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

February 14, 2024

[redacted], OWNER
THE RIDGE AT HERITAGE MEADOWS LLC
1126 ROSS AVENUE
FORD CITY, PA, 16226

RE: THE RIDGE AT HERITAGE MEADOWS
1126 ROSS AVENUE
FORD CITY, PA, 16226
LICENSE/COC#: 45289

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/08/2023, 10/05/2023 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 RIDGE AT HERITAGE MEADOWS* **License #**: *45289* **License Expiration**: *12/14/2023*

Address: *1126 ROSS AVENUE, FORD CITY, PA 16226*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *THE RIDGE AT HERITAGE MEADOWS LLC*

Address: *1126 ROSS AVENUE, FORD CITY, PA, 16226*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *04/07/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *32* **Waking Staff**: *24*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *09/08/2023*

Inspection Dates and Department Representative

09/08/2023 On Site: [redacted]

10/05/2023 Off Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *45* **Residents Served**: *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *25*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

09/08/2023 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *10/22/2023*

Inspections / Reviews *(continued)*

10/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2024*

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

11/17/2023 POC Submission

Submitted By: *Erin Graham* **Date Submitted**: *01/31/2024*

Reviewer: *Jonathan Weaver* **Follow Up Type**: *POC Submission* **Follow Up Date**: *11/28/2023*

12/06/2023 POC Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2024*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *01/31/2024*

02/14/2024 Document Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2024*

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

42b - Abuse

1. Requirements

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

Description of Violation

On [redacted] resident #1, complained of right hip pain. Staff member A, a Registered Nurse, completed an assessment of resident #1, and the resident was sent to the hospital. The hospital's radiology department took x-rays of Resident #1's right hip and determined that "no acute abnormality or fracture" was indicated. The resident was discharged back to the home on [redacted]., with discharge instructions indicating "the full extent or seriousness of your medical condition may not be obvious on the initial evaluation performed here. If your symptoms worsen or do not improve contact your personal physician or return to the Emergency Department, should your symptoms worsen, please return to the ER for further evaluation".

On [redacted], staff members B and C were on duty from [redacted]. At approximately [redacted]., staff member B attempted to reposition Resident #1 away from the edge of [redacted] mattress. During the repositioning attempt Staff member B heard Resident #1 make a whining noise showing symptoms of being in pain. Shortly before [redacted] a.m., staff member C observed Resident #1 to be in pain and stated to staff member B that there was something wrong. At [redacted] Resident #1's yelling and crying had increased. Staff member C indicated "we knew something was definitely wrong". "I feel awful about all of this, it's not something a person should go through it's just not. At approximately [redacted]., staff member D, went into resident #1's room and observed the resident's right leg to be turned inward and requested staff member A, to reexamine Resident #1's leg.
Staff member A reassessed Resident #1's right leg at approximately [redacted]., and suspected Resident #1 might have a fracture of the right leg.

The home failed to send the resident out to hospital until [redacted]. Resident #1 was admitted with an angulated impacted subcapital femoral neck fracture of the right hip and the resident underwent right hip hemiarthroplasty.

Plan of Correction ***Accept [redacted] - 12/06/2023)***

ALL ELEMENTS OF IMMEDIATE, CORRECTIVE AND PREVENTATIVE ACTION INCLUDED:

9/9; 9/10; 9/11/2023: Review of inspection findings in regards to regulation violation 42b with staff scheduled to work on 6/26; 6/27; 6/28/23; reviewed series of events with all staff scheduled. Completed by [redacted], RN, PCHA

9/10/2023: Phone call made by [redacted], RN, BSN to resident POA to discuss inspection findings and regulation violation. POA notified of DHS findings of regulation violation. Completed by [redacted].

9/11/2023; 13:02: Phone call made to Supervisor [redacted] to discuss regulation and findings by surveyor. Completed by [redacted], RN, PCHA
Follow up/return phone call to be made by Supervisor [redacted] to [redacted] RN, PCHA
Request made by [redacted], RN, PCHA to Supervisor [redacted] to contact Armstrong County Area on Aging Ombudsman [redacted].
Completed by [redacted], ,RN, ,PCHA

42b Abuse (continued)

10/05/23; 12:39pm: Phone call made by Surveyor [redacted] to [redacted], RN, PCHA for telephonic exit interview and findings including regulation 42b.
Completed by [redacted], RN, PCHA

10/10/23 15:11: Phone call made by Supervisor [redacted] to [redacted], RN, PCHA to discuss regulation violation.
Completed by [redacted], RN, PCHA

10/18 13:00: Review of findings of regulation violation 42b as read from inspection summary to staff listed in inspection summary; review of interviews, reports from staff members ; education on regulation 42b provided by [redacted], RN, PCHA to staff members A,B,C,D and manager [redacted] completed on this date.
Completed by [redacted], RN, PCHA

11/16/23 9:17: Phone call by Supervisor [redacted] to [redacted], RN, PCHA to discuss regulation violation 42b
Completed by [redacted], RN, PCHA

To be completed by 12/8/2023: Education to all staff on regulation 42b. Staff to read and sign education.
To be completed by [redacted], RN, PCHA

Education on regulation 42b to be completed on semi annual basis 2 x per year beginning with first education review by 12/8/2023: regulation 42b to all staff to read and sign acknowledgement.
Documentation will be kept in education binder or staff file under education documentation.
2 x per year will commence 12/8/23 and anticipated completion date will be 12/31/2024.
To be completed by [redacted], RN, PCHA or designated member of management.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented [redacted] - 02/14/2024)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

At 11:52 a.m., there was 8 to 10 inches of mold on the top and bottom of the baseboard immediately next to the shower located in the home's lower level community shower room.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

On 9/8/23 during the inspection, the shower room in question was cleaned by a DCS at the request of [redacted], manager.
Upon cleaning and disinfecting of the shower, [redacted], DHS Surveyor re inspected the room and witnessed the correction.

Starting on Tues 10/24/2023 Staff education will be issued by [redacted], Administrator or a designated member

85a - Sanitary Conditions (continued)

of Administration to all staff members educating on sanitary conditions.

Starting on Tues 10/24/2023 the night shift staff will be given an audit tool to document and complete for disinfecting/cleaning of all shower room surfaces.

This will be completed 2 x weekly x 1 month then 1 x weekly x 1 month then 1 x monthly x 6 months.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 02/14/2024)

88a - Surfaces

3. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At 11:34 a.m., the door granting egress to the common bathroom located next to the home's laundry room had a broken left stop approximately 3.5 feet the floor. The broken stop had a jagged edge presenting a potential skin tear hazard.

Plan of Correction ***Accept ([redacted] - 10/27/2023)***

On 9/8/23 during the inspection, [redacted], manager purchased wood from the local hardware store and repaired the broken door stop.
On 9/8/23, after completion of this repair, [redacted], DHS Surveyor witnessed the complete repair.

Beginning on 10/24/23, staff will be given education on observing and reporting maintenance concerns to a member of management.

Beginning on 10/24/23, Admin [redacted] or another designated member of management will complete an audit tool to check door stops for cracks, breaks or other areas of concern.

This audit tool will be completed 1 x weekly x 4 weeks then 1 x monthly for 6 months

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented ([redacted] - 02/14/2024)

101j2 - Bedroom Chairs

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

At 11:45 a.m., lower-level bedroom #6 was occupied by 2 residents; however, there was only 1 chair in this room.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

On 9/8/23 during the inspection, [redacted], RN, Assistant Administrator placed 1 chair in Bedroom #6 on the lower level, witnessed by [redacted], DHS Surveyor.

101j2 - Bedroom Chairs (continued)

Please note that 1 of the 2 residents in the bedroom utilize a wheelchair to serve as the 2nd chair for that bedroom.

Starting on 10/24/23, staff education will be given to all staff to educate on the requirement of 1 chair per resident to be present in bedrooms at all times.

Starting on 10/24/23 an audit tool will be completed by [redacted] or another member of management to assess all resident rooms for presence of appropriate number of chairs.

This audit tool will be completed 2 x weekly x 1 month then 1 x weekly x 1 month then 1 x monthly x 6 months

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented ([redacted] - 02/14/2024)

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

At 11:44 a.m., resident #2 did not have access to a source of light that could be turned on/off at bedside. The resident's bed side lamp was inoperable.

At 11:46 a.m., resident #3 had no access to a source of light that could be turned on/off at bedside. The lamp on the dresser was approximately 4 feet from the edge of the resident's mattress.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Resident #2:
On 9/8/23, in the presence of [redacted], DHS Surveyor, [redacted], RN/Assistant Administrator, inspected the lamp, tightened the light bulb and corrected the lamp; he then tested it by turning it on. It was operable.

Resident #3:
On 9/8/23 during the inspection, [redacted] placed a 2nd lamp on her side of the nightstand to allot for 2 lamps on the same nightstand.
This was witnessed by surveyor [redacted].

PLEASE NOTE: There is a shared nightstand with a shared lamp. On the nightstand there was also a radio. Tom Smith felt that Resident #2 was incapable of reaching the lamp. Management also reported to [redacted] that this resident does not have the cognitive ability to comprehend use of a lamp, whether it be a table lamp or a touch light installed on her headboard

Beginning on 10/24/23 staff education will be issued in regards to regulations involving light sources.

Beginning on 10/24/23 an audit tool will be completed by [redacted], Administrator or a designated employee of the facility to assess all resident lamps for accessibility and function.

101j7 - Lighting/Operable Lamp (continued)

This will be completed 2 x weekly x 1 month then 1 x weekly x 1 month then 1 x monthly x 6 months

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 02/14/2024)

103c - Food Protected

7. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

At 11:15 a.m., there was an opened plastic bag of approximately 30 frozen omelets in freezer #3

At 11:40 a.m., there was a full plastic container pitcher of Kool-Aid that was uncovered in the refrigerator located in the kitchen on the lower floor of the home.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

On 9/8/23, as witnessed by [redacted], DHS Surveyor, [redacted], RN/Assistant Admin, secured the bag of omelets by taping them shut and dating the package. [redacted] then proceeded to dump the pitcher of Kool-Aid down the sink.

Beginning on 10/24/23, staff education on regulations involving the protection of food/drink by covering, labeling and dating all items will be issued to all staff.

Beginning on 10/24/23, an audit tool will be completed by [redacted], Administrator, or a designated member of management or shift supervisor to assess for all foods/drinks to be secured closed with dates and identification.

This audit will be completed 1 x daily x 2 weeks then 2 x weekly x 1 month then 1 x weekly thereinafter.

Licensee's Proposed Overall Completion Date: *12/05/2023*

Implemented [redacted] - 02/14/2024)

103f - Refrigerator/Freezer Temps

8. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 11:25 a.m., there was no thermometer in refrigerator #2.

At 11:29 a.m., there was no thermometer in freezer # 2.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept [redacted] - 10/27/2023)***

During the following food supply restock (completed every other week), [redacted] located the original thermometer in Refrigerator #2, which had been in the refrigerator the entire time.

On 9/8/23, [redacted], manager, supplied 2 new thermometers for both the refrigerator and the freezer of #2. This was witnessed by DHS Surveyor, [redacted] prior to completion of the inspection.

Beginning on 10/24/23 staff education will be issued to all staff in regards to necessity and reasoning for thermometers in all refrigerators and freezers/coolers.

Beginning on 10/24/23 the facility's current audit tool already in use to check for presence of thermometers will be increased to 1 x daily x 2 weeks then 2 x weekly x 1 month then return to 1 x weekly thereinafter.

This will be completed by [redacted], Administrator or a designated member of management and/or shift supervisor.

Licensee's Proposed Overall Completion Date: *12/05/2023*

Implemented [redacted] - 02/14/2024)

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.

Description of Violation

The last fire drill observed by a fire safety expert was conducted more then 12 months ago.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The facility's annual fire drill with a fire safety expert was conducted on 5/10/2023 at 18:30 with a designated evacuation time of SEVEN (7) minutes. This letter was present and shown to inspectors on the day of the inspection, however, lacked the signature of the fire safety expert.

Immediately after the inspection, Manager [redacted], notified the fire chief of the volunteer fire department that conducted the inspection and requested his signature to complete the letter.

Documentation of the letter, with the chief signature will be submitted with the accepted POC.

Beginning on 10/24/23 staff education will be issued explaining need for annual fire drill with a fire safety expert, documentation of said drill and documentation of the allotted evacuation time for all residents and staff.

Beginning on 10/24/23 an audit tool will be completed by [redacted], Administrator, or a designated member of management to assess for the presence of A. The documentation of the annual fire safety letter B. the signature of the fire safety expert and C. the designated evacuation time of staff/residents.

This audit tool will be completed 1 x weekly x 1 month then 1 x monthly x 6 months

132b Safety Inspection/Fire Drill *(continued)*

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 02/14/2024)

132d - Evacuation

10. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the fire drills held on 8/31/22, 9/15/22, 10/21/22, 11/14/22, 12/29/22, 1/5/23, 2/1/23, 3/1/23, 4/11/23, 5/1/23, 6/13/23, 7/31/23, and 8/29/23.

Plan of Correction ***Accept [redacted] - 11/17/2023)***

The facility's annual fire drill with a fire safety expert was conducted on 5/10/2023 at 18:30 with a designated evacuation time of SEVEN (7) minutes. This letter was present and shown to inspectors on the day of the inspection, however, lacked the signature of the fire safety expert.
All fire drills conducted since the annual drill were completed within the documented time of the letter from the fire safety expert; the non compliance was in the missing signature on the letter.

Immediately after the inspection, Manager [redacted], notified the fire chief of the volunteer fire department that conducted the inspection and requested his signature to complete the letter.

Documentation of the letter, with the chief signature will be submitted with the accepted POC.

Beginning on 10/24/23 staff education will be issued explaining need for annual fire drill with a fire safety expert, documentation of said drill and documentation of the allotted evacuation time for all residents and staff.

Beginning on 10/24/23 an audit tool will be completed by [redacted], Administrator, or a designated member of management to assess for the presence of A. The documentation of the annual fire safety letter B. the signature of the fire safety expert and C. the designated evacuation time of staff/residents.

This audit tool will be completed 1 x weekly x 1 month then 1 x monthly x 6 months

UPDATE:

The audit tool will also include checking for the documented time of each fire drill to ensure that the time is within the designated evacuation time as determined by the fire safety expert.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 02/14/2024)

184a - Resident's Meds Labeled

11. 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 #4 is prescribed [redacted]; subcutaneous solution pen injector 100 unit/ML inject a baseline of 0 units before breakfast and lunch, and two units before dinner + current sliding scale three times daily before meals given when meal in front of patient. Hold if meal will be missed. [redacted] call MD. However, pharmacy label not with medication.

Resident #4 is prescribed [redacted]. However, the pharmacy label was not with medication.

Plan of Correction ***Accept ([redacted] - 10/27/2023)***

Resident #4 label for the [redacted] was located on the original box that the other, unopened, pens of insulin were located in which is the refrigerator where they are required to be kept until opening.
The insulin pen was located in a zip lock bag with the resident's name but no corresponding label.

Immediately, on 9/8/23, witnessed by [redacted], Administrator [redacted], placed a photocopy of the insulin orders for Resident #4 in the zip lock bag with [redacted] insulin pen.

Beginning on 10/24/23 education on presence of pharmacy label on or with medication, such as insulin, will be given to medication technicians.

Beginning on 10/24/23 an audit tool will be completed by [redacted] or a designated member of the facility, such as a med tech, to assess for medication label/orders on or with insulin pens or vials for any residents receiving insulin injections.

This tool will be completed 1 x weekly x 1 month then 2 x monthly every other week x 6 months

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted] - 02/14/2024)

185a - Implement Storage Procedures

12. 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 is prescribed [redacted]. Inhale one [redacted] into nebulizer by mouth every 4 hours as needed for shortness of breath. However, this medication was not available in home.

Resident #4 is prescribed [redacted]; take one tablet by mouth every 4 to 8 hours as needed for pain, do not exceed 3 grams of APAP/24HRs from all sources. However, this medication is not available in the home.

185a - Implement Storage Procedures (continued)

Resident #5 is prescribed [redacted] + [redacted], take by mouth 10ml every 6 hours as needed. However, this medication is not available in the home.

Resident #5 is prescribed [redacted], apply to under breasts and on stomach as needed. However, this medication is not available in the home.

Plan of Correction **Accept ([redacted] - 10/27/2023)**

Resident #2 is receiving services through a hospice agency. The hospice agency manages the physician orders for all hospice-associated medications.
The medication technicians utilize the electronic medication reordering system through our EMAR program to reorder in appropriate time intervals prior to running out of a medication. The pharmacy then sends the request for a prescription refill to the medical provider of the hospice agency. Once received, the pharmacy then delivers the medications.
The medication had been requested for refill by medication technicians prior to depleting the medication supply. The pharmacy had sent refill requests to the hospice agency. The delay was a result of the hospice agency not sending orders to refill in a timely manner.

On 9/8/23, during the inspection, Assistant Admin/RN David Riggle contacted the hospice agency [redacted] Hospice and spoke to clinical manager [redacted], RN to explain the nature of the situation and request urgent refill of medication.
The medication was then delivered to the PCH by the pharmacy on 9/8/23 and administered as directed starting at 20:00 on 9/8/23.

Resident #4 PRN [redacted] order was to have been discontinued and not refilled when she began a new order for a Buprenorphine patch for pain management. The resident was subsequently hospitalized on several occasions for respiratory and/or cardiac failure due to her significant co-morbidities and the discontinuation of oxycodone order was not removed from the EMAR, even though she was no longer receiving the medication and the facility did not have the medication in stock due to this.

Resident #5 PRN [redacted] was not present in the facility as it had been discarded due to expiration date and no recent use in the prior 6 months.
Resident #5 [redacted] was discontinued due to inefffective reaction and she was instead prescribed [redacted] ointment for treatment of skin erruption. The [redacted] was subsequently discarded due to it's discontinuation but the order was not removed from the EMAR.

All discontinued medications for Residents #4 and #5 were documented by discontinue orders by the PCP of each resident, respectively. Documentation will be submitted during POC process.

Beginning on [redacted] staff education will be issued in regards to use of PRNs and the requirement that they be present in the home if the medication is still an active order OR the need for a discontinue order to be obtained when the medication is destroyed.

Beginning on [redacted] an audit tool will be completed by [redacted], Administrator or designated medication technician to audit the medication carts for the presence of PRN orders with presence of PRN medications on hand.

This will be completed 1 x weekly x 1 month then 2 x a month, every other week x 1 month then 1 x monthly on a

185a - Implement Storage Procedures (continued)

continuous basis

Licensee's Proposed Overall Completion Date: *12/05/2023*

Implemented [redacted] - 02/14/2024)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident #2 is prescribed [redacted] Inhale one ampule into nebulizer & inhale by mouth 4 times daily for shortness of breath. However, this medication was not administered on multiple dates and times to include [redacted]. The medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 10/27/2023)***

Resident #2 is receiving services through a hospice agency. The hospice agency manages the physician orders for all hospice-associated medications.
The medication technicians utilize the electronic medication reordering system through our EMAR program to reorder in appropriate time intervals prior to running out of a medication. The pharmacy then sends the request for a prescription refill to the medical provider of the hospice agency. Once received, the pharmacy then delivers the medications.
The medication had been requested for refill by medication technicians prior to depleting the medication supply. The pharmacy had sent refill requests to the hospice agency. The delay was a result of the hospice agency not sending orders to refill in a timely manner.

On 9/8/23, during the inspection, Assistant Admin/RN [redacted] contacted the hospice agency, [redacted] Hospice and spoke to clinical manager [redacted], RN to explain the nature of the situation and request urgent refill of medication.

The medication was then delivered to the PCH by the pharmacy on 9/8/23 and administered as directed starting at 20:00 on 9/8/23.

We have made multiple attempts to discuss this regulation with hospice agencies and the pharmacy.

Starting on 10/24/23 education will be issued to medication technicians about the importance of requesting and receiving medication refills in a timely manner to avoid a resident missing doses.

Beginning on 10/24/23 an audit tool to assess for the presence of hospice-associated medications and the inventory will be completed for all residents receiving hospice services.
This will be completed by [redacted], Administrator, or a designated medication technician.

The audit tool will be completed 1 x weekly x 1 month then 2 x a month, every other week then 1 x monthly on a continuous basis.

187d - Follow Prescriber's Orders (continued)

Beginning on 10/24/23 a poster will be hung in the medication storage rooms for medication technicians to utilize to refer to which resident is on which hospice service and what medications are covered by said hospice agencies, along with direct contact numbers for the hospice agencies.

Licensee's Proposed Overall Completion Date: *12/05/2023*

Implemented (- 02/14/2024)

225c - Additional Assessment

14. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's support plan dated was not updated to include the hospice services provided by Hospice Care that had begun on .

Plan of Correction ***Accept (- 12/06/2023)***

** PLEASE NOTE: As referenced in the resident's RASP, he receives outside services at Life Armstrong, a facility where he also receives his shower as he requests to only shower 1 x weekly.*
Due to this, hospice aides are not involved in his RASP and they are not ordered as part of his plan of care with hospice.
There has been NO significant change or involvement on the part of hospice that would constitute a reason to update the RASP as referenced in the POC report stating "if the condition of the resident SIGNIFICANTLY changes prior to the annual assessment."
was placed on hospice due to qualifying medical diagnosis and his refusal to be transported to the hospital, in the event such a need would arise; Not because of a "significant" change.

Despite this, , the assistant administrator/RN did update the RASP to indicate the hospice agency and phone number.

Documentation of this change along with his newest annual RASP will be submitted during the POC process.

REQUEST WITHDRAW OF VIOLATION.

UPDATE:

A. The immediate corrective action was documented in this POC that it was corrected by , RN, BSN, Asst. Administrator

B Corrective action was completed by , RN, BSN, Asst. Administrator by including the hospice agency name and phone number on the resident's newest RASP.

C. Preventative action will include a monthly audit of RASP to assess for information such as a hospice agency name and phone number, regardless of their level of involvement in the resident's plan of care.
This will be completed by or a designated member of the facility to audit RASP 1 x monthly for this

225c - Additional Assessment (continued)

information and update as needed when this change occurs.

D. Staff education will be issued by [redacted], RN, PCHA for all staff to read in regards to regulation 225c and inclusion of information such as hospice agency and contact information; will be completed by 12/8/2023

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented ([redacted] - 02/14/2024)