

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

April 6, 2023

[REDACTED]
LOWRIE AID OPCO LLC
[REDACTED]

RE: LOWRIE PLACE
100 STERLING VILLAGE DRIVE
BUTLER, PA, 16001
LICENSE/COC#: 44496

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/22/2022, 12/23/2022, 01/03/2023, 01/06/2023 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: *LOWRIE PLACE* License #: *44496* License Expiration: *04/18/2024*
 Address: *100 STERLING VILLAGE DRIVE, BUTLER, PA 16001*
 County: *BUTLER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED]

Legal Entity

Name: *LOWRIE AID OPCO LLC*
 Address: *330 NORTH WABASH, SUITE 3700, CHICAGO, IL, 60611*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *37* Waking Staff: *28*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint* Exit Conference Date: *01/06/2023*

Inspection Dates and Department Representative

12/22/2022 - On-Site: [REDACTED]
 12/23/2022 - Off-Site: [REDACTED]
 01/03/2023 - Off-Site: [REDACTED]
 01/06/2023 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *47* Residents Served: *32*

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: *32*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *5* Have Physical Disability: *0*

Inspections / Reviews

12/22/2022 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/28/2023*

Inspections / Reviews *(continued)*

03/03/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/16/2023

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 03/17/2023

04/06/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/16/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

15c - Supervision

1. Requirements

2600.

15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [REDACTED], at approximately [REDACTED], resident #1, who is diagnosed with [REDACTED] and pain, rang his/her call bell. Staff person A answered the ring and went to resident's bedroom. The resident was visibly in pain and asked for pain medication. Resident is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as needed for pain. Staff person did not administer this medication. Resident rang his/her call bell again at approximately [REDACTED], and [REDACTED] still in pain. Staff person A did not administer the prescribed Morphine Sulfate 20mg/ml.

At approximately [REDACTED], during staff shift change, resident #1 told staff person B that staff person A did not administer pain medication. Staff person B told this to staff person C, and both staff persons went into resident's room and observed the resident in visible pain – crying on the toilet attempting to soothe his/herself with a cold towel. The home did not immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of staff person A.

Plan of Correction**Accept (JW - 03/03/2023)**

Lowrie Place hereby respectfully request an Informal Dispute Resolution for review and removal of violations pursuant to 55 Pa. Code Ch. 2600.15.c, 2600.16.c, 2600.42.b, 2600.187.d, and 2600.188.b which were cited during an unannounced complaint survey that concluded on January 06, 2023. Lowrie Place appreciates the privilege to respond to the survey process via the Informal Dispute Resolution. The process affords us the opportunity to collect data that may have not been presented during the actual survey.

Dispute Description

2600.15.c-Supervision

Lowrie Place disputes violation 2600.15.c-Supervision. The LIS description of Violation reads:

On [REDACTED], at approximately [REDACTED] resident #1, who is diagnosed with [REDACTED] and pain, rang his/her call bell. Staff person A answered the ring and went to resident's bedroom. The resident was visibly in pain and asked for pain medication. Resident is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as needed for pain. Staff person did not administer this medication. Resident rang his/her call bell again at approximately [REDACTED], and [REDACTED], still in pain. Staff person A did not administer the prescribed Morphine Sulfate 20mg/ml.

At approximately [REDACTED], during staff shift change, resident #1 told staff person B that staff person A did not administer pain medication. Staff person B told this to staff person C, and both staff persons went into resident's room and observed the resident in visible pain – crying on the toilet attempting to soothe his/herself with a cold towel. The home did not immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of staff person A.

Lowrie Place respectfully disputes the finding of the home needing to immediately submit to the Department's personal care home regional office a plan supervision or notice of suspension of the affected staff person, staff

15c - Supervision (continued)

person A, as the record for Resident #1 reflects the resident was evaluated and medicated for pain by staff person A, per physician's orders.

Resident #1 alerted their call bell at [REDACTED] on [REDACTED]. Staff person A responded in approximately 2 minutes and resident #1 requested pain medication. At approximately [REDACTED] Staff person A administered Acetaminophen 325mg 2 tabs to resident #1 according to current physician's orders (see attachment #1). Staff person A evaluated Acetaminophen effectiveness and documented these findings approximately one hour later (see attachment #2). At [REDACTED] on [REDACTED], resident #1 alerted their call bell requesting assistance to the bathroom for a bowel movement. This assistance was provided by staff person B. Resident did not complain of pain during bathroom assistance. Resident #1 then alerted [REDACTED] call bell at [REDACTED] on [REDACTED] requesting Lidocaine ointment to rectal area for increased pain. Staff person A applied Lidocaine ointment at approximately [REDACTED] according to physician's prescription (see attachment #1). Staff person A evaluated Lidocaine ointment effectiveness and documented these findings at approximately [REDACTED] (see attachment #2). Review of resident #1 call bell report reflects no additional alerts were made on [REDACTED] (see attachment #3).

Resident #1 Mini Mental State Exam completed [REDACTED] produced a score of 30/30, which reflects intact cognitive ability including ability to request pain medications and/or request assistance if needed (see attachment #4).

Certified Registered Nurse Practitioner (CRNP) from resident #1 Primary Care Provider's (PCP) office documented on 1/19/23, "the patient is currently being followed by Hospice for [REDACTED]. Most recently a situation occurred where the patient was given Tylenol for pain over [REDACTED] Morphine. [REDACTED] is awake, alert and oriented to person, place, month and year. [REDACTED] is aware of the medications [REDACTED] is taking for pain. When administering pain medication, depending on the severity of the pain, the medication that is the least sedating and with the least amount of side effects is used. Tylenol is the least sedating and has the least amount of side effects in [REDACTED] current pain regimen. The patient's cognition is intact and allows [REDACTED] to understand what medication [REDACTED] is receiving." (see attachment #5) Resident #1 was appropriately medicated by staff person A, who followed the resident's current prescription medications orders. While Morphine Sulfate 20mg/ml was ordered as needed for pain, staff person A administered both Acetaminophen and Lidocaine ointment to resident #1 after evaluating resident. In addition, resident #1 reported to staff person A positive effectiveness of each medication post administration. Staff person A did not meet regulatory requirement for suspension or supervision.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Plan of Correction

- Resident #1 was assessed by Hospice Nurse on [REDACTED] with no pain or abnormal findings noted. Resident #1

15c - Supervision (continued)

was also assessed by CSM on [REDACTED] with no pain or abnormal findings noted.

- On 12/22/22, when alerted by the inspector from the Department of Human Services that this incident was being considered potential abuse, ED placed staff person A on administrative leave and submitted a notice of suspension of staff person A to the Department's personal care home regional office. Staff person A returned to work on [REDACTED]
- On 12/23/22, ED and CSM interviewed other residents and staff to ensure no other incidents which would require reporting under regulation 2600.15c occurred and had not been reported. No other incidents were identified.
- On 12/23/22, ED and CSM audited 24-hour report and concern log for past 90 days to ensure no other incidents which would require reporting under regulation 2600.15c occurred and had not been reported. No other incidents were identified.
- On 1/30/23, RDCS will provide in-service to ED and CSM on requirements set within regulation 2600.15c. (Exhibit 1 – In-service)
- Starting 1/30/23, CSM or designee will audit 3 residents MARs, medications and physician's orders weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure no other incidents requiring reporting under regulation 2600.15c home occurred which were not reported. (Exhibit 2 – Audit Tool)
- ED will discuss the results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 1/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented (CB - 04/06/2023)

16c - Written Incident Report**2. Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED], at approximately [REDACTED] resident #1, who is diagnosed with [REDACTED] and pain, rang his/her call bell. Staff person A answered the ring and went to resident's bedroom. The resident was visibly in pain and asked for pain medication. Resident #1 is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as needed for pain. Staff person A did not administer this medication. Resident #1 rang his/her call bell again at approximately [REDACTED] and [REDACTED] still in pain. Staff person A did not administer the prescribed Morphine Sulfate 20mg/ml.

The home did not report this prescription medication error to the Department.

Plan of Correction

Accept (JW - 03/03/2023)

Lowrie Place disputes violation 2600.16.c-Written Incident Report. The LIS description of Violation reads:

16c - Written Incident Report (continued)

On [REDACTED], at approximately [REDACTED] resident #1, who is diagnosed with [REDACTED] and pain, rang his/her call bell. Staff person A answered the ring and went to resident's bedroom. The resident was visibly in pain and asked for pain medication. Resident #1 is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as needed for pain. Staff person A did not administer this medication. Resident #1 rang his/her call bell again at approximately [REDACTED] and [REDACTED], still in pain. Staff person A did not administer the prescribed Morphine Sulfate 20mg/ml.

The home did not report this prescription medication error to the Department.

Lowrie Place respectfully disputes the finding of the home needing to report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline as the record for Resident #1 reflects the resident was evaluated and medicated for pain by staff person A, per physician's orders, with no prescription medication error occurring.

Resident #1 alerted their call bell at 2:08am on [REDACTED]. Staff person A responded in approximately 2 minutes and resident #1 requested pain medication. At [REDACTED] Staff person A administered Acetaminophen 325mg 2 tabs to resident #1 according to current physician's orders (see attachment #1). Staff person A evaluated Acetaminophen effectiveness and documented these findings approximately one hour later (see attachment #2). At 4:55am on [REDACTED], resident #1 alerted their call bell requesting assistance to the bathroom for a bowel movement. This assistance was provided by staff person B. Resident did not complain of pain during bathroom assistance. Resident #1 then alerted [REDACTED] call bell at [REDACTED] on [REDACTED] requesting Lidocaine ointment to rectal area for increased pain. Staff person A applied Lidocaine ointment at approximately [REDACTED] according to physician's prescription (see attachment #1). Staff person A evaluated Lidocaine ointment effectiveness and documented these findings at approximately [REDACTED] (see attachment #2). Review of resident #1 call bell report reflects no additional alerts were made on [REDACTED] (see attachment #3).

Resident #1 Mini Mental State Exam completed [REDACTED] produced a score of 30/30, which reflects their intact cognitive ability including ability to request pain medications and/or request assistance if needed (see attachment #4).

CRNP from resident #1 PCP's office documented on [REDACTED], "the patient is currently being followed by Hospice for [REDACTED]. Most recently a situation occurred where the patient was given Tylenol for pain over [REDACTED] Morphine. [REDACTED] is awake, alert and oriented to person, place, month and year. [REDACTED] is aware of the medications [REDACTED] is taking for pain. When administering pain medication, depending on the severity of the pain, the medication that is the least sedating and with the least amount of side effects is used. Tylenol is the least sedating and has the least amount of side effects in [REDACTED] current pain regimen. The patient's cognition is intact and allows [REDACTED] to understand what medication [REDACTED] is receiving." (see attachment #5)

Resident #1 was appropriately medicated by staff person A, who followed the resident's current prescription medications orders. While Morphine Sulfate 20mg/ml was ordered as needed for pain, staff person A administered both Acetaminophen and Lidocaine ointment to resident #1 after evaluating resident. In addition, resident #1 reported to staff person A positive effectiveness of each medication post administration.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Plan of Correction

- Resident #1 was assessed by Hospice Nurse on [REDACTED] with no pain or abnormal findings noted. Resident #1

16c - Written Incident Report (continued)

was also assessed by CSM on [REDACTED] with no pain or abnormal findings noted.

- On 12/22/22, when alerted by the inspector from the Department of Human Services that this incident was being considered a medication error and potential abuse, ED submitted a reportable incident to the Department's personal care home regional office regarding this incident.
- On 12/23/22, ED and CSM interviewed other residents and staff to ensure no other incidents which would require reporting under regulation 2600.16c occurred and had not been reported. No other incidents were identified.
- On 12/23/22, ED and CSM audited 24-hour report and concern log for past 90 days to ensure no other incidents which would require reporting under regulation 2600.16c occurred and had not been reported. No other incidents were identified.
- On 1/30/23, RDCS will provide in-service to ED and CSM on requirements set within regulation 2600.16c. (Exhibit 3 – In-service)
- Starting 1/30/23, ED or designee will audit 3 residents MARs, medications and physician's orders weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure no other incidents which would require reporting under regulation 2600.16c home occurred which were not reported. (Exhibit 2 – Audit Tool)
- ED will discuss the results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 1/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented (CB - 04/06/2023)

42b - Abuse**3. 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 #1 is diagnosed wit [REDACTED]

[REDACTED] Resident #1 is prescribed routine pain medications to include Oxycodone 10mg, 1 tablet by mouth four times daily, MS Contin 15mg, 1 tablet by mouth every 12 hours, and as needed pain medication to include Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour.

On [REDACTED] at approximately [REDACTED], resident #1, rang his/her call bell. Staff person A answered the ring and went to resident's bedroom. The resident was visibly in pain and asked for pain medication. Staff person A did not administer the resident's Morphine Sulfate 20mg/ml. Resident #1 rang his/her call bell again at approximately [REDACTED]. and [REDACTED], still in pain. Again, staff person A did not administer the prescribed Morphine Sulfate 20mg/ml.

At approximately [REDACTED] during staff shift change, resident #1 told staff person B that staff person A did not administer pain medication. Staff person B told this to staff person C, and both staff persons went into resident's room and observed resident #1 in visible pain – crying on the toilet attempting to soothe his/herself with a cold towel. The resident stated he/she was also anxious and afraid the pain would reach a level where it would become uncontrollable with pain medication.

42b - Abuse (continued)

Plan of Correction

Accept (JW - 03/03/2023)

Lowrie Place disputes violation 2600.42.b-Abuse. The LIS description of Violation reads:

Resident #1 is diagnosed with [REDACTED]

[REDACTED] Resident #1 is prescribed routine pain medications to include Oxycodone 10mg, 1 tablet by mouth four times daily, MS Contin 15mg, 1 tablet by mouth every 12 hours, and as needed pain medication to include Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour.

On [REDACTED] resident #1, rang his/her call bell. Staff person A answered the ring and went to resident's bedroom. The resident was visibly in pain and asked for pain medication. Staff person A did not administer the resident's Morphine Sulfate 20mg/ml. Resident #1 rang his/her call bell again at approximately [REDACTED], still in pain. Again, staff person A did not administer the prescribed Morphine Sulfate 20mg/ml. At approximately [REDACTED], during staff shift change, resident #1 told staff person B that staff person A did not administer pain medication. Staff person B told this to staff person C, and both staff persons went into resident's room and observed resident #1 in visible pain – crying on the toilet attempting to soothe his/herself with a cold towel. The resident stated he/she was also anxious and afraid the pain would reach a level where it would become uncontrollable with pain medication.

Lowrie Place respectfully disputes the finding as the record of Resident #1 reflects the resident was evaluated and medicated for pain by staff person A, per physician's orders, and evaluated post administration of ordered pain medications which resulted in positive effectiveness.

Resident #1 alerted their call bell at [REDACTED]. Staff person A responded in approximately 2 minutes and resident #1 requested pain medication. At approximately [REDACTED] Staff person A administered Acetaminophen 325mg 2 tabs to resident #1 according to current physician's orders (see attachment #1). Staff person A evaluated Acetaminophen effectiveness and documented these findings approximately one hour later (see attachment #2). At [REDACTED], resident #1 alerted their call bell requesting assistance to the bathroom for a bowel movement. This assistance was provided by staff person B. Resident did not complain of pain during bathroom assistance. Resident #1 then alerted [REDACTED] call bell at [REDACTED] on [REDACTED] requesting Lidocaine ointment to rectal area for increased pain. Staff person A applied Lidocaine ointment at approximately [REDACTED] according to physician's prescription (see attachment #1). Staff person A evaluated Lidocaine ointment effectiveness and documented these findings at approximately [REDACTED] (see attachment #2). Review of resident #1 call bell report reflects no additional alerts were made on [REDACTED] (see attachment #3).

Resident #1 Mini Mental State Exam completed [REDACTED] produced a score of 30/30, which reflects their intact cognitive ability including ability to request pain medications and/or request assistance if needed (see attachment #4).

CRNP from resident #1 PCP's office documented on 1/19/23, "the patient is currently being followed by Hospice for rectal cancer. Most recently a situation occurred where the patient was given Tylenol for pain over [REDACTED] r Morphine. [REDACTED] is awake, alert and oriented to person, place, month and year. [REDACTED] is aware of the medications s [REDACTED] is taking for pain. When administering pain medication, depending on the severity of the pain, the medication that is the least sedating and with the least amount of side effects is used. Tylenol is the least sedating and has the least amount of side effects in her current pain regimen. The patient's cognition is intact and allows [REDACTED] to understand what medication [REDACTED] is receiving." (see attachment #5).

42b - Abuse (continued)

Resident #1 was appropriately medicated by staff person A, who followed the resident's current prescription medications orders. While Morphine Sulfate 20mg/ml was ordered as needed for pain, staff person A administered both Acetaminophen and Lidocaine ointment to resident #1 after evaluating resident. In addition, resident #1 reported to staff person A positive effectiveness of each medication post administration.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Plan of Correction

- Resident #1 was assessed by Hospice Nurse on [REDACTED] with no abnormal findings. Resident #1 was also assessed by CSM on [REDACTED] with no abnormal findings.
- On 12/22/22, when alerted by the inspector from the Department of Human Services that this incident was being considered potential abuse, staff person A was placed on administrative leave pending the outcome of the investigation. [REDACTED] returned to work on [REDACTED] and was provided with education regarding 2600.42b on 01/20/23.
- On 12/23/22, ED and CSM interviewed residents as well as staff and no other instances of neglect, intimidation, physical or verbal abuse, mistreatment, corporal punishment or discipline were identified.
- On 1/30/23, ED will re-educate all staff on the requirements set within regulation 2600.42b. (Exhibit 7 Inservice)
- Starting 1/30/23, ED or designee will review 2 resident records, 24-hour log and incident log weekly x 4 weeks and bi-weekly x 4 weeks and monthly x 1 month to ensure continued compliance with regulation 2600.42b. (Exhibit 4 – Audit Tool)
- Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 1/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented (CB - 04/06/2023)

187d - Follow Prescriber's Orders**4. Requirements**

2600.

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

Description of Violation

Resident #1 is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as need for pain. On [REDACTED] at approximately [REDACTED] resident #1 asked for pain medication. This was not administered to the resident.

Plan of Correction

Accept (JW - 03/03/2023)

Lowrie Place disputes violation 2600.187.d-Follow Prescriber's Orders. The LIS description of Violation reads: Resident #1 is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as need for pain. On [REDACTED] at approximately [REDACTED] resident #1 asked for pain medication. This was not administered to the resident

187d - Follow Prescriber's Orders (continued)

Lowrie Place respectfully disputes the finding of Resident #1 prescription orders were not followed as the record of Resident #1 reflects the resident was evaluated and medicated for pain by staff person A, per physician's orders, and evaluated post administration of ordered pain medications which resulted in positive effectiveness.

Resident #1 alerted their call bell at [REDACTED] on [REDACTED]. Staff person A responded in approximately 2 minutes and resident requested pain medication. At approximately [REDACTED] Staff person A administered Acetaminophen 325mg 2 tabs to resident #1 according to current physician's orders (see attachment #1). Staff person A evaluated Acetaminophen effectiveness and documented these findings approximately one hour later (see attachment #2). At [REDACTED] on [REDACTED] resident #1 alerted their call bell requesting assistance to the bathroom for a bowel movement. This assistance was provided by staff person B. Resident did not complain of pain during bathroom assistance. Resident #1 then alerted [REDACTED] call bell at [REDACTED] on [REDACTED] requesting Lidocaine ointment to rectal area for increased pain. Staff person A applied Lidocaine ointment at approximately [REDACTED] according to physician's prescription (see attachment #1). Staff person A evaluated Lidocaine ointment effectiveness and documented these findings at approximately [REDACTED] (see attachment #2). Review of resident #1 call bell report reflects no additional alerts were made on [REDACTED] (see attachment #3).

Resident #1 Mini Mental State Exam completed [REDACTED] produced a score of 30/30, which reflects their intact cognitive ability including ability to request pain medications and/or request assistance if needed (see attachment #4).

CRNP from resident #1 PCP's office documented on 1/19/23, "the patient is currently being followed by Hospice for [REDACTED]. Most recently a situation occurred where the patient was given Tylenol for pain over [REDACTED] Morphine. [REDACTED] is awake, alert and oriented to person, place, month and year. [REDACTED] is aware of the medications [REDACTED] is taking for pain. When administering pain medication, depending on the severity of the pain, the medication that is the least sedating and with the least amount of side effects is used. Tylenol is the least sedating and has the least amount of side effects in [REDACTED] current pain regimen. The patient's cognition is intact and allows [REDACTED] to understand what medication [REDACTED] is receiving." (see attachment #5).

Resident #1 was appropriately medicated by staff person A, who followed the resident's current prescription medications orders. While Morphine Sulfate 20mg/ml was ordered as needed for pain, staff person A administered both Acetaminophen and Lidocaine ointment to resident #1 after evaluating resident. In addition, resident #1 reported to staff person A positive effectiveness of each medication post administration.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Plan of Correction

- Resident #1 was assessed by Hospice Nurse on [REDACTED] with no pain or abnormal findings noted. Resident #1 was also assessed by CSM on [REDACTED] with no pain or abnormal findings noted.
- On 12/22/22, when alerted by the inspector from the Department of Human Services that this incident was being considered a medication error, ED submitted a reportable incident to the Department's personal care home regional office regarding this incident.
- On 12/27/22, CSM audited the medication administration records (MARs) for the past 60 days to ensure there were no other incidents where the home did not follow the directions of the prescriber. No other incidents were identified.
- On 1/30/23, RDCS will provide in-service to ED and CSM on requirements set within regulation 2600.187d. (Exhibit 5 – In-service)

187d - Follow Prescriber's Orders (continued)

- Starting 1/30/23, CSM or designee will review 3 residents MARs, medications and physician's orders weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure continued compliance with regulation 2600.187d. (Exhibit 2 – Audit Tool)
- ED will discuss the results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 1/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented (CB - 04/06/2023)

188b - Medication Error Reporting**5. Requirements**

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as need for pain. On [REDACTED] at approximately [REDACTED] resident #1 asked for pain medication. This was not administered to the resident, resulting in a medication error. This medication error was not immediately reported to the resident, the resident's designated person and the prescriber.

Plan of Correction

Accept (JW - 03/03/2023)

Lowrie Place disputes violation 2600.188.b-Medication Error Reporting. The LIS description of Violation reads:

Resident #1 is prescribed Morphine Sulfate 20mg/ml, give 0.25ml by mouth/under the tongue every one hour as need for pain. On [REDACTED], at approximately [REDACTED], resident #1 asked for pain medication. This was not administered to the resident, resulting in a medication error. This medication error was not immediately reported to the resident, the resident's designated person and the prescriber.

Lowrie Place respectfully disputes the finding of a medication error occurring which voids the need for a medication error being immediately reported to the resident, the resident's designated person and the prescriber. The record of Resident #1 reflects the resident was evaluated and medicated for pain by staff person A, per physician's orders, and evaluated post administration of ordered pain medications which resulted in positive effectiveness.

Resident #1 alerted their call bell at [REDACTED] on [REDACTED]. Staff person A responded in approximately 2 minutes and resident requested pain medication. At approximately [REDACTED], Staff person A administered Acetaminophen 325mg 2 tabs to resident #1 according to current physician's orders (see attachment #1). Staff person A evaluated Acetaminophen effectiveness and documented these findings approximately one hour later (see attachment #2). At [REDACTED] on [REDACTED], resident #1 alerted their call bell requesting assistance to the bathroom for a bowel movement. This assistance was provided by staff person B. Resident did not complain of pain during bathroom assistance. Resident #1 then alerted [REDACTED] call bell at [REDACTED] on [REDACTED] requesting Lidocaine ointment to rectal area for increased pain. Staff person A applied Lidocaine ointment at approximately [REDACTED] according to physician's prescription (see attachment #1). Staff person A evaluated Lidocaine ointment effectiveness and documented these findings at approximately 6:00am (see attachment #2). Review of resident #1 call bell report reflects no additional alerts were made on [REDACTED] (see attachment #3).

Resident #1 Mini Mental State Exam completed [REDACTED] produced a score of 30/30, which reflects their intact cognitive ability including ability to request pain medications and/or request assistance if needed (see attachment #4).

188b - Medication Error Reporting (continued)

CRNP from resident #1 PCP's office documented on [REDACTED], "the patient is currently being followed by Hospice for [REDACTED]. Most recently a situation occurred where the patient was given Tylenol for pain over [REDACTED] Morphine. [REDACTED] is awake, alert and oriented to person, place, month and year. [REDACTED] is aware of the medications [REDACTED] is taking for pain. When administering pain medication, depending on the severity of the pain, the medication that is the least sedating and with the least amount of side effects is used. Tylenol is the least sedating and has the least amount of side effects in [REDACTED] current pain regimen. The patient's cognition is intact and allows her to understand what medication she is receiving." (see attachment #5).

Resident #1 was appropriately medicated by staff person A, who followed the resident's current prescription medications orders. While Morphine Sulfate 20mg/ml was ordered as needed for pain, staff person A administered both Acetaminophen and Lidocaine ointment to resident #1 after evaluating resident. In addition, resident #1 reported to staff person A positive effectiveness of each medication post administration.

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Plan of Correction

- On 12/22/22, when alerted by the inspector from the Department of Human Services that this incident was being considered a medication error, ED and CSM notified the resident, resident's designated person and resident's PCP about this incident.
- On 12/23/22, ED and CSM interviewed other residents and staff to ensure no other incidents which would require reporting under regulation 2600.188b occurred and had not been reported. No other incidents were identified.
- On 12/27/22, CSM audited the medication administration records (MARs) for the past 60 days to ensure no other incidents which would require reporting under regulation 2600.188b occurred and had not been reported. No other incidents were identified.
- On 1/30/23, RDCS will provide in-service to ED and CSM on requirements set within regulation 2600.188b. (Exhibit 6 – In-service)
- Starting 1/30/23, ED or designee will audit 3 residents MARs, medications and physician's orders weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure no other incidents which would require reporting under regulation 2600.188b home occurred which were not reported. (Exhibit 4 – Audit Tool)
- ED will discuss the results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 1/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented (CB - 04/06/2023)