observed by December 31st.
- c. **On-going Monitoring?**

190a - Completion Medication Course (continued)

Both the Team Member Development and Education Coordinator and Resident Wellness Director will work together to schedule due observations immediately and ongoing. Once the observations are completed, the Team Member Development and Education Coordinator will sign as the Train the Trainer on the Annual Practicums. Annual Practicums will be audited quarterly to ensure the observations are completed and signed.

Designated position responsible and specify target date for correction.

Full compliance by December 31st, 2022. The Team Member Development and Education Coordinator, the Resident Wellness Director, and the Executive Operations Officer moving forward.

Licensee's Proposed Overall Completion Date: 01/10/2023

Implemented (█ - 01/03/2023)