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

April 24, 2024

[redacted]
TITHONUS GREENSBURG LP
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/25/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *NEWHAVEN COURT AT LINDWOOD* **License #**: *42936* **License Expiration**: *06/10/2024*

Address: *100 FREEDOM WAY, GREENSBURG, PA 15601*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *TITHONUS GREENSBURG LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *129* **Waking Staff**: *97*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *01/25/2024*

Inspection Dates and Department Representative

01/25/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *131* **Residents Served**: *98*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *19* **Residents Served**: *18*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *98*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

01/25/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/11/2024*

02/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/24/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/23/2024*

Inspections / Reviews *(continued)*

02/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/24/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/30/2024*

02/20/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/24/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/30/2024*

04/24/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/24/2024*

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

182c - Medication Administration

1. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On [redacted] at approximately [redacted], staff member A did not confirm the identity of resident [redacted] prior to administering medications to resident [redacted] As a result, staff member A administered at least 2 of resident [redacted] medications to resident [redacted], which were not prescribed to resident [redacted]

Plan of Correction ***Accept [redacted] 02/16/2024)***

Violation Review: *2600.182.C. Medication administration includes the following activities, based on the needs of the resident:*

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth, or other route as ordered by the prescriber, in accordance with the limitations specified in subsection.
7. Complete documentation in accordance with 2600.187.

Violation Interpretative Statement: *On [redacted], staff member A did not confirm the identity of resident [redacted] prior to administering medications to resident [redacted]. As a result, staff member A administered at least 2 of resident [redacted] medications to resident [redacted], which were not prescribed to resident [redacted]*

Description of the Repair of the Immediate Problem:

182c - Medication Administration (continued)

Resident [redacted] reported the concern to the Wellness Department. Out of an abundance of precaution, Resident [redacted] was sent to the local Emergency Room for further observation and evaluation. The physician was also notified of the report concerning Resident [redacted] Resident [redacted] had no side effects, continued to have normal vitals, no issues, no symptoms, no signs of any issues, and communicated no concerns while in the Emergency Room and upon return. Resident [redacted] returned to our community with no new orders and remained stable with no symptoms/normal vitals thereafter. Staff member A (who was a Licensed Practical Nurse) was questioned about the report and communicated that Resident [redacted] received the correct medication and an error did not occur. Their statement also said that there was no error and medications were administered correctly to Resident [redacted] (see attached). The home reported the concern to Bureau of Human Services Licensing per protocol/policy, and within timeframe, out of an abundance of precaution. Out of an abundance of precaution, Staff member A was also immediately pulled from the medication cart during the investigation and was not permitted to pass medications pending the investigation. No other related concerns or issues were identified/found during our investigation.

Determine / document the Root Cause of the Violation: *Per Resident [redacted], Staff member A did not identify the correct Resident before administering medications.*

Detail Action Steps / System Developed to prevent future occurrence:

a. Teaching or Training? *Staff member A was immediately pulled from the medication cart and was not permitted to administer medications until retraining occurred. Staff member A started employment with the home on [redacted]. Upon employment, Staff member A had 10 days of training on the mediation carts with direct supervision. After the incident on [redacted] the Senior Wellness and Operations Specialist of our company provided retraining to Staff member A on [redacted] (see attached). All medication associates will be retrained on all medication policies and procedures by February 12, 2024 (see attached training/signatures) by the Resident Wellness Director. The Resident Wellness Director will also provide monthly training in the monthly departmental meeting as a refresher/reminder. Record of the training will be kept in the monthly departmental meeting binder in the Administrator's office.*

b. On-going Monitoring? *Immediately following the retraining that took place on [redacted] Staff member A received additional retraining with direct supervision on the medication carts for three weeks. On [redacted], Staff member A did not return and no longer is employed at the home. All medication associates are observed quarterly by the Senior Living Wellness and Operations Specialist for quarterly med observations where they must demonstrate the following to the observer to continue with their certification: medication administered as prescribed, correct medication, correct time, correct resident, and correct route. The next round of quarterly observations for all current staff persons qualified to administer medications are due [redacted], and will be completed by [redacted]. Documentation of all observations are kept in the Resident Wellness Director's office for verification and reference. The RWD also joins the observations to ensure the medication associates are following all processes and procedures in place. Medication associates are also observed to ensure they are providing medication administering to one Resident at a time as well as scanning each medication into the system which is a double check to ensure all medication rights are being followed.*

Designated position responsible and specify target date for correction.

182c - Medication Administration (continued)

Staff member A was retrained on [redacted], as a precaution and was in the middle of receiving additional medication cart retraining. Staff member A did not return on [redacted] and is no longer employed at the home. Monitoring and observations on all medication associates will continue and be ongoing on a quarterly basis. The Resident Wellness Director is responsible for all medication associates by ensuring all medication rights are being followed. All medication associates are trained to follow and adhere to all medication procedures in the home as well as report any issues/concerns immediately. The Resident Wellness Director will retrain all medication associates on all medication policies and procedures by [redacted] (see attached training/signatures). The next round of quarterly observations for all current staff persons qualified to administer medications due [redacted], and will be completed by [redacted]. Documentation of all observations are kept in the Resident Wellness Director's office for verification and reference.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] 04/24/2024)

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

On [redacted] at approximately [redacted], staff member A did not confirm the identity of resident [redacted] prior to administering medications to resident [redacted]. As a result, staff member A administered at least 2 of resident [redacted] medications to resident [redacted] which were not prescribed to resident [redacted]

On [redacted] at approximately [redacted], staff member B administered [redacted] of [redacted] to Resident [redacted] however, Resident [redacted] is prescribed [redacted] subcutaneously at bedtime.

Plan of Correction ***Accept [redacted] - 02/16/2024)***

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

Violation Interpretative Statement: *On [redacted], staff member A did not confirm the identity of resident [redacted] prior to administering medications to resident [redacted]. As a result, staff member A administered at least 2 of resident [redacted] medications to resident [redacted], which were not prescribed to resident [redacted]*

On [redacted], at approximately [redacted], staff member B administered [redacted] of [redacted] to Resident [redacted] however, Resident [redacted] is prescribed [redacted] units subcutaneously at bedtime.

187d - Follow Prescriber's Orders (continued)

Description of the Repair of the Immediate Problem: *Resident [redacted] immediately reported the concern to the Wellness Department. Out of an abundance of precaution, Resident [redacted] was sent to the local Emergency Room for further observation and evaluation. The physician was also notified of the report concerning Resident [redacted]. Resident [redacted] had no side effects, continued to have normal vitals, no issues, no symptoms, no signs of any issues, and communicated no concerns while in the Emergency Room and upon return. Resident [redacted] returned to our community with no new orders and remained stable with no symptoms/normal vitals thereafter. Staff member A (who was a Licensed Practical Nurse) was questioned about the report and communicated that Resident [redacted] received the correct medication and an error did not occur. Their statement also said that there was no error and medications were administered correctly to Resident [redacted] (see attached). The home reported the concern to Bureau of Human Services Licensing per protocol/policy, and within timeframe, out of an abundance of precaution. Out of an abundance of precaution, Staff member A was also immediately pulled from the medication cart during the investigation and was not permitted to pass medications pending the investigation. No other related concerns or issues were identified/found during our investigation.*

Staff member B immediately realized the error and immediately reported the error to the direct supervisor and direct manager per policy should a medication error occur. Staff member B followed all reporting procedures as trained. Resident [redacted] was sent to the local Emergency Room for further observation and evaluation. The physician was also notified concerning Resident [redacted]. Resident [redacted] had no side effects, continued to have normal vitals, showed no signs/concerns, had normal blood sugars, no issues, no symptoms, and communicated no concerns while in the Emergency Room and upon return. Resident [redacted] returned to our community with no new orders and remained stable with no symptoms or concerns thereafter. The medication error was immediately reported to the Bureau of Human Services Licensing per regulatory policy. Staff member B was removed from administering blood sugars and insulins during the investigation.

Determine / document the Root Cause of the Violation: *Per Resident [redacted] Staff member A did not identify the correct Resident before administering medications.*

Staff member B took [redacted] from a bag and accidentally grabbed the [redacted] instead of the [redacted] per order. In addition, per our existing protocol, medication associates are not permitted to administer insulin without a second checker verifying that the [redacted] and units are correct before administering. Staff member B failed to have a second checker verify the [redacted] and units per our existing protocol.

Detail Action Steps / System Developed to prevent future occurrence:

a. Change of practice? *Medication Associates are unable to sign off on any insulin administration without a second signature in electronic medication administration record to ensure verification of the insulin administration was double-checked and accurate before administering. This change was immediately put in place by the Resident Wellness Director the next day after the error occurred (12/19/2023).*

b. Teaching or Training?

187d - Follow Prescriber's Orders (continued)

Staff member A was immediately pulled from the medication cart and was not permitted to administer medications until retraining occurred. Staff member A started employment with the home on [redacted]. Upon employment, Staff member A had 10 days of training on the mediation carts with direct supervision. After the incident on [redacted], the Senior Wellness and Operations Specialist of our company provided retraining to Staff member A on [redacted] (see attached). All medication associates will be retrained on all medication policies and procedures by [redacted] (see attached training/signatures) by the Resident Wellness Director. The Resident Wellness Director will also provide monthly training in the monthly departmental meeting as a refresher/reminder. Record of the training will be kept in the monthly departmental meeting binder in the Administrator's office.

Staff member B is no longer permitted to administer blood sugars and insulins in the home moving forward. The Resident Wellness Director will retrain all medication associates on all medication policies and procedures by [redacted] (see attached training/signatures). The Resident Wellness Director will also provide monthly training in the monthly departmental meeting as a refresher/reminder. Record of the training will be kept in the monthly departmental meeting binder in the Administrator's office.

b. On-going Monitoring? *Immediately following the retraining that took place on [redacted], Staff member A received additional retraining with direct supervision on the medication carts for three weeks. On [redacted] Staff member A did not return and no longer is employed at the home. All medication associates are observed quarterly by the Senior Living Wellness and Operations Specialist for quarterly med observations where they must demonstrate the following to the observer to continue with their certification: medication administered as prescribed, correct medication, correct time, correct resident, and correct route. The next round of quarterly observations for all current staff persons qualified to administer medications due [redacted], and will be completed by [redacted]. Documentation of all observations are kept in the Resident Wellness Director's office for verification and reference. The RWD also joins the observations to ensure the medication associates are following all processes and procedures in place. Medication associates are also observed to ensure they are providing medication administering to one Resident at a time as well as scanning each medication into the system which is a double check to ensure all medication rights are being followed.*

Medication Associates are unable to sign off on the medication administration record without a second signature to ensure verification of all insulin administration was double-checked and accurate before administering. This change was immediately put in place by the Resident Wellness Director the next day after the error occurred ([redacted]).

Designated position responsible and specify target date for correction. *Staff member A was retrained on [redacted], as a precaution and was in the middle of receiving additional medication cart retraining. Staff member A did not return on [redacted] and is no longer employed at the home. Monitoring and observations on all medication associates will continue and be ongoing on a quarterly basis. The Resident Wellness Director is responsible for all medication associates by ensuring all medication rights are being followed. All medication associates are trained to follow and adhere to all medication procedures in the home as well as report any issues/concerns immediately. The Resident Wellness Director will retrain all medication associates on all medication policies and procedures by [redacted] (see attached training/signatures). The next round of quarterly observations for all current staff persons qualified to administer medications due [redacted], and will be completed by [redacted]. Documentation of all observations are kept in the Resident Wellness Director's office for verification and reference.*

On [redacted], Staff member B is no longer permitted to administer insulins/blood sugars in the home moving

187d - Follow Prescriber's Orders (continued)

forward. The Resident Wellness Director will retrain all medication associates on all medication policies and procedures by [redacted] (see attached training/signatures). The next round of quarterly observations for all current staff persons qualified to administer medications due [redacted], and will be completed by [redacted] Documentation of all observations are kept in the Resident Wellness Director's office for verification and reference.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/24/2024)