

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

June 26, 2023

[REDACTED]
LCB CHADDS FORD LLC
[REDACTED]

RE: THE RESIDENCE AT CHADDS FORD
1778 WILMINGTON PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14536

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/06/2023, 03/07/2023 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: *THE RESIDENCE AT CHADDS FORD* License #: *14536* License Expiration: *12/06/2023*
 Address: *1778 WILMINGTON PIKE, GLEN MILLS, PA 19342*
 County: *DELAWARE* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *LCB CHADDS FORD LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *1 1* Date: *10/08/2019* Issued By: *Chadds Ford Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *89* Waking Staff: *67*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *03/07/2023*

Inspection Dates and Department Representative

03/06/2023 On Site [REDACTED]
03/07/2023 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *108* Residents Served: *69*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Reflections* Capacity: *24* Residents Served: *19*

Hospice
 Current Residents: *2*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *69*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *20* Have Physical Disability: *0*

Inspections / Reviews

03/06/2023 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/27/2023*

03/28/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *05/03/2023*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/02/2023*

Inspections / Reviews *(continued)*

04/05/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/03/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 05/05/2023

06/26/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/03/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

28f - Resident's Funds and 30-day Refund

1. Requirements

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident 1 was discharged on [REDACTED] 22. The home did not issue a refund until [REDACTED] /22.

Plan of Correction

Accept ([REDACTED] - 03/28/2023)

The corporate accounting office will be in-serviced March 25, 2023 through April 7, 2023 on the regulation that refunds must be issued within 30 days of discharge, or 30 days after all personal belonging are removed from the apartment. A flow sheet has been developed to track discharge dates and the dates the refund checks are issued. A weekly reminder will be sent to the corporate accounting office indicating the refund checks that need to be issued, along with the due date.

This task will be completed by the Business Office Director or the Executive Director to maintain ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/27/2023

Implemented ([REDACTED] - 05/09/2023)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member A's 1st day of work was [REDACTED] 21, however their criminal background check was not completed until [REDACTED] /21.

Staff member B's 1st day of work was [REDACTED] /20, however their criminal background check was not completed until [REDACTED] /22

Plan of Correction

Accept ([REDACTED] 03/28/2023)

This violation had previously been corrected in April 2022. When the current administrator began, it was self-identified that a background check was not in compliance with the regulation. The administrator completed a full audit of associate files and completed a background check for those not previously done, and for those completed but that the final report had not been received. This information was given to the surveyor at the time of the survey. All back-ground checks for new associates hired since April 2022 have been completed and are in compliance with this regulation.

A Criminal Background Tracking Audit has been used for all new hires since April 2022. All associate files are and will continue to be audited prior to the associate's start date for pre-hire compliance with the completion of the background check by the Administrator.

Licensee's Proposed Overall Completion Date: 03/25/2023

51 - Criminal Background Check (*continued*)

Implemented (█ - 05/09/2023)

85a - Sanitary Conditions

3. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident 2's glucometer has a reading of █ at █ pm on █. This reading was found on resident 3's glucose log on █ at █ pm. Resident 3's glucometer has no corresponding reading.

Resident 2's glucometer has a reading of █ at █ pm on █. This reading was found on resident 3's glucose log on █ at █ pm. Resident 3's glucometer has no corresponding reading.

Plan of Correction

Accept (█ - 04/05/2023)

On these two occasions the nurse shared the glucometer due to resident #3 being out of test strips. The strips had been ordered but had not yet been delivered.

Both glucometers were immediately sanitized. The supply of test strips for all residents with a glucometer was assessed and found to be in good supply. There was a new stock glucometer that can be used in emergency situations (not everyone on the care team was aware of this). The care team will be educated that glucometers can never be shared, the availability of a stock (new) glucometer which can be used and then it must be discarded or given to the resident. The transcription discrepancies were reviewed on March 8, 2023 individually with those who were noted to have made them. Education will be completed for all nurses and med techs on the importance of accurate documentation and transcription, the need for proper calibration of the date and time of equipment used, and that a glucometer and never be used for more than one resident. . This education will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

Test strip supply will be audited weekly by the nurse/med tech to help ensure adequate supply and the timeliness and accuracy of reordering. The Resident Care Director/Resident Services Supervisor will audit the glucometers for proper calibration, test results and corresponding documentation weekly and will address any discrepancies found directly with those associates involved. The weekly audit will begin the week of April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented (█ - 05/09/2023)

91 - Telephone Numbers

4. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 3/6/23 at 3:08PM, There were no emergency telephone numbers to include the nearest hospital and fire

91 - Telephone Numbers (continued)

department on or by the telephone in resident room [REDACTED].

Plan of Correction

Accept [REDACTED] 04/05/2023)

One resident had a cell phone in [REDACTED] apartment and did not have a list of emergency numbers in [REDACTED] apartment. The resident was given the list of emergency numbers on March 6, 2023 when it was discovered that [REDACTED] did not have one. On March 9, 2023 frames were purchased so the numbers could be posted in each apartment. These frames with the required emergency numbers have been placed in all apartments and secured to the wall inside the apartment door. This was completed on March 22, 2023.

The maintenance, housekeeping, and care team will be educated on the need to have the emergency phone list in each apartment and the rationale behind it by April 7, 2023. The residents were educated on the need to have the emergency numbers accessible, the numbers required and the location of the posting in each apartment at a resident meeting held during happy hour on March 16, 2023.

The housekeepers will verify with weekly housekeeping services that the frame with the emergency numbers is present in the apartment. The resident care team will look for the presence of the numbers each time they exit an apartment. They will report to their supervisor or Executive Director if the frame/numbers are not present. This weekly verification began on March 28, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented ([REDACTED] - 05/09/2023)

101j7 - Lighting/Operable Lamp**5. 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 3/6/23 at 2:15PM, Resident 4 did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept ([REDACTED] - 04/05/2023)

The lamp was noted to be on the resident's dresser not on the bedside table, at the time of inspection. While still in the apartment with the surveyor the administrator told the resident that the lamp needed to be on the nightstand within reach of the bedside. The resident stated that [REDACTED] doesn't want it there, [REDACTED] wants it on the dresser. The lamp was temporarily moved to the nightstand. A wall mount push light was purchased March 13, 2023 and placed on the wall next to the bed on March 16, 2023. The lamp was returned to the dresser per resident right and preference.

The housekeeping and care departments will be educated on the need to have a working light at the bedside and the rationale behind it by April 7, 2023.

The housekeepers will verify with weekly housekeeping services that the light is present and working. The care team will verify that there is a working light next to the bed when assisting to make the bed. They will report to their supervisor or the Executive Director if the light is not present or not functioning. This weekly verification began on March 28, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

101j7 - Lighting/Operable Lamp (continued)

Implemented () - 06/26/2023

103g - Storing Food

6. Requirements

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

Description of Violation

On 3/6/23 at 3:00PM there was uncovered cheesecake in the Secure Dementia Care Unit refrigerator.

Repeated Violation-8/31/21 et al

Plan of Correction

Accept () - 04/05/2023

The food was immediately removed from the refrigerator. The items were found in the country kitchen on the memory care neighborhood. The Resident Care Aide placed the resident's dessert in the refrigerator at lunch time because the resident did not want it at the time of the meal.

A sign was placed on the refrigerator on March 25, 2023 reminding all associates that items must be covered, labeled, and dated. The Resident Care Aides and dining associates will be educated on the need to cover and date all food items that are placed in the refrigerator. This will be completed by April 7, 2023 by the Administrator/Reflections Director/Resident Care Director/Resident Services Supervisor/Dining Services Manager.

The refrigerator will be checked daily on walking rounds by the Director of Reflections or the Manager on Duty. This item has been added to the First Impressions Checklist. This began on March 27, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented () - 05/09/2023

103i - Outdated Food

7. Requirements

2600. 103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 3/6/23 at 3:00PM, there was a metal container of ranch dressing and 2 pitchers of juice that were unlabeled and undated in the Secure Dementia Care Unit refrigerator.

Repeated Violation-8/31/21 et al

Plan of Correction

Accept () - 04/05/2023

The Ranch dressing was placed in the refrigerator after the lunch meal, it was covered but not dated. The 2 pitchers of soda were placed in the refrigerator at lunch time to be available for the afternoon snack. The pitchers were covered but not dated. The items were immediately dated.

The dining team and care team will be educated on the need to cover and date all food items that are placed in

103i - Outdated Food (continued)

the refrigerator. This will be completed by April 7, 2023 by the Administrator/Reflections Director/Resident Care Director/Resident Services Supervisor/Dining Services Manager.

The refrigerator will be checked daily on walking rounds by the Director of Reflections or the Manager on Duty. This item has been added to the First Impressions Checklist. This began on March 27, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented (█) - 05/09/2023

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 3/6/23 at 2:20PM, there was an accumulation of lint in the lint trap in the first floor dryer in the laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept (█) - 04/05/2023

One of 8 dryers in the community had lint in the trap. The dryer was warm and had just been used. The lint was a thin layer and solid grey in color, there were no visible layers indicating that it had been more than one load worth of lint. There are residents that do their own laundry. There was a sign on the wall behind the dryers indicating that the lint must be removed after each load.

On March 25, 2023 the signs were updated and placed on the dryer next to the controls for an increased visual reminder. The residents were educated on the need to empty the lint after each load and the fire safety reasoning behind it on March 16, 2023 at a resident meeting held during happy hour. The Housekeeping and care team will be educated by the Administrator/Resident Care Director/Resident Care Supervisor/Maintenance Manager on the regulation that requires the lint to be emptied after each use and the fire safety reasoning behind it by April 7, 2023.

All department managers will audit the dryers for lint during daily walking rounds. This item has been added to the First Impressions Check list. This began on March 27, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented (█) - 05/09/2023

132b - Safety Inspection/Fire Drill

9. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

132b - Safety Inspection/Fire Drill (continued)

Description of Violation

The last fire safety inspection and fire drill observed by a fire safety expert was conducted on [REDACTED] 22. Prior to that the last fire safety inspection and fire drill observed by a fire safety expert was [REDACTED]/2019

Plan of Correction

Accept ([REDACTED] - 03/28/2023)

This violation had previously been corrected April 5, 2022. This was self-identified when the current administrator began in 2022, it was noticed that the supervised drill and inspection had not been completed by December 31, 2022 as required due to the suspension of the regulation ending. The vendor was contacted, the inspection was completed, and the letter was written on April 5, 2022. This information was provided to the surveyor during the inspection.

The 2023 inspection and supervised fire drill is scheduled for April 5, 2023.

The administrator and/or the Director of Maintenance will schedule the supervised drill annually. An annual reminder has been placed on the administration calendar.

Licensee's Proposed Overall Completion Date: 03/25/2023

Implemented ([REDACTED] - 05/09/2023)

132c - Fire Drill Records

10. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted on 1/20/2022 at 9AM, 2/28/2022 at 5PM, 3/31/2022 at 11AM do not include the exit route used, the number of residents in the home at the time of the drill, and the number of residents evacuated

Plan of Correction

Accept ([REDACTED] - 03/28/2023)

This violation had previously been corrected with the April 2022 fire drill. When the current administrator began in April 2022, it was self-identified that the fire drill form being used was not compliant, and all the regulatory information was not included. The community immediately began using the DHS provided fire drill log, and as noted by the surveyor has been in compliance with all fire drills since.

Prevention of future occurrence: This violation will remain in compliance with the continued use of the DHS Fire Drill Log by the administrator and/or Maintenance Director.

Licensee's Proposed Overall Completion Date: 03/25/2023

Implemented ([REDACTED] - 05/09/2023)

183b - Meds and Syringes Locked

11. Requirements

183b - Meds and Syringes Locked (continued)

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/6/23 at 2:42PM, there was [REDACTED] and [REDACTED] on the bathroom counter in resident 5's room. Resident 5 is not assessed as capable of self administering medications.

Plan of Correction**Accept ([REDACTED] - 04/05/2023)**

The medications were removed from the apartment the day of the survey. The resident is assessed as needing assistance to take medications. The resident did not have current orders for the medications and the associates were not aware that they were present. The resident reported that [REDACTED] doesn't use them and that [REDACTED] daughter had put them there. [REDACTED] told the Resident Care Director to discard them.

The family was notified of the finding on March 8, 2023 by the Resident Care Director and they were educated on the regulation that only medications that are currently ordered can be in the community and that all medications must be given to and stored by the care team unless the medication is ordered to self-administer and the resident is assessed as being able to self-administer.

The housekeeping and care teams will be educated on this regulation and the need to report to the Resident Care Director if any medications are observed in the apartment. This training will be completed by the Resident Care Director/Resident Services Supervisor/Executive director by April 7, 2023. The residents were educated on this regulation March 16, 2023 at a resident meeting held during Happy Hour.

The housekeeping team will observe weekly with housekeeping services and the care team will observe any time they enter the resident's apartment for the presence of medications and immediately report the finding to their supervisor and the Resident Care Director. This began on March 27, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented ([REDACTED] - 06/26/2023)**183d - Prescription Current****12. Requirements**

2600.

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

Description of Violation

On 3/7/23, 2 bottles of [REDACTED] 50mg prescribed for resident 6, were in the home's 4th floor medication cart; however, the medication was discontinued on [REDACTED] 23.

On 3/7/23, Bottles of [REDACTED] capsule and [REDACTED] prescribed for resident 7, were in the home's 1st floor medication cart; however, resident 7 does not have a current order for either medication.

Plan of Correction**Accept ([REDACTED] - 04/05/2023)**

The medication was immediately removed from the medication cart and discarded. The nurse had received and noted the order to discontinue the medication, she removed it from the medication administration record however,

183d - Prescription Current (continued)

she did not remove it from the medication cart.

All nurses will be educated on the procedure to discontinue medications. The medication techs will be educated on the need to observe for, remove and report to their supervisor and the Resident Care Director any medication found on the medication cart that does not have a current order. This should occur with each medication administration. All nurses and medication techs will be educated on the use of the medication audit tool which is completed for each resident weekly. This education will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The weekly medication audit tool will be assigned to a specific nurse or medication tech. All items needing follow up will be completed by the nurse on duty. The completed audit tool will be given to the Resident Care Director and the Resident Services Supervisor for review and verification of follow-up and follow through. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented (█) - 06/26/2023)

183e - Storing Medications**13. 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 3/7/23 at 10:23AM, there was 1 loose white round pill in 4th floor medication cart.

Plan of Correction

Accept (█) - 04/05/2023)

The pill was immediately removed from the medication cart. The entire cart was audited on March 8, 2023. No other loose pills or debris were discovered.

The nurses and medication techs will be educated on the need to keep the cart clean and free of loose pills or other debris. The medication cart audit tool will be reviewed as part of the education and the tool will be updated to include cleaning of the medication storage drawer with each audit. This training will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The weekly medication audit tool will be assigned to a specific nurse or medication tech. All items needing follow up will be completed by the nurse on duty. The completed audit tool will be given to the Resident Care Director and the Resident Services Supervisor for review and verification of follow-up and follow through. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented (█) - 06/26/2023)

184a - Resident's Meds Labeled

14. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident 5 is prescribed [redacted] 40mg tablet take 1 tablet by mouth at bedtime as needed. However, the medication label reads take 1 tablet by mouth everyday at bedtime.

Repeated Violation-8/31/21 et al

Plan of Correction

Accept [redacted] - 04/05/2023)

The order was immediately reviewed, and it was verified that the order as written on the MAR was correct. A "Direction Change See Chart" sticker was placed on the packaging label to alert anyone administering the medications that the label on the package reads different than what is written on the MAR.

All nurses and medication techs will be educated that the MAR and the label must match. If there is a discrepancy the written order must be verified and if the MAR is correct, then a "Direction Change" sticker must be placed on the package. This training will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023. An audit of MAR matches the label will be included on the medication audit tool.

The weekly medication audit tool will be assigned to a specific nurse or medication tech. All items needing follow up will be completed by the nurse on duty. The completed audit tool will be given to the Resident Care Director and the Resident Services Supervisor for review and verification of follow up and follow through. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented ([redacted] 06/26/2023)

185a - Implement Storage Procedures

15. 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 2's blood glucose reading on 3/6/23 at 12:59PM was [redacted] However, it was documented as [redacted] Resident 2's blood glucose reading on 3/2/23 at 4:47PM was [redacted] However it was documented as [redacted]

On 3/7/23 at 11:19AM, Resident 3's glucometer was calibrated to 7/7 at 7:26AM.

Resident 8's prescribed blood glucose reading on 2/6/23 at 6:09AM was [redacted] However, it was not documented on the log.

Resident 8's prescribed blood glucose reading on 2/23/23 at 6:40AM was [redacted] However, it was documented as [redacted].

Plan of Correction

Accept ([redacted] - 04/05/2023)

All glucometers were assessed and if indicated were calibrated with the correct date and time. The MARs were reviewed to evaluate who made these transcription discrepancies and to see if this was isolated to one nurse/med tech or multiple.

185a - Implement Storage Procedures (continued)

The transcription discrepancies were reviewed individually with those who were noted to have made them. Education will be completed for all nurses and med techs on the importance of accurate documentation and transcription and the need for proper calibration of the date and time of equipment used. This education will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The Resident Care Director/Resident Services Supervisor will audit the glucometers for proper calibration, test results and corresponding documentation weekly and will address any discrepancies found directly with those associates involved. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented [REDACTED] - 06/26/2023)

16. 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 [REDACTED] 325mg tablet take 2 tablets by mouth every 6 hours as needed. On 3/7/23 this medication was not available in the home.

Resident 8 is prescribed [REDACTED] 4gm chew one tablet by mouth as needed. On 3/7/23, this medication was not available in the home.

Resident 8 is prescribed [REDACTED] ointment apply [REDACTED] twice a day as needed. On 3/7/23, this medication was not available in the home.

Repeated Violation-8/31/21 et al

Plan of Correction

Accept [REDACTED] 04/05/2023)

[REDACTED] was available in house with a stock supply. Unless the resident uses it frequently a stock supply is used to decrease the amount of medication containers, cost to the resident and waste. The [REDACTED] and [REDACTED] were ordered from the pharmacy the day of the survey and they arrived that evening.

All nurses and med techs will be educated that all PRN medications must be available in the home at all times. The medication audit tool will include verifying that all PRN medications are available and with adequate supply. All nurses and medication techs will be educated on the use of the medication audit tool which is completed for each resident weekly. This education will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The weekly medication audit tool will be assigned to a specific nurse or medication tech. All items needing follow up will be completed by the nurse on duty. The completed audit tool will be given to the Resident Care Director and the Resident Services Supervisor for review and verification of follow-up and follow through. This will begin on April 3, 2023 and will be ongoing indefinitely.

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented [REDACTED] - 05/09/2023

187a - Medication Record

17. Requirements

2600.

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

Description of Violation

Resident 5 is prescribed [REDACTED] 100unit/ml inject sub-Q as per sliding scale with each meal: 200-250=4u, 251-300=5u, 301-350=6u, 351-400=7u, >400=8u. However, resident's 5's medication administration record does not indicate the amount [REDACTED] administered for the following readings: 3/7/23 7:55AM [REDACTED], 3/4/23 2:02PM [REDACTED] 3/1/23 6:11PM [REDACTED] 2/28/23 5:49PM [REDACTED]

Plan of Correction

Accept (MS - 04/05/2023)

The documentation system was reviewed the day of the survey and it was discovered that the sliding scale information including how much PRN insulin is given is not accessible to those administering the medications. The e-mar company was contacted on March 13, 2023 to alert them to the issue. A paper Diabetic flow sheet was put into place on March 10, 2023 to allow this information to be properly documented.

All nurses and med techs were advised of the use of the diabetic flow sheet to document the blood glucose results and the amount of sliding scale insulin administered on March 10, 2023. All nurses and med techs will be further educated on the use of the diabetic flow sheet by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The Resident Care Director/Resident Services Supervisor will audit the diabetic flow sheets for completion and accuracy weekly. Any discrepancies found will be addressed directly with those associates involved. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented (MS - 05/09/2023)

187d - Follow Prescriber's Orders

18. Requirements

2600.

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

Description of Violation

Resident 5 is prescribed [REDACTED] 100unit/ml inject sub-Q as per sliding scale with each meal: 200-250=4u, 251-300=5u, 301-350=6u, 351-400=7u, >400=8u. However, this was not completed at dinnertime/evening on 3/2/23, 3/3/23, 3/4/23, 3/5/23, 3/6/23.

Resident 7 is prescribed [REDACTED] take 1 tablet by mouth every 6 hours as needed. However on 2/24/23 this was

187d - Follow Prescriber's Orders (continued)

administered at 8AM and 12PM, 4 hours apart.

Resident 8 is prescribed [redacted] daily, however no [redacted] was completed on 3/5/23 and 3/6/23.

Resident 9 is prescribed [redacted] 1 capsule by mouth three times daily, however this was only administered once on 2/23/23.

Repeated Violation-8/31/21 et al, 12/20/21 et al, and 3/24/22.

Plan of Correction

Accept [redacted] 04/05/2023)

All residents noted were assessed and no adverse effects noted. The documentation system was reviewed the day of the survey and it was discovered that the sliding scale information including how much PRN insulin is given is not accessible to those administering the medications. The e-mar company was contacted on March 13, 2023 to alert them to the issue. The blood glucose testing was not omitted for resident # 8 on 3/5 and 3/6, it was documented that the resident refused (MAR given to the surveyor attached). In review of the Pregabalin medication was given 2 times on February 23, and it was ordered 3 times. The nurse documented not given but did not indicate the reason why.

A paper Diabetic flow sheet was put into place on March 10, 2023 to allow this information to be properly documented and the nurses and med techs will be educated on the use of the document. The nurses and med techs will be educated on PRN orders and the parameters associated with them for frequency that must be followed. The nurses and med techs will be educated on the need to document why a medication is not given. Will contact the e-mar company by March 31, 2023 to see if the generic "did not give" option can be disabled. This education will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The Resident Care Director/Resident Services Supervisor will audit the diabetic flow sheets and MARs for completion, proper notes and accuracy weekly. Any discrepancies found will be addressed directly with those associates involved. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented [redacted] - 06/26/2023)

19. Requirements

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

Description of Violation

Resident 6 is prescribed [redacted] 20MG Tablets take 1 tablet by mouth as bedtime. However, this medication was not administered to resident 6 on [redacted]/23 because the medication was not available in the home.

Plan of Correction

Accept [redacted] 04/05/2023)

This resident does not use the facility pharmacy. [redacted] supplies the medications. [redacted] was aware that the medication was in need of a refill, and [redacted] did not bring the medication in timely.

187d - Follow Prescriber's Orders (continued)

The Reflections Director educated the family on March 9, 2023 on the need to have the medication here and available. They were made aware that this delay caused a regulatory violation and that in the future if the medication is not provided timely the facility pharmacy will provide the medication and the resident will incur charges for the medication. The nurses and med techs will be educated on the need to report to the Reflections Director/Resident Care Director/Resident Services Supervisor if a family has been requested to bring a refill of a medication and they do not bring it timely putting the resident at risk of running out of the medication. The medication audit tool will be used to help reorder medications timely. This education will be completed by the Resident Care Director/Resident Services Supervisor/Executive Director by April 7, 2023.

The weekly medication audit tool will be assigned to a specific nurse or medication tech. All items needing follow up will be completed by the nurse on duty. The completed audit tool will be given to the Resident Care Director and the Resident Services Supervisor for review and verification of follow-up and follow through. This will begin on April 3, 2023 and will be ongoing indefinitely.

Licensee's Proposed Overall Completion Date: 04/07/2023

Implemented [REDACTED] - 06/26/2023)