Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

May 20, 2024

MENTOR ABI LLC

RE: NEURORESTORATIVE PENNSYLVANIA
6816 WEST LAKE ROAD
FAIRVIEW, PA, 16415
LICENSE/COC#: 44663

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/15/2024, 02/16/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *NEURORESTORATIVE PENNSYLVANIA* **License #**: *44663* **License Expiration**: *10/30/2024*

Address: *6816 WEST LAKE ROAD, FAIRVIEW, PA 16415*

County: *ERIE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MENTOR ABI LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/12/2015* **Issued By**: *Fairview Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *14* **Waking Staff**: *11*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/04/2024*

Inspection Dates and Department Representative

02/15/2024 - On-Site:

02/16/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *7*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *6* **Are 60 Years of Age or Older**: *1*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

02/15/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/24/2024*

Inspections / Reviews *(continued)*

04/09/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/29/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *04/16/2024*

04/23/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/29/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *05/31/2024*

05/20/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/29/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident is prescribed The resident was not administered the medication on , at The home became aware of the incident on , at However, this incident was not reported to the department until , at

Resident is prescribed multiple medications to include tablet take 3 tablets by mouth at bedtime; tablet tab take one tablet in the AM at another tab at and another with bedtime; two tabs by mouth twice daily; capsule cap take one capsule by mouth twice daily for anxiety at 2:00 p.m., then at bedtime; tablet tab 1 tablet by mouth twice a day one in the a.m., and one at HS; tablet tab take 1.5 tabs by mouth at . On 1/20/24, the resident was not administered this medication until approximately 12:00 a.m., and suffered an adverse. However, the home failed to notify the department.

Resident is prescribed capsule take one capsule by mouth twice daily for anxiety at 2:00 p.m., then at bedtime. The resident was not administered this medication on at The home became aware of the incident on , at However, this incident was not reported to the department until ,

Resident is prescribed tablet by mouth every day at noon. The resident was not administered this medication on . The home became aware of the incident on , at However, this incident was not reported to the department until ,

Resident is prescribed tab take one tablet by mouth in the a.m., at 8:00 a.m., another at 2:00 p.m., and another with bedtime dose making a total dose of . The resident was not administered this medication on at . the home became aware of the incident on at . However, this incident was not reported to the department until ,

Resident is prescribed tablet tab take one tab by mouth three times daily. The resident was not administered the medication on at The home became aware of the incident on , at However, this incident was not reported to the department until , at .

Resident is prescribed everyday at noon. The medication was not administered to the resident on , at The home became aware of the incident on , at However, this incident was not reported to the department until , at

Resident is prescribed capsule cap one cap by mouth every day. The resident was not administered this medication on The home became aware of the incident on , at However, this incident was not reported to the department until , at

Resident is prescribed apply to shoulder four times daily. The resident was not

16c - Written Incident Report (continued)

administered this medication on , at The home became aware of the incident on , at However, this incident was not reported to the department until , at

Plan of Correction ***Accept - 04/23/2024)***

On the program administrative team reviewed the med errors and noted concerns related to the process. The team was educated at that time by on the requirements. A Med Error Procedure How To and Checklist were created for administrative team to ensure all requirements are completed. The Checklist is submitted to the PD, HSS and QIS for review to ensure all was completed per regulations.

The on-call was new to her position and did not realize she could not wait until the business day to report the errors (the majority occurred on Christmas Day). All med errors were reported immediately on the next business day and the supervisor was educated on the requirement to provide notifications within the required time frames.
On February 26, 2024 created an Allegation of Abuse Checklist. The checklist was reviewed with the administrative team was educated on utilization as well as reporting procedure requirements.
All Allegations of Abuse are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes monthly reviews of the Reportable Incidents to ensure all reporting requirements were met. Documentation of the reviews is kept on the programs Equality Grid.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented - 05/20/2024)

16d - Final Incident Report

2. Requirements

2600.
16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

On , at approximately ., Resident was administered the following medications prescribed for and belonging to Resident , , , , . Resident experienced an adverse reaction that required his admission to UPMC Hamot hospital on 1/20/24. The home reported this incident to the department. However, the home failed to notify the department that resident was released from and then re-admitted to UPMC Hamot hospital on 1/24/24, not discharged until 2/6/24, and was subsequently discharged from the home due to the resident requiring an increased level of care.

Plan of Correction ***Accept - 04/23/2024)***

On 3/22/24 the administrative team was educated by on the requirement to send updates. The Med Error Procedure How To with instructions to send updates if any significant change occurs. The team was educated on utilizing this form on by .
Incidents requiring a DHS reportable are reviewed during the programs Daily Stand-Up. Moving forward the HSS will review the instructions with the team to verify all steps were completed.

A Med Error Procedure how to was created by on ; at that time the team was educated on the new procedure. A checklist to go with it was created by on .
The program began reviewing med error process on the daily stand up utilizing the checklist on 2/27. The checklist

16d - Final Incident Report (continued)

is reviewed with the on-call to ensure none of the steps were missed. The checklists are sent to the team after completion and saved in the file.
All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. The team also meets with the Executive team every other Wednesday to review med errors.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented - 05/20/2024)

42b - Abuse

3. Requirements

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

Description of Violation

On resident was prescribed the following medications to be received at .
On , at approximately 8:00 p.m., resident was administered the following medications prescribed to resident At approximately ., resident began having an adverse reaction to the medications administered to in error. Staff recognized that behavior was altered from baseline, and had a diminished level of consciousness. At approximately 10:29 p.m., the home contacted local emergency services (EMS). Fairview Fire and Rescue was dispatched to the home for an overdose. When EMS arrived on scene resident was lying supine in bed and was unresponsive to verbal and painful stimuli. EMS assessed that Resident s airways had become compromised and required suction while on-site. The resident was transported to UPMC Hamot Hospital. Resident was admitted for lethargy and a change in mental status. Resident was subsequently assessed with:
Resident was discharged back to the home on , at ., Upon returning to the home resident was assessed by staff member A, the in-house Speech Pathologist. Staff member A determined that resident was determined to be not at baseline due to: increased , requiring a full assist for feeding secondary to uncontrollable arm movements, notable challenges with tongue facilitation, signs and symptoms of aspiration on trial of pudding thick liquid water, and challenges in initiating and completing productive throat clearing.
On , at approximately 7:00 p.m., resident was transported to UPMC Hamot Hospital Emergency room. Resident was admitted to the UPMC Hamot hospital at with and at baseline, and moderate too severe , acute , acute with , and . On resident was ordered continuous. On , resident was ordered a On , resident was discharged from UPMC Hamot hospital and transported to Fairview Manor due to resident requiring an increase in level of care.

Plan of Correction ***Accept - 04/23/2024)***

The staff member that had the medication error was suspended at that time pending investigation; following the investigation the staff was terminated. During the staff meeting on the staff were provided education by regarding the impacts of med errors on the participants we serve and the importance of completing

42b - Abuse (continued)

a Medication Pass as its taught. On [redacted] the program implemented an updated Med Error Procedure to include all action steps for staff following a med error; these steps include education, retraining, additional observations and disciplinary action.
All med errors are reviewed on a daily basis with the entire team and on a bi-weekly basis with the executive team to determine action items necessary.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year.

On 4/9/24 the Health Services Supervisor began looking for an outside agency to provide training. [redacted] will be reaching out to local schools and the pharmacy to find a provider. The goal is to obtain an outside trainer to present during the May staff meeting on 5/21/24. In the interim, the HSS will provide training and education to all staff during the staff meeting on 4/22/24.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented [redacted] - 05/20/2024)

182c - Medication Administration

4. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
1. Identify the correct resident.
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 B placed multiple medications for multiple residents into medication cups and indicated on the respective residents' medication administration records that their medications had been administered. However, staff member B did not begin the medication pass of the ordered medications for residents indicated below until approximately 8:00 p.m. These residents include.

Resident [redacted], is prescribed [redacted] tablet tab 1 tab by mouth at bedtime, [redacted] tablet tab 1 tab by mouth three times daily, [redacted] tablet tab 1 tab by mouth at bedtime, [redacted] tablet tab 1 tab by mouth twice daily, [redacted] tablet tab 1 tab by mouth three times daily, [redacted] cap two caps by mouth every day, [redacted] tablet tab 1 tab by mouth twice daily. Resident [redacted] medication administration record indicates an administration date and time of 1/20/24, at 8:00 p.m., for the previously identified medications.

Resident [redacted] is prescribed [redacted] tablet tab 1 tab by mouth twice daily, [redacted] tablet tab 1 tab by mouth three times daily, [redacted] capsule cap one cap by mouth twice daily, [redacted] tablet tab 1 tab by mouth at bedtime [redacted] tab ER 24H tab 1 tab by mouth twice daily, [redacted] mg tablet tab takes [redacted] by mouth twice a day, [redacted] tablet tab 1 tab by mouth twice daily, [redacted] tablet [redacted] give one tablet by mouth in the evening related to [redacted] and recurrent seizures. Resident [redacted]

182c - Medication Administration (continued)

medication administration record indicates an administration date and time of 1/20/24, at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth three times daily, tablet tab 1.5 tabs by mouth three times daily, capsule cap one cap by mouth twice daily, tablet Tab 2 tabs by mouth three times daily, tablet tab 1 tab by mouth four times daily, tablet tab 1 tab by mouth twice daily, tablet tab 0.5 tab by mouth every 12 hours, tablet tab 0.5 tab by mouth at bedtime, capsule cap one cap by mouth at bedtime, tablet tab 1 tab by mouth at bedtime then ER 24 Tab 2 tabs by mouth every evening, tablet tab 1 tab by mouth twice daily you tablet tab 1 tab by mouth every evening. Resident medication administration record indicates an administration date and time of 1/20/24, at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tab by mouth three times daily, tablet tab 1 tab by mouth every day, if you're a tablet tab 1 tab by mouth twice daily, tablet tab 1 tab by mouth three times daily, tablet tab 1 tab by mouth every 12 hours, tablet tab 1 tab by mouth at bedtime. Resident medication administration record indicates an administration date and time of 1/20/24, at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tablet by mouth twice a day, tablet tab 1 tab by mouth every day, tablet tab one tab by mouth twice daily, tablet Tab 2 tabs by mouth twice daily, tablet tab 1 tab by mouth twice daily, tablet tab 1 tab by mouth twice daily, or tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth at bedtime tab 1 tab by mouth twice daily. Resident medication administration record indicates an administration date and time of 1/20/24, at 8:00 p.m., for the previously identified medications.

Plan of Correction ***Accept - 04/23/2024)***

The staff member that had the medication error was suspended at that time pending investigation; following the investigation the staff was terminated. During the staff meeting on 1/23/23 the staff were provided education by regarding the impacts of med errors on the participants we serve and the importance of completing a Medication Pass as its taught. On 2/8/2024 the program implemented an updated Med Error Procedure to include all action steps for staff following a med error; these steps include education, retraining, additional observations and disciplinary action.
All med errors are reviewed on a daily basis with the entire team and on a bi-weekly basis with the executive team to determine action items necessary.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. On 4/9/24 the Health Services Supervisor began looking for an outside agency to provide training. She will be reaching out to local schools and the pharmacy to find a provider. The goal is to obtain an outside trainer to present during the May staff meeting on 5/21/24. In the interim, the HSS will provide training and education to all staff during the staff meeting on 4/22/24.

182c - Medication Administration *(continued)*

Licensee's Proposed Overall Completion Date: *04/23/2024*

Implemented 05/20/2024)

186b - Medication Used by Resident

5. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On at approximately 7:45 p.m., resident was administered prescribed for and belonging too resident . Resident was admitted to UPMC Hamot hospital on , at approximately 10:13 p.m. for and a change of mental state.

On at approximately 7:45 p.m., resident was administered , prescribed for and belonging too resident Resident was admitted to UPMC Hamot hospital on at approximately 10:13 p.m. for and a change of mental state.

On at approximately 7:45 p.m., resident was administered , prescribed for and belonging too resident . Resident was admitted to UPMC Hamot hospital on at approximately 10:13 p.m., for and a change of mental state.

On at approximately 7:45 p.m., resident was administered , prescribed for and belonging too resident Resident was admitted to UPMC Hamot hospital on at approximately 10:13 p.m., for and a change of mental state.

On , at approximately 7:45 p.m., resident was administered , prescribed for and belonging too resident Resident was admitted to UPMC Hamot hospital on , at approximately 10:13 p.m., for and a change of mental state.

On , at approximately 7:45 p.m., resident was administered prescribed for and belonging too resident . Resident was admitted to UPMC Hamot hospital on , at approximately 10:13 p.m., for and a change of mental state.

On , at approximately 7:45 p.m., resident was administered prescribed for and belonging too resident . Resident was admitted to UPMC Hamot hospital on at approximately 10:13 p.m., for and a change of mental state.

On at approximately 7:45 p.m., resident was administered , prescribed for and belonging too resident Resident was admitted to UPMC Hamot hospital on , at approximately 10:13 p.m., for and a change of mental state.

Plan of Correction ***Accept - 04/23/2024)***

The staff member that had the medication error was suspended at that time pending investigation; following the investigation the staff was terminated. During the staff meeting on 1/23/23 the staff were provided education by regarding the impacts of med errors on the participants we serve and the importance of completing

186b - Medication Used by Resident (continued)

a Medication Pass as its taught. On 2/8/2024 the program implemented an updated Med Error Procedure to include all action steps for staff following a med error; these steps include education, retraining, additional observations and disciplinary action.
All med errors are reviewed on a daily basis with the entire team and on a bi-weekly basis with the executive team to determine action items necessary.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. On 4/9/24 the Health Services Supervisor began looking for an outside agency to provide training. She will be reaching out to local schools and the pharmacy to find a provider. The goal is to obtain an outside trainer to present during the May staff meeting on 5/21/24. In the interim, the HSS will provide training and education to all staff during the staff meeting on 4/22/24.

Licensee's Proposed Overall Completion Date: *04/23/2024*

Implemented 05/20/2024)

187a - Medication Record

6. 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 is prescribed tablet tab take one tablet by mouth every evening. Resident was not administered this medication on , at 8:00 p.m. However, Resident January 2024, medication administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed tablet tab take one tablet by mouth every evening. Resident was not administered this medication on at 8:00 p.m. However, Resident January 2024, medication administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed tablet take one tablet by mouth twice daily. Resident was not administered this medication on , at 8:00 p.m. However, Resident January 2024, medication administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed tablet one tab by mouth twice daily. Resident was not administered this medication on , at 8:00 p.m. However, Resident January 2024, medication administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed capsule take one cap by mouth two times a day. Resident was not administered this medication on at 8:00 p.m. However, Resident January 2024, medication administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed tablet take one tab by mouth three times daily. Resident was not administered this medication on , at 8:00 p.m. However, Resident January 2024, medication

187a - Medication Record (continued)

administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed tablet take one tab by mouth twice daily. Resident was not administered this medication on at 8:00 p.m. However, Resident January 2024, medication administration record indicates the medication was administered on the corresponding date and time.

Resident is prescribed tablet by mouth every day at noon. Resident was not administered this medication on . However, the medication's non-administration was not documented on resident December 2023, medication administration record for the corresponding date and time. The field was blank.

Resident is prescribed capsule take one capsule by mouth twice daily for anxiety at 2:00 p.m., then at bedtime. Resident was not administered this medication on at 2:00 p.m. However, the medication's non-administration was not documented on resident 's December 2023, medication administration record for the corresponding date and time. The field was blank.

Resident is prescribed tablet tab one tab by mouth three times daily. Resident was not administered this medication on , at 8:00 p.m. However, resident December 2023, medication administration record indicates the medication was administered for the corresponding date and time.

Plan of Correction ***Accept - 04/23/2024)***

The staff member that had the medication error was suspended at that time pending investigation; following the investigation the staff was terminated. During the staff meeting on 1/23/23 the staff were provided education by regarding the impacts of med errors on the participants we serve and the importance of completing a Medication Pass as its taught. On 2/8/2024 the program implemented an updated Med Error Procedure to include all action steps for staff following a med error; these steps include education, retraining, additional observations and disciplinary action.

All med errors are reviewed on a daily basis with the entire team and on a bi-weekly basis with the executive team to determine action items necessary.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. On 4/9/24 the Health Services Supervisor began looking for an outside agency to provide training. She will be reaching out to local schools and the pharmacy to find a provider. The goal is to obtain an outside trainer to present during the May staff meeting on 5/21/24. In the interim, the HSS will provide training and education to all staff during the staff meeting on 4/22/24.

All Med Techs were assigned training "Right Documentation" by on this is to be completed in Relias by 4/15/24.

Education of Med Error Procedure was completed by on .

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented 05/20/2024)

187b - Date/Time of Medication Admin.

7. Requirements

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

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 at approximately 7:15 p.m., staff member B placed multiple medications for multiple residents into multiple medication cups and indicated on the following residents' medication administration records that their respective medications had been administered. However, staff member B did not begin the medication pass of the residents' medications until approximately 8:00 p.m. These residents include.

Resident , is prescribed tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth three times daily, tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth twice daily, tablet tab 1 tab by mouth three times daily, cap two caps by mouth every day, tablet tab 1 tab by mouth twice daily. Resident s medication administration record indicates an administration date and time of at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tab by mouth twice daily, tablet tab 1 tab by mouth three times daily, capsule cap one cap by mouth twice daily, tablet tab 1 tab by mouth at bedtime tab ER 24H tab 1 tab by mouth twice daily, mg tablet tab takes by mouth twice a day, GM cream apply topically to affected area twice daily, tablet tab 1 tab by mouth twice daily, give one tablet by mouth in the evening related to and recurrent . Resident medication administration record indicates an administration date and time of , at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth three times daily, tablet tab 1.5 tabs by mouth three times daily, capsule cap one cap by mouth twice daily, tablet Tab 2 tabs by mouth three times daily, tablet tab 1 tab by mouth four times daily, tablet tab 1 tab by mouth twice daily, tablet tab 0.5 tab by mouth every 12 hours, tablet tab 0.5 tab by mouth at bedtime, capsule cap one cap by mouth at bedtime, tablet tab 1 tab by mouth at bedtime then 2 tabs by mouth every evening, tablet tab 1 tab by mouth twice daily you tablet tab 1 tab by mouth every evening. Resident medication administration record indicates an administration date and time of at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tab by mouth three times daily, tablet tab 1 tab by mouth every day, if you're a tablet tab 1 tab by mouth twice daily, tablet tab 1 tab by mouth three times daily, tablet tab 1 tab by mouth every 12 hours, tablet tab 1 tab by mouth at bedtime. Resident medication administration record indicates an administration date and time of , at 8:00 p.m., for the previously identified medications.

Resident is prescribed tablet tab 1 tablet by mouth twice a day, tablet tab 1 tab by mouth every day, tablet tab one tab by mouth twice daily, tablet Tab 2 tabs by mouth twice daily, tablet tab 1 tab by mouth twice daily, tablet tab 1 tab by mouth twice daily, or tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth at bedtime, tablet tab 1 tab by mouth at bedtime

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

tablet tab 1 tab by mouth twice daily. Resident medication administration record indicates an administration date and time of , at 8:00 p.m., for the previously identified medications.

Plan of Correction ***Accept 04/23/2024)***

The staff member that had the medication error was suspended at that time pending investigation; following the investigation the staff was terminated. During the staff meeting on 1/23/23 the staff were provided education by regarding the impacts of med errors on the participants we serve and the importance of completing a Medication Pass as its taught. On 2/8/2024 the program implemented an updated Med Error Procedure to include all action steps for staff following a med error; these steps include education, retraining, additional observations and disciplinary action.
All med errors are reviewed on a daily basis with the entire team and on a bi-weekly basis with the executive team to determine action items necessary.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. On 4/9/24 the Health Services Supervisor began looking for an outside agency to provide training. She will be reaching out to local schools and the pharmacy to find a provider. The goal is to obtain an outside trainer to present during the May staff meeting on 5/21/24. In the interim, the HSS will provide training and education to all staff during the staff meeting on 4/22/24.
All Med Techs were assigned training "Right Documentation" by on ; this is to be completed in Relias by 4/15/24.
Education of Med Error Procedure was completed by on

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented - 05/20/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident is prescribed tablet tab take one tablet by mouth every evening. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet tab take by mouth twice daily. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet tab take one tablet by mouth every evening. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet tab take one tab tablet by mouth three times a day. However, the resident was not administered this medication on at 8:00 p.m.

Resident is prescribed tablespoon 12 hour tab 1 tab by mouth every 12 hours. However, the

187d - Follow Prescriber's Orders (continued)

resident was not administered this medication on at 8:00 p.m.

Resident is prescribed tab one tab by mouth every evening. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet tab 1 tab by mouth twice daily. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed capsule take one cap by mouth two times a day. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet one tab by mouth three times daily. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet tab 1 tab by mouth three times daily. However, the resident was not administered this medication on , at 8:00 p.m.

Resident is prescribed tablet tab 1 tab by mouth at bedtime. The resident's January 2024, medication administration record indicates an administration time of 8:00 p.m. However, the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed tablet take 3 tablets by mouth at bedtime. The resident's January 2024, medication administration record indicates an administration time of 8:00 p.m. However, the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed tablet tab take one tablet in the a.m., at 8:00 a.m., another tab at 2:00 p.m., and another with bedtime dose for a total of . The resident's January 2024, medication administration record indicated a bedtime administration time of 8:00 p.m. However, on , the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed Tab two tabs by mouth at bedtime. The resident's January 2024, medication administration record indicated an administration time of 8:00 p.m. However, on the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed two tabs by mouth twice daily. The resident's January 2024, medication administration record indicated an administration time of 8:00 p.m. However, on , the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed capsule cap take one capsule by mouth twice daily for anxiety at 2:00 p.m., then at bedtime. The resident's January 2024, medication administration record indicates a bedtime administration time of 8:00 p.m. However, on the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed tablet tab take 1.5 tabs by mouth at HS. The resident's January 2024, medication administration record indicates an administration time of 8:00 p.m. However, on , the

187d - Follow Prescriber's Orders (continued)

resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed tablet tab one tablet by mouth twice a day one in the a.m., and one at HS. The resident's January 2024, medication administration record indicates an administration time of 8:00 p.m. However, on the resident was not administered this medication until approximately 12:00 a.m. The resident suffered an adverse reaction.

Resident is prescribed tablet 1 tab by mouth twice daily. However, the resident was not administered this medication on at 8:00 p.m.

Resident is prescribed tablet every day at noon. However, the resident was not administered this medication on

Resident is prescribed capsule take one capsule by mouth twice daily for anxiety at 2:00 p.m., then at bedtime. However, the resident was not administered this medication on at 2:00 p.m.

Resident is prescribed tab take one tablet by mouth in the a.m., at 8:00 a.m., and another at 2:00 p.m., and another with bedtime dose making a total dose of . However, the resident was not administered this medication on at 2:00 p.m.

Resident is prescribed tablet tab take one tab by mouth three times daily. However, the resident was not administered the medication on at 12:00 p.m.

Resident is prescribed every day at noon. However, the medication was not administered to the resident on .

Resident is prescribed capsule cap one cap by mouth every day. However, the resident was not administered this medication on

Resident is prescribed to shoulder four times daily. However, the resident was not administered this medication on , at 12:00 p.m.

Resident is prescribed take one tablet by mouth twice a day. However, the medication was not administered on , at 8:00 p.m.

Resident is prescribed take one tablet by mouth twice a day. However, the medication was not administered on , at 8:00 a.m.

Resident is prescribed take one tablet by mouth twice a day. However, the medication was not administered on , at 8:00 a.m.

Plan of Correction ***Accept 04/23/2024)***

The staff member that had the medication error was suspended at that time pending investigation; following the investigation the staff was terminated. During the staff meeting on 1/23/23 the staff were provided education by regarding the impacts of med errors on the participants we serve and the importance of completing a Medication Pass as its taught. On 2/8/2024 the program implemented an updated Med Error Procedure to include

187d - Follow Prescriber's Orders (continued)

all action steps for staff following a med error; these steps include education, retraining, additional observations and disciplinary action.
All med errors are reviewed on a daily basis with the entire team and on a bi-weekly basis with the executive team to determine action items necessary.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. On 4/9/24 the Health Services Supervisor began looking for an outside agency to provide training. She will be reaching out to local schools and the pharmacy to find a provider. The goal is to obtain an outside trainer to present during the May staff meeting on 5/21/24. In the interim, the HSS will provide training and education to all staff during the staff meeting on 4/22/24.
All Med Techs were assigned training "Right Documentation" by [redacted] on [redacted]; this is to be completed in Relias by 4/15/24.
Education of Med Error Procedure was completed by [redacted] on [redacted].

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented [redacted] - 05/20/2024)

188b - Medication Error Reporting

9. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident’s designated person and the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] tablet take 3 tablets by mouth at bedtime; [redacted] tablet tab take one tablet in the a.m., at 8:00 a.m., another tab at 2:00 a.m., and another with bedtime. The resident's medication administration record indicated a bedtime administration time of 8:00 p.m. On [redacted] the resident was not administered the medication until approximately 12:00 a.m. The resident suffered an adverse reaction. However, the home failed to notify the prescribing physician.

Resident [redacted] is prescribed [redacted] two tabs by mouth twice daily; [redacted] capsule cap take one capsule by mouth twice daily for anxiety at 2:00 p.m., then at bedtime. The resident's medication administration record indicated a bedtime administration time of 8:00 p.m. On [redacted], the resident was not administered the medication until approximately 12:00 a.m. The resident suffered an adverse reaction. However, the home failed to notify the prescribing physician.

Resident [redacted] is prescribed [redacted] tablet tab 1 tablet by mouth twice a day one in the a.m., and one at HS. The resident's medication administration record indicated a bedtime administration time of 8:00 p.m. On [redacted], the resident was not administered the medication until approximately 12:00 a.m. The resident suffered an adverse reaction. However, the home failed to notify the prescribing physician.

Resident [redacted] is prescribed [redacted] tablet tab take 1.5 tabs by mouth at HS. The resident's medication administration record indicated a bedtime administration time of 8:00 p.m. On [redacted], the resident was not administered the medication until approximately 12:00 a.m. The resident suffered an adverse reaction. However, the

188b - Medication Error Reporting (continued)

home failed to notify the prescribing physician.

Plan of Correction ***Accept - 04/23/2024)***

On 2/26/2024 the program administrative team reviewed the med errors and noted concerns related to the process. The team was educated at that time by Katy Peterson on the requirements. A Med Error Procedure How To and Checklist were created for administrative team to ensure all requirements are completed. The Checklist is submitted to the PD, HSS and QIS for review to ensure all was completed per regulations.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The QIS completes an annual analysis of all med errors in October of each year. The team also meets with the Executive team every other Wednesday to review med errors.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented - 05/20/2024)

227a - Support Plan 30 Days

10. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident assessment and support plan dated , indicated an assessment of supervision need as, extensive with a description of supervision needs that indicates in part, participant is to utilize a seat belt alarm when seated in wheelchair for safety and to reduce falls. On , at approximately 5:00 p.m., resident fell from wheelchair onto the floor. However, resident did not have seat belt alarm activated at the time of falling from wheelchair.

Plan of Correction ***Accept - 04/23/2024)***

Participants assessments were completed by and a new RASP was finalized on . All staff were trained on the RASP by . All program staff will be educated by and on every individuals support plan by . The program will conduct spot audits to ensure staff are following RASPs to care for participants.

Spot checks began the week of 2/25. They were to be completed 1x weekly for 4 weeks, bi-weekly for 8 weeks and monthly for 3 months. They are being documented on a form created by . The tracker is being completed by the administrative team of the building and will be submitted to upon completion and kept in the DHS file on the shared drive.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented - 05/20/2024)