pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SYCAMORE ESTATES, LLC**
LEGAL ENTITY

To operate **SYCAMORE ESTATE PERSONAL CARE RESIDENCE**
NAME OF FACILITY OR AGENCY

Located at **717 DUQUESNE BLVD, DUQUESNE, PA 15110**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **49** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 8, 2023** until **June 8, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454501**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 8, 2023

[REDACTED] Owner
Sycamore Estates, LLC
717 Duquesne Boulevard
Duquesne, Pennsylvania 15110

RE: Sycamore Estate Personal Care Residence
License/COC #: 454501

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 22, 2023, June 23, 2023, and September 19, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 454500) dated June 7, 2023 – June 7, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 8, 2023 to June 8, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SYCAMORE ESTATE PERSONAL CARE RESIDENCE* **License #**: *45450* **License Expiration**: *06/07/2024*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA 15110*

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

Administrator

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

Legal Entity

Name: *SYCAMORE ESTATES, LLC*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA, 15110*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/14/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *06/22/2023*

Inspection Dates and Department Representative

06/22/2023 - On-Site: [redacted]
06/23/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served**: *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *6* **Are 60 Years of Age or Older**: *27*
Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

06/22/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/21/2023*

07/24/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/08/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/28/2023*

07/31/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/08/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/01/2023*

11/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/08/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/23/23, the emergency medical plan binder was unlocked, unattended and accessible at the East Up nurse's station. The emergency medical plan binder contained transfer sheets which includes the dates of birth, social security numbers and medical information for numerous residents, including residents #1, #2, and #3.

Plan of Correction ***Directed (- 07/31/2023)***

Face sheets for the resident were removed from the emergency preparedness binder and replaced with a resident list that only contains the resident name and room number for evacuation purposes. please see new list attached The binder was removed 6/29/2023. All resident records are locked in the medication room only accessible by staff and as needed by visiting medical providers with staff assistance.

DIRECTED: By 8/10/23: All staff persons shall be educated that resident information shall be kept in an area that is locked. Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall inspect the home weekly to ensure all resident information is kept in an area that is locked. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented (- 11/07/2023)

20b3 - Written Receipts

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

No written receipts were obtained from resident #4 for numerous cash disbursements, to include the following:

- *$20 withdrawal on 6/19/23*
- *$20 withdrawal on 6/19/23*
- *$20 withdrawal on 5/19/23*
- *$30 withdrawal on 5/3/23*

No written receipts were obtained from resident #6 for numerous cash disbursements, to include the following:

- *$85 withdrawal on 6/1/23*
- *$368 withdrawal on 5/15/23*
- *$120 withdrawal on 4/21/23*

No written receipts were obtained from resident #7 for numerous cash disbursements, to include the following:

20b3 - Written Receipts (continued)

- *$10 withdrawal on 6/19/23*
- *$20 withdrawal on 6/12/23*
- *$10 withdrawal on 6/8/23*
- *$20 withdrawal on 5/15/23*

Plan of Correction ***Directed ███ - 07/31/2023)***

As it is not a requirement of 2600 to do PNA accounts for residents, Sycamore Estate will no longer do PNA accounts Please see attached the quarterly and the final report signed by residents 4,6,and 7 attached. All of the funds were dispersed by 07/20/2023 the contract already read we will not do financial management we have sent out with the July emails, notification that we will return to the contract and not provide financial assistance./

DIRECTED: By 8/5/23: The administrator shall update the home's description of services to indicate the home will no longer offer assistance with financial management. All residents and their designated persons shall receive a copy of the home's new description of services by 8/10/23. Documentation of acknowledgment shall be kept in each resident's record. ███ 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented ███ - 11/07/2023)

20b8 - Quarterly Account

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident’s designated person, an itemized account of financial transactions made on the resident’s behalf on a quarterly basis.

Description of Violation

Resident #4 does not receive an itemized account of financial transactions on a quarterly basis.

Plan of Correction ***Directed (███ - 07/31/2023)***

As it is not a requirement of 2600 to do PNA accounts for residents, Sycamore Estate will no longer do PNA accounts Please see attached the quarterly and the final report signed by residents 4,6,and 7 attached. the contract already read we will not do financial management we have sent out with the July emails, notification that we will return to the contract and not provide financial assistance./

DIRECTED: By 8/5/23: The administrator shall update the home's description of services to indicate the home will no longer offer assistance with financial management. All residents and their designated persons shall receive a copy of the home's new description of services by 8/10/23. Documentation of acknowledgment shall be kept in each resident's record. ███ 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented ███ - 11/07/2023)

82a - Poisonous Materials

4. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 6/22/23, there was an unlabeled bottle of yellow liquid on a serving cart in the temporary kitchen. Staff person B identified the unknown liquid as Lysol Multi-Surface Cleaner.

Plan of Correction ***Directed - 07/31/2023)***

All plain chemical bottles that are not the original cleaner bottle have been thrown out all small spray bottles with original labels and contents were purchased see photos attached

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator shall inspect the home to ensure all poisonous materials are stored in their original, labeled containers. 7/31/23

DIRECTED: By 8/10/23: All staff persons shall be educated that all poisonous materials shall be stored in their original, labeled containers. Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23

DIRECTED: Beginning on 8/7/23: The administrator/shift supervisor shall inspect the home weekly to ensure all poisonous materials are stored in their original, labeled containers. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

82b - Poisonous Material Storage

5. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

On 6/22/23, an unlabeled bottle of Lysol Multi-Surface cleaner was stored on a serving cart in the temporary serving area next to an opened, unsealed bag of Snyder's mini pretzels and an opened, unsealed bag of Members Mark wavy potato chips.

Plan of Correction ***Directed - 07/31/2023)***

No cleaning products will be stored in the food prep areas of the Kitchen. see training and task list attached.
Kitchen personnel were trained and will be responsible for keeping the food prep area clear of chemicals except during cleaning times.
The Kitchen Manager will be responsible for monitoring proper Chemical storage in the kitchen. the unmarked bottles were disposed of 6/29/2023.

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator shall inspect the home to ensure all poisonous materials are stored separately from food, food preparation surfaces and dining surfaces. 7/31/23

DIRECTED: By 8/10/23: All staff persons shall be educated that all poisonous materials are to be stored separately from food, food preparation surfaces and dining surfaces. Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23

82b - Poisonous Material Storage (continued)

DIRECTED: Beginning on 8/7/23: The kitchen manager shall inspect the home weekly to ensure all poisonous materials are being stored separately from food, food preparation surfaces and dining surfaces. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 6/22/23, there were 2 unlabeled, used towels and 2 unlabeled, used washcloths present in the shared bathroom of bedroom S-1.

Plan of Correction ***Accept - 07/31/2023)***

a one to one exchange for clean towels etc. has been established when they are used staff will remove them from shower area and replace them in the resident rooms with clean ones. This is part of the shower ADL's procedure. This procedure was reviewed with all residents and staff during a resident council meeting on 07/06/2023 as well as a staff meeting on 07/07/2023 See attached memo. The one to one exchange started 07/07/2023 The exchange is as many towels and wash cloths as used get returned clean. All staff check assigned rooms every shift. see attached room check schedule

Licensee's Proposed Overall Completion Date: *07/28/2023*

Not Implemented (- 11/07/2023)

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 6/23/23, the hot water temperature at the following sinks exceeded 120 degrees Fahrenheit:

Location	Time	Temperature (degrees Fahrenheit)
• Bathroom F	10:10 AM	131.9
• Bathroom E	10:13 AM	136.1
• East Up Shower Room	10:16 AM	127.3
• East Down Shower Room	10:26 AM	131.3

Plan of Correction ***Directed - 07/31/2023)***

All hot water tanks were recalibrated to proper temp. and the temperatures were checked with the new thermometer see attached. This is a thermometer identical to state inspectors use. Tanks were recalibrated on 07/06/2023 Owner is responsible for maintenance in the facility and are checked quarterly and recorded in the office by the owner

DIRECTED: Beginning on 8/4/23: The administrator shall measure the hot water temperatures from at least 2

89b - Hot Water Temperature (continued)

sources from each hot water tank daily for 1 week then monthly thereafter to ensure hot water temperatures in areas accessible to residents does not exceed 120 degrees Fahrenheit. Documentation of the hot water temperatures shall be kept. 7/31/23

DIRECTED: By 8/10/23: All staff persons shall be educated that hot water temperatures in areas accessible to residents shall not exceed 120 degrees Fahrenheit. Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

93a - Handrails

8. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 6/22/23, no handrail was present at the step leading out to the porch from the 1st floor North emergency exit.

Plan of Correction ***Directed - 07/31/2023)***

We have purchased handles for the one step doors and will install on the door frames on the knob side when they arrive See attached. the hand rails will be delivered July 31 and installed that day.

DIRECTED: By 8/4/23, then monthly thereafter: The administrator shall inspect each ramp, interior stairway and outside steps to ensure a well-secured handrail is present. 7/31/23

Directed Completion Date: *08/04/2023*

Implemented (- 11/07/2023)

101j7 - Lighting/Operable Lamp

9. Requirements

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

Description of Violation

On 6/22/23, resident #4's bedside lamp was not within reach of resident #4's bed.

On 6/22/23, no operable lamp or other source of lighting was present at resident #5's bedside.

Plan of Correction ***Directed (- 07/31/2023)***

The layout of room Resident 4 was changed to accommodate easier access to the lamp at the bedside. room was rearranged on July 11, 2023
The resident #5 in is alone in that room and Upon inspection of the room on July 11, 2023 there was a lamp at bedside. the other bed will not be occupied.all rooms were checked by on that date for

101j7 - Lighting/Operable Lamp (continued)

compliance.weekly checks were implemented 07/03/2023.
Each staff person is assigned a room to check for safety, cleanliness and compliance they are to do these checks every shift and is checked weekly by the administrator or her designee. see attached schedule

DIRECTED: By 8/10/23: All staff persons shall be educated that each resident shall have an operable lamp or other source of lighting that can be turned on/off at bedside. Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

10. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

On 6/22/23, there was no grab bar at the toilet in the East Wing employee bathroom.

Plan of Correction ***Directed - 07/31/2023)***

a new 36 inch grab bar was installed in the Staff Bathroom we had this in stock and installed it. Grab bar was installed on 07/6/2023
On July 11,2023 the administrator completed a full compliance check of the facility.
Each staff person is assigned a room to check for safety, cleanliness and compliance they are to do these checks every shift and is checked weekly by the administrator or her designee.

DIRECTED: Beginning on 8/4/23: The administrator shall inspect all toilets and bath areas to ensure grab bars, hand rails or assist bars are present and to ensure all bathtubs and showers have slip-resistant surfaces. 7/31/23

Directed Completion Date: *08/10/2023*

Implemented (- 11/07/2023)

103d - Storing Food Off Floor

11. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 6/22/23, there were 2 gallon bottles of vinegar present on the floor under the table in the temporary serving area.

On 6/22/23, there was a 5 gallon container of sugar present on the floor to the left of the stove.

Plan of Correction ***Directed - 07/31/2023)***

The 2 Gallon Bottles of Vinegar are cleaning products and were moved to the cleaning storage, the Sugar was placed on the shelf in the temporary area the dry good storage in the new kitchen opening 07/19/2023 will accommodate all dry storage off the floor The Kitchen Manager will be responsible for monitoring proper food storage every shift and reporting to administrator starting 07/06/2023. The cleaning training and implementation was 07/06/2023

103d - Storing Food Off Floor (continued)

see attached education for staff was completed on 07/06/2023 and recorded in the office in their staff record.

DIRECTED: By 8/10/23: All staff persons shall be educated that food shall be stored off the floor. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 7/31/23

Directed Completion Date: *08/10/2023*

Implemented █ - 11/07/2023)

103e - Left Overs

12. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 6/22/23, there was an undated styrofoam container containing 3 chicken wings in the refrigerator.

Plan of Correction ***Directed █ - 07/31/2023)***

A new label dispenser and a variety of food label's were purchased to be mounted on the wall in the new kitchen next to the refrigerator and freezer.
see attached receipts for both. The Kitchen Manager will be responsible for monitoring proper food storage and labeling every shift and reporting to administrator starting 07/06/2023. The cleaning training and implementation was 07/06/2023 see. Label holder and labels were installed on 07/20/2023.
Chicken wings were disposed of 06/22/2023

DIRECTED: By 8/10/23: All staff persons shall be educated that leftover food shall be labeled and dated. Documentation of the education shall be kept in accordance with 2600.65i. █ 7/31/23

Directed Completion Date: *08/10/2023*

Implemented (█ - 11/07/2023)

103g - Storing Food

13. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 6/22/23, there was an opened, unsealed bag of Snyder's mini pretzels and an opened, unsealed bag of Members Mark wavy potato chips on a serving cart in the temporary serving area.

Plan of Correction ***Directed (█ - 07/31/2023)***

Snack Bag clips were purchased for Chips and Pretzels etc. see attached photo on 07/03/2023.The Kitchen Manager will be responsible for monitoring proper food storage and labeling every shift and reporting to administrator. starting 07/06/2023. The cleaning training and implementation was 07/06/2023 see

103g - Storing Food (continued)

DIRECTED: By 8/10/23: All staff persons shall be educated that all food items must be stored in closed or sealed containers. Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23

Directed Completion Date: *08/10/2023*

Implemented (- 11/07/2023)

132a - Monthly Fire Drill

14. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Numerous staff persons indicated they are notified in advance of scheduled fire drills by either staff person A or staff person B.

Plan of Correction ***Directed (- 07/31/2023)***

The fire drills in our facility are unannounced to our residents, we discuss our timing of fire drills with our key staff to limit our liability as the care of a resident may be impacted if care needs to be interrupted. Doing unannounced fire drills for key staff creates both safety and additional liability risks.
Amendment: in the future the only one who will have knowledge of the upcoming fire drill will be the person who is preforming it. (DIRECTED: This procedure shall be implemented by 8/1/23. 7/31/23).

DIRECTED: By 8/5/23: The administrator shall educate all staff persons responsible for conducting monthly fire drills to ensure fire drills are unannounced to staff persons and residents and that the only person who has advanced knowledge of fire drills is the staff person conducting the fire drill. Documentation of the staff education shall be kept in accordance with 2600.65i. 7/31/23

DIRECTED: Beginning on 8/10/23: The administrator shall interview at least 1 staff person who participated in the most recent fire drill monthly for 3 months to ensure fire drills are unannounced to residents and staff persons. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

132f - Alternate Exit Routes

15. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Residents were evacuated through the "main exit" during 9 of the last 11 fire drills.

Plan of Correction ***Directed (LM - 07/31/2023)***

The exits "blocked" during drills will vary and are included in the fire drill chart see attached for the July fire drill on 07/19/2023.
the person running the fire drill will follow the attached chart and temp block the exit by standing in front of it.

132f - Alternate Exit Routes (continued)

DIRECTED: By 8/5/23: The administrator shall educate all staff persons responsible for conducting fire drills that exits shall be alternated during each monthly fire drill. Documentation of the education shall be kept in accordance with 2600.65i. LM 7/31/23

DIRECTED: Beginning on 8/10/23: The administrator shall monitor the fire drill records monthly to ensure exit routes are being alternated. LM 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented (LM - 11/07/2023)

162c - Menus Posted

16. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 6/22/23 and 6/23/23, no menus were posted in a conspicuous and public place in the home.

Plan of Correction ***Directed - 07/31/2023)***

Menus were posted on 06/25/2023 in two areas of the facility with the installation of new communications boards one located in our Great room and one located in our dining room near the kitchen. The Kitchen Manager starting 06/25/2023 will be responsible for Preparing new menus and monitoring the posting and distribution of menus. See attached photos.

DIRECTED: Beginning on 8/4/23: The kitchen manager shall inspect the home at least weekly to ensure the current menu, as well as the menu 1 week in advance, is posted in a conspicuous and public place in the home. 7/31/23

Directed Completion Date: *08/04/2023*

Not Implemented - 11/07/2023)

183e - Storing Medications

17. 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

On 6/23/23. resident #4's Novolog insulin pen was opened and undated. According to the manufacturer's instructions, the Novolog must be discarded within 28 days of opening.

Plan of Correction ***Directed - 07/31/2023)***

A new pen was opened and dated as well as the old pen was disposed of on 06/23/2023 the resident took all medications from the home with her when she left the facility on 07/6/2023
All pens were checked on 06/23/2023 by the administrator and her designee all medication staff were retrained on proper labeling of dated when opened medications on 07/07/2023 documentation of training during staff meeting

183e - Storing Medications (continued)

is recorded in the staff charts in office.

DIRECTED: Beginning on 8/4/23: The administrator shall inspect all medication storage areas weekly for 1 month then monthly thereafter to ensure all medications are properly stored in accordance with 2600.183e, including open insulin pens. 7/31/23

Directed Completion Date: *08/04/2023*

Not Implemented 11/07/2023)

185a - Implement Storage Procedures

18. 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 #4's blood glucose was incorrectly documented, or not documented at all on resident #4's May 2023 and June 2023 medication administration records (MAR) on numerous dates/times, to include the following:

Date	Time	Glucometer Reading	MAR documentation
5/2/23	3:57 PM	113	108
5/3/23	4:15 PM	139	Not recorded
5/3/23	7:00 PM	116	139
5/4/23	4:07 PM	138	139
5/11/23	8:19 AM	155	170
5/11/23	11:43 AM	170	155
5/11/23	4:00 PM	No glucometer reading	120
6/20/23	4:00 PM	No glucometer reading	96

Resident #6 is prescribed the following medications; however, they were not available in the home for administration on 6/23/23:

- *Tessalon Perle 100mg-Take 2 capsules by mouth 3 times daily as needed for cough*
- *Zyprexa 10mg-Take 1 tablet by mouth 2 times daily as needed for aggression*

Plan of Correction ***Directed - 07/31/2023)***

The two staff people involved in these medication documentation errors were offered retraining on the documentation of the medication training and one has refused asking to be removed from passing medications at request due to the stress of the med pass responsibility on next shift 06/29/2023 the other staff person was given updated training on 07/17/2023 and we are also actively moving to electronic MARS and will be full time on electric MARS by August 1, 2023
on July 11, 2023 during the staff meeting a new staff task list was instituted for use that day moving forward all medication aids will have duties each skife see the attached duties list section MED TECH

DIRECTED: Within 48 hours of receipt of the plan of correction: Unless discontinued in writing by the prescriber, resident #6's Tessalon Perle 100mg and Zyprexa 10mg shall be present in the home and available for

185a - Implement Storage Procedures (continued)

administration. ██ 7/31/23

DIRECTED: By 8/10/23: All staff persons qualified to administer medications shall be educated on the home's medication administration procedures to ensure accurate blood sugar documentation. The staff training shall also include re-education on the home's procedures for re-ordering medications to ensure medications are delivered prior to depleting the current supply. Documentation of the education shall be kept in accordance with 2600.65i. ██ 7/31/23

DIRECTED: Beginning on 8/4/23: The administrator shall review blood sugar documentation and glucometer readings for all residents prescribed blood sugar checks weekly for 1 month, then monthly thereafter to ensure accurate and complete blood sugar documentation is maintained. ██ 7/31/23

DIRECTED: By 8/10/23: The administrator shall review the medications of all residents to ensure all prescribed medications are present in the home and available for administration. Beginning on 9/1/23: The administrator shall audit the medications for at least 5 residents monthly to ensure all prescribed medications are present in the home and available for administration. ██ 7/31/23

Directed Completion Date: *09/01/2023*

Not Implemented ██ - 11/07/2023)

187a - Medication Record

19. Requirements

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

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

On 12/20/22, resident #6 was prescribed Hydrocortisone AC 25mg suppository-Insert 1 suppository into rectum 2 times a day for 7 days; however, this medication is still present on resident #6’s June 2023 MAR.

Plan of Correction ***Directed ██ - 07/31/2023)***

The two staff people involved in these medication documentation errors were offered retraining on the

187a - Medication Record (continued)

documentation of the medication training and one has refused asking to be removed from passing medications at request due to the stress of the med pass responsibility on next shift 06/29/2023 the other staff person was given updated training on 07/17/2023 and we are also actively moving to electronic MARS and will be full time on electric MARS by August 1, 2023
A discontinuation order was sent to the pharmacy by the PCP and the hydrocortisone was removed from the Paper MAR by the designee on 06/23/2023
the July MAR review was compleated on 06/29/2023 by the designee all medications were present and accounted for
All staff were trained on the proper documentation proceedure and notificationb to the administrator on 07/11/2023 (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23)

DIRECTED: Beginning on 8/10/23: The administrator shall review the MAR's for at least 5 residents monthly to ensure accuracy and to ensure only current prescribed medications are present on resident MAR's. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

187b - Date/Time of Medication Admin.

20. 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

On 12/20/22, resident #6 was prescribed Hydrocortisone AC 25mg suppository-Insert 1 suppository into rectum 2 times a day for 7 days; however, resident #6's June 2023 MAR is initialed by staff persons as administering the medication to resident #6 twice daily from 6/1/23 through 6/22/23.

Plan of Correction ***Directed (- 07/31/2023)***

The two staff people involved in these medication documentation errors were offered retraining on the documentation of the medication training and one has refused asking to be removed from passing medications at request due to the stress of the med pass responsibility on next shift 06/29/2023 the other staff person was given updated training on 07/17/2023 see attached and we are also actively moving to electronic MARS and will be full time on electric MARS by August 1, 2023
the July MAR review was compleated on 06/29/2023 by the designee all medications were present and accounted for
All staff were trained on the proper documentation procedure and notification to the administrator on 07/11/2023 (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. /31/23)

DIRECTED: Beginning on 8/10/23: The administrator shall review the MAR's of at least 5 residents monthly to ensure proper documentation of medication administration. 7/31/23

Directed Completion Date: *08/10/2023*

Not Implemented - 11/07/2023)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident #4 is prescribed Admelog Solostar insulin-Inject subcutaneously 4 times a day per sliding scale; however, from 5/10/23 through approximately 7/1/23, resident #4 has been administered Novolog insulin on a daily basis.

Plan of Correction ***Directed - 07/31/2023)***

Per Dr. this residents PCP Resident 4 was able to substitute Nolvolog Insulin for the Admelog Solostar as this is what is on the formulary at the System Pharmacy. This is the residents choice to obtain free insulin from as is a
Dr sent updated insulin orders to new facility We are no longer caring for this resident.
the July MAR review was completed on 06/29/2023 by the designee all medications were present and accounted for
All staff were trained on the proper documentation procedure and notification to the administrator on 07/11/2023. (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. 7/31/23)

DIRECTED: By 8/10/23: The administrator shall review the medications of all residents to ensure all prescribed medications are present in the home and available for administration and are being administered in accordance with prescribers' orders. Beginning on 9/1/23: The administrator shall audit the medications for at least 5 residents monthly to ensure all prescribed medications are present in the home and available for administration in accordance with prescribers' orders. 7/31/23

Directed Completion Date: *09/01/2023*

Not Implemented - 11/07/2023)

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

Facility Information

Name: *SYCAMORE ESTATE PERSONAL CARE RESIDENCE* **License #**: *45450* **License Expiration**: *06/07/2024*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA 15110*

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

Administrator

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

Legal Entity

Name: *SYCAMORE ESTATES, LLC*
Address: *717 DUQUESNE BLVD, DUQUESNE, PA, 15110*
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/14/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date**: *09/27/2023*

Inspection Dates and Department Representative

09/19/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older**: *27*
Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *2* **Have Physical Disability**: *1*

Inspections / Reviews

09/19/2023 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/08/2023*

10/10/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/16/2023*

10/16/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/03/2023*

11/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

60a - Staff/Support Plan

1. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

According to resident #1's support plan, dated [redacted]23, resident #1 requires 2 the assistance of 2 staff persons to transfer in/out of bed/chair with use of a Hoyer lift; however, on 9/9/23 and 9/10/23 from approximately11:30 PM through 7:00 AM, only 1 staff person was present in the home, which is not adequate to evacuate all residents in the event of an emergency.

Plan of Correction ***Directed ([redacted] - 10/16/2023)***

The Rasp states "with use of Hoyer Lift" in an emergency situation the Hoyer lift would not be used, an alternative one person plan is in place for anyone requiring assistance with full transfer this plan is attached it basically states: a portable fabric stretcher located at the bedside of the resident should be placed on the fall mat at bedside, bed is at the low setting while residents are in them at night the resident is placed by the drag method onto the stretcher and pulled out of room to closest exit or fire safe area. and to NOT use the Hoyer lift in an emergency evacuation.

The schedule has been changed to include 2 staff overnight. one works 11pm to 7:30am and the other works 12 midnight to 8:30 am relieving the 4pm to 12:30 staff person.

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator/supervisor shall review the home's schedule daily to ensure adequate staffing is present in the home at all times to meet the needs of the residents as specified in the resident's assessment and support plan, which includes a minimum of 2 staff persons present in the home at all times. [redacted] 10/16/23

See attached schedule

Proposed Overall Completion Date: 10/11/2023

Directed Completion Date: *10/17/2023*

Not Implemented ([redacted] 11/07/2023)

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 9:48 AM, there was an unlabeled back brush in the shower stall in the shared bathroom of bedroom S-1.

Plan of Correction ***Directed ([redacted] - 10/16/2023)***

The back brush owner was identified and the brush was labeled with permanent marker by the administrator. Staff will be trained on personal items that may be a violation without labeling, at the next staff meeting on October 18, 2023 documentation of the training received on 10/18/2023 will be documented in the office in the training record.

85a - Sanitary Conditions (continued)

All residents will be informed of the same information at the resident council meeting and by memo. the Meeting is scheduled for October 11, 2023.
The housekeeping supervisor will monitor the room checks.

DIRECTED: Beginning on 10/20/23: Housekeeping staff shall check all bathrooms daily to ensure sanitary conditions are maintained and that there are no unlabeled hygiene items present in common bathrooms. 10/16/23

Proposed Overall Completion Date: 10/18/2023

Directed Completion Date: *10/20/2023*

Not Implemented - 11/07/2023)

89b - Hot Water Temperature

3. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At 9:38 AM, the hot water temperature at the 1st floor staff bathroom sink was 146.4 degrees Fahrenheit.

At 10:12 AM, the hot water temperature at the common bathroom "F" sink was 122.1 degrees Fahrenheit.

Plan of Correction ***Directed - 10/16/2023)***

The maintenance department will check temps from 2 sources daily for 2 weeks and then weekly after and a chart has been developed for hot water tank temperature checks these will be completed and documented weekly starting in October 16th (DIRECTED: Immediately: Documentation of all hot water temperatures shall be kept, which includes the date of the hot water check, the source of the hot water being checked, the hot water temperature at the source and the name of the staff person checking the hot water temperatures. 10/16/23).
the documentation will be kept in the office.

Proposed Overall Completion Date: 10/25/2023

Directed Completion Date: *11/01/2023*

Not Implemented (- 11/07/2023)

101j7 - Lighting/Operable Lamp

4. Requirements

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

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

Description of Violation

No lightbulb was present in resident #2's bedside lamp. No other operable source of lighting was present at resident #2's bedside.

Plan of Correction ***Accept - 10/16/2023)***

The light bulb was replaced by housekeeping on the date of the inspection 09/19/2023 the resident was reminded to not remove light bulb from lamp and was shown how to turn it on and off. the current daily room check covers all light bulbs being checked.
all lamps were checked by housekeeping on 09/22/2023
reminders of room check information will be trained and staff education will be concluded on 10/18/2023 and be kept in the training record in the office.
Each staff person has an assigned room to check every shift as well as the housekeeping department daily room check.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Not Implemented - 11/07/2023)

132a - Monthly Fire Drill

5. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

No fire drills were conducted in July, 2023 or August, 2023.

Plan of Correction ***Directed - 10/16/2023)***

An unannounced fire drill was held for the 11pm to 7am shift on 09/25/2023 at 5:50am
and another on 09/29/2023 at 1:15 pm with north wing exit blocked
this covers September and the overnight shift drill needed.
Fire drills are now listed on the administrators Google Calendar and allerted through phone
the next unannounced drill is on the calendar for October 16th during the 3-11 shift .
Administrator will be responsible for ensuring the drills will be completed and documented

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall review all fire drill records monthly to ensure an unannounced fire drill is held each month. 10/16/23

Proposed Overall Completion Date: 10/16/2023

Directed Completion Date: *10/16/2023*

Not Implemented - 11/07/2023)

162c - Menus Posted

6. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

The only menu posted in a conspicuous and public place in the home ended on 9/23/23.

Plan of Correction ***Directed - 10/16/2023)***

Menus were posted 09/19/2023 while inspectors were in facility by the Chef.
Menus are posted for the current week and the week coming up before breakfast on Sunday morning the first day of the menu by the 7am kitchen staff person.
This has been reviewed with both kitchen staff by the administrator, and documented.
Chef will review menus with the office each friday for Sunday posting. (DIRECTED: The chef weekly checks shall begin on 10/20/23. 10/16/23)

DIRECTED: Beginning on 10/22/23: The administrator shall check the home weekly to ensure the current week's menu, as well as a menu for 1 week in advance, are posted in a public and conspicuous place in the home. 10/16/23).

Proposed Overall Completion Date: 10/11/2023

Directed Completion Date: *10/22/2023*

Not Implemented - 11/07/2023)

183a - Original Containers and Injections

7. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Resident #3 is prescribed Furosemide 20 mg tablets–Take 3 tablets (60 mg) by mouth daily. On 9/19/23, Furosemide-20 mg tablets were present and mixed in with a bottle of resident #3's Furosemide-40 mg tablets.

Plan of Correction ***Directed - 10/16/2023)***

All new medication 20 mg furosemide in a new bottle was delivered by the containing the correct dose as well as directions on 09/21/2023
the Furosemide bottle was destroyed on 09/21/2023 by administrator
all medications coming into the facility will be placed in the check in area for the administrator or the designee to check into the facility so the correct medications are documented correctly on the MAR and placed into rotation correctly. this will be trained at the staff meeting on 10/18/2023 documentation of the training will be kept in the training records in the office.
this went into effect on 09/21/2023
Random audits of the medications to ensure proper storage will be done by the Administrator 09/21/2023 records will be kept in the office (DIRECTED: Beginning on 10/20/23: The administrator shall review the medications of at least 5 residents weekly for 4 weeks then monthly thereafter to ensure all medications are present in their original containers. Documentation of the audits shall be kept. 10/16/23

Proposed Overall Completion Date: 10/18/2023

183a - Original Containers and Injections *(continued)*

Directed Completion Date: *11/03/2023*

Not Implemented (- 11/07/2023)

183e - Storing Medications

8. 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

There were 4 loose medication tablets in the bottom of the medication cart.

Plan of Correction ***Directed (10/16/2023)***

The medication in question was disposed o by The designee on 09/19/2023 the cleaning of the medication drawers are assigned to the 3-11 medication techs see shift checklist
the medication room is checked every Monday for cleanliness and job complexation by the designee Administrator if designee is not available. starting 09/ 25/2023.
Staff will be trained on proper storage and sanitization of the medications and medication room. training will be recorded in the training record in the office. (DIRECTED: All staff persons qualified to administer medications shall be reeducated on proper medication storage procedures by 10/30/23. Documentation of the education shall be kept in accordance with 2600.65i. 0/16/23).

Proposed Overall Completion Date: 10/18/2023

Directed Completion Date: *10/30/2023*

Not Implemented (- 11/07/2023)

184a - Resident's Meds Labeled

9. 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 #4 is prescribed Santyl Ointment–Apply to right posterior heel once daily; however, the pharmacy label does not include the prescribed dosage or instructions for administration.

Plan of Correction ***Directed 10/16/2023)***

The instructions were documented on the discharge orders for wound care and copied and attached to the box .
the direction change label was used to show proper information
these orders were also in the packaging of the wound care supplies .
the pharmacy states they only had apply as directed.

184a - Resident's Meds Labeled (continued)

The pharmacy will contact the doctor for more specific information on these products.

Staff training will be conducted by [redacted] medication trainer on the change of label directions label procedure on 10/18/2023 and recorded in the training record in the office.

DIRECTED: Beginning on 10/20/23: The administrator shall review the medications of at least 5 residents weekly for 4 weeks then monthly thereafter to ensure accurate and complete pharmacy labels are present on resident medications in accordance with prescriber's orders. Documentation of the audits shall be kept. [redacted] 10/16/23

Proposed Overall Completion Date: 10/18/2023

Directed Completion Date: *11/03/2023*

Not Implemented ([redacted] - 11/07/2023)

185a - Implement Storage Procedures

10. 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 #5 is prescribed the following medications; however, on 9/19/23, the medications were not available in the home for administration:

- *Baclofen 10 mg–Take ½ tablet by mouth 2 times daily as needed*
- *Olanzapine 10 mg–Take 1 tablet 2 times daily as needed*

Plan of Correction

Directed [redacted] - 10/16/2023)

these PRN medications were found to be expired 09/14/2023 During a check of all PRN medications done by Designee [redacted].This and one other medication were sent back the pharmacy on 09/15/2023 these 2 medications had not been used in more than 6 months so the prescribing doctor needed to be called for refills and they were not back into the facility until they were refilled on 09/21/2023 these two medications were sent to [redacted] new facility on [redacted]/2023 when [redacted] transferred.
These PRN medications are checked weekly for count and expiration
Medication retraining on the homes procedure for medications supply in the home will be held on 10/18/2023 by [redacted] Medication trainer. This training will be recorded in the office in the record.

DIRECTED: Beginning on 10/20/23: The administrator shall review the medications of at least 5 residents weekly for 4 weeks then monthly thereafter to ensure all medications are present in the home and available for administration in accordance with prescriber's orders. Documentation of the audits shall be kept. [redacted] 10/16/23

Proposed Overall Completion Date: 10/18/2023

Directed Completion Date: *11/03/2023*

185a - Implement Storage Procedures *(continued)*

Not Implemented [redacted] - 11/07/2023)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #3 is prescribed Novolog Flexpen insulin-Inject subcutaneously 3 times daily in accordance with sliding scale: 70-130=0 units; 131-180=4 units; 181-240=5 units; 241-300=6 units; 301-350=7 units; 351-400=8 units; >400= 9 units and call MD. However, resident #3's September 2023 medication administration record (MAR) only indicates to call MD for blood glucose >400 and does not include the 9 units of insulin that are to be administered.

Resident #4 is prescribed Albuterol 90 mcg–Take 2 puffs every 6 hours as needed for wheezing; however, resident #4’s September 2023 MAR indicates Albuterol 90 mcg–Take 1 puff as needed for COPD. Also, resident #4's September 2023 MAR does not include the frequency of administration for resident #4's Albuterol.

Resident #4 is prescribed Santyl Ointment–Apply to right posterior heel once daily; however, this medication is not present on resident #4's September 2023 MAR.

Resident #4 is prescribed Tramadol 50 mg–Take 1 tablet by mouth every 6 hours as needed for moderate or sever pain; however, resident #4 ’s September 2023 MAR indicates Tramadol 50 mg-Take 1 tablet by mouth 3 times daily as needed for pain.

Plan of Correction ***Directed [redacted] - 10/16/2023)***

Resident #3 Insulin documentation of 9 units was updated by the pharmacy see attached document.
Resident #4 albuterol documentation at pharmacy corrected the september MAR states as needed every 6 hours. this is the frequency, note this medication was not needed or given in September. see attached MAR

187a - Medication Record (continued)

Resident #4 the dressing changes were changed to Medi honey on 9/12/2023 as the Santly was unavailable due to shortages. see attached paper work from AHN Santyl Ointment was never used for the dressings for the right heal it had been used on a prior wound.
Resident #4 dosage of Tramadol was updated in MAR from 3 times a day to max 4 times a day . these orders were transmitted from [redacted] Hospital to the Pharmacy [redacted] via fax. 10/4/2023

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator shall review the current MAR's for residents #3 and #4 to ensure each resident has an accurate and complete MAR in accordance with prescriber's orders.[redacted] 10/16/23

Medications coming into the facility from outside pharmacys ie: mail order and hospital discharge will be placed in the incoming medication area to be checked onto the MAR and rotation. this practice has been since 09/21/2023
Medication retraining on the homes procedure for medications documentation in the home will be held on 10/18/2023 by [redacted] Medication trainer. This training will be recorded in the office in the record.
Administrator will review at least 6 Resident Mars for accuracy weekly and keep documentation in the office. starting 10/10/2023 (DIRECTED: The administrator shall review at least 5 resident MAR's monthly for accuracy and completeness in accordance with prescriber's orders immediately following the weekly MAR reviews for 6 residents. Documentation of the audits shall be kept. [redacted] 10/16/23).

Proposed Overall Completion Date: 10/18/2023

Directed Completion Date: *11/03/2023*

Not Implemented [redacted] - 11/07/2023)

187b - Date/Time of Medication Admin.

12. 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 #4 was prescribed Amoxicillin/Clavulanate 875 mg/125 mg-Take 1 tablet by mouth 2 times daily for 5 days. The medication was administered to resident #4 twice daily from 9/12/23 through 9/16/23; however, staff persons continued to document the administration of the medication on resident #4's September 2023 MAR twice daily on 9/17/23, 9/18/23 and the morning of 9/19/23.

Plan of Correction ***Directed [redacted] 10/16/2023)***

The programmer's at SMART have installed a d/c medication date portion of the programing to prevent this error. The medication removed itself after the end date portion of the program was installed on 09/21/2023
Staff will review documentation at the staff meeting on October 18th 2023 reviewed by [redacted], Trainer. training will be recorded in the training record in the office

DIRECTED: Beginning on 10/20/23: The administrator shall review the MAR's of at least 5 residents weekly for 4 weeks then monthly thereafter to ensure accurate and complete medication administration documentation is present. Documentation of the audits shall be kept. [redacted] 10/16/23

Proposed Overall Completion Date: 10/18/2023

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

Directed Completion Date: *11/03/2023*

Not Implemented [redacted] - 11/07/2023)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident #3 is prescribed blood glucose checks 3 times daily with meals, as well as Novolog Flexpen insulin sliding scale coverage with meals; however, resident #3's blood glucose was not tested on 9/15/23 at dinner, so it is unable to be determined if Novolog should have been administered to resident #3.

Resident #3 is prescribed Furosemide 20 mg–Take 3 tablets (60 mg total) by mouth daily; however, resident #3 was administered 3 Furosemide 40 mg tablets (120mg total) daily from 9/1/23 through 9/19/23.

Plan of Correction ***Directed [redacted] - 10/16/2023)***

All new medication in a new bottle was delivered by the [redacted] containing the correct dose as well as directions.
all medications coming into the facility will be placed in the check in area for the administrator or the designee to check into the facility so the correct medications are documented correctly on the MAR and placed into rotation correctly.
this went into effect on 09/21/2023
Administrator will review at least 6 Resident Mars for accuracy weekly and keep documentation in the office. starting 10/10/2023 (DIRECTED: The weekly reviews shall also include a review of all 6 resident medications to ensure all prescribed medications are present in the home in accordance with prescriber's orders. The administrator shall also review the medications and MAR's at least 5 residents monthly for accuracy and completeness in accordance with prescriber's orders immediately following the weekly MAR reviews for 6 residents. Documentation of the audits shall be kept. [redacted] 10/16/23).
Medication retraining on the homes procedure for medications documentation in the home will be held on 10/18/2023 by [redacted] Medication trainer. This training will be recorded in the office in the record.

Proposed Overall Completion Date: 10/18/2023

Directed Completion Date: *11/03/2023*

Not Implemented [redacted] - 11/07/2023)